University of Alberta

The Tension between Making a Decision to Stay or Leave and Becoming a Mother for Women who Experience Intimate Partner Violence during Pregnancy

by

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ABSTRACT

Intimate partner violence and abuse is a serious health issue for women. Not only must women manage the social, physical and psychological consequences of the violence and abuse, but they must also decide whether to stay or leave the relationship. Based on my clinical experience, I think that when intimate partner violence and abuse occur during pregnancy, these two tasks become more complex because of their potential impact on the health of the unborn child and on the woman's ability to undertake the developmental work associated with pregnancy. Little is written about how pregnancy influences the ability of women to address the challenges of violence and abuse, and thus nurses lack guidance about how to intervene at this time. The aim of my research was to address this gap by developing a description of how women made the decision to stay or leave an abusive intimate partner relationship when the violence and abuse took place during pregnancy.

Using an interpretive description research design, I conducted interviews with 8 women who were 18 years of age and older, who had experienced intimate partner violence and abuse during pregnancy, and who subsequently left the relationship. Data were generated and analyzed concurrently. Theoretical sampling, data generation, and analysis continued until no new data were obtained.

The violence and abuse frequently occurred over long periods of time, often beginning prior to pregnancy and continuing after the birth of the baby. Participants reported that despite the abuse, they tried to make the relationship

work so the father would be present for the baby. This period of "trying to make the relationship work" often took place over many months or years, in hopes that their partners' abusive behaviours would eventually change. A crisis of some kind, such as a call by a neighbor to the police, provided an opportunity for some of the women to reflect on their experiences and realize that the violence and abuse they were experiencing was not their fault. There was a tension between decisions related to the developmental work associated with pregnancy and decisions related to the management of their partners' abusive behaviour. The women in this study each said they eventually realized that they needed to put their baby's needs ahead of her own desires to maintain a relationship with their partners, but this was not a linear process, nor was it a decision that was made with finality in mind. Sometimes the women tested to see if the relationship was really over by going to shelters but also asked their partners to attend counselling, or asked other family members to intervene in some way. The women were questioning if they needed to be a single parent. The women who decided to leave the relationship permanently, often despite limited resources, decided they had "had enough". The decision to leave was underpinned by the woman's belief that she could make a better life with her child(ren) on her own.

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My heartfelt thanks are extended to the women who volunteered their time and shared their stories with me. The honesty, hope, and determination each woman displayed during her interview was a source of inspiration, and allowed me to appreciate how complex her decision-making process was. Their assistance has enhanced my knowledge and skills for working with women (who experience intimate partner violence and abuse) and their families. I applaud the women's determination to make a better life for themselves and their children.

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CHAPTER ONE

Introduction

Intimate partner abuse and violence during pregnancy is a serious issue because it has long term consequences for the health status of women and their children. Of concern to nurses and all health care professionals are the pervasive implications of intimate partner violence and abuse on women's physical, psycho-social and emotional health. How pregnant women take on and define their roles as mothers is affected by their experiences of intimate partner violence and abuse, and this in turn influences how pregnant women feel about themselves as new mothers. The aim of my research was to develop an in-depth description of pregnant women's decision-making related to staying or leaving an abusive intimate partner relationship.

Research with pregnant women who have experienced intimate partner violence and abuse has focused on issues related to leaving the abusive partner. One area that researchers have just begun to address is how pregnant women make decisions related to staying or leaving an abusive intimate partner relationship, with particular emphasis on how this decision influences and is influenced by efforts to define their maternal and parenting roles (Lutz, 2005a, 2005b; Lutz, Curry, Robrecht, Libbus, & Bullock, 2006). In a study done by Lutz, et al., the authors reanalyzed data from two previous studies and proposed a construct called "double binding" that integrates the developmental process of becoming a mother with the process of maintaining a relationship with an abusive intimate partner. While the study highlighted the conflict that women experience,

knowledge about how pregnant women make decisions to stay or leave an abusive intimate partner relationship was lacking. More recently, research has focused on the decision-making process women use when making a decision to seek shelter from intimate partner violence and abuse (Stork, 2008). While Stork's research is helpful for counsellors who are trying to design interventions for women who go to shelters, it does not address the how the women make the actual decision to stay or leave an abusive relationship during pregnancy.

In this study I addressed these gaps by exploring women's own perceptions of becoming a mother, while at the same time making decisions about staying in or leaving an abusive intimate partner relationship. The difference between my study and research done by others was that I asked women directly about their decision-making to stay or leave. The study enabled me to explore the decision making process in greater depth, particularly the tension the women experienced in their decision-making.

Researcher's "Voice"

My research focus is derived from my clinical practice as a nurse, which encompasses women's health issues across the life span and has a specific focus on female adolescents and women of childbearing age. My world view of nursing is influenced by feminist approaches that are threaded through my practice in my interaction with all patients and in how I think about offering programs and services for women and families that values women's perceptions of their lives. My thinking has been particularly influenced by feminist standpoint theory, because the researcher seeks to focus on locating knowledge or inquiry in

women's experiences (Naples, 2003; Harding, 1986; Smith, 1987). My clinical background includes over 30 years as a registered nurse including roles in remote nursing stations, public health centres in urban and remote communities, telephone triage, youth clinics, emergency room care for sexual assault survivors, and ambulatory care programs delivering high risk prenatal care. In my clinical practice I have cared for women who have experienced intimate partner abuse. From my experience, whether the abuse took the form of a sexual assault or a combination of physical, sexual, or emotional abuse, all the women needed care that was sensitive to their needs, respectful of them, and that returned power to the women, in order to help them regain their battered self-esteem. Early in my practice I struggled to know how to care for these women; I wondered why some women seemed to recover from the experience of abuse, while others struggled in a downward spiral that often involved alcohol and/or street drug use and subsequent abuse by other intimate partners. In my practice many women who were abused by their intimate partners developed physical and mental health problems. I am particularly interested in women who have become pregnant while in an abusive relationship, because of the implications for three lives, those of the woman, the child, and the father. My intent is to further the research into intimate partner violence by keeping an open mind and offering a different way to think about abuse and violence against women that takes into account a view of the woman within the context of her family relationships. "Only by keeping an open mind and thinking differently about the problem of violence against women will

we be able to develop new approaches, new theories, and new paradigms that will reduce violence against women" (Tjaden, 2004, p. 1246).

Background to the Problem

Nursing as a discipline has a unique way of evaluating the health-related needs of individuals that is not replicated by any other discipline (Banks-Wallace, Despins, Adams-Leander, McBroom, & Tandy, 2008). The development and utilization of a strong knowledge base to guide practice are essential if nursing is to remain relevant in the health care arena and capable of addressing pressing health issues for venerable populations, such as women who experience intimate partner violence and abuse (Banks-Wallace, et. al).

In this dissertation I provide a description of the experience of women during the period when they are deciding whether to stay in or leave the intimate partner relationship and a discussion of how this decision is influenced by perceptions about becoming a mother and perceptions about the relationship with the father of the unborn child. This experience is sometimes referred to as "double-binding" because the woman is torn between her relationship with her unborn child and her relationship with the father of the child (Lutz, 2005a, 2005b; Lutz, et al, 2006). My review of the literature indicated that few researchers have examined the viewpoint of women making decisions about staying or leaving an abusive intimate partner relationship during pregnancy (Lutz, 2005b; Lutz et al, 2006).

Abuse during pregnancy is associated with numerous health problems. These health problems further emphasize the importance of understanding the

experience of abused pregnant women. Potential physical health problems related to intimate partner violence and abuse at any time may include: (a) gynaecologic problems such as sexually transmitted infections, urinary tract infections, vaginal infections, and painful intercourse; (b) central nervous system problems such as back pain, headaches, fainting, and seizures; and (c) chronic stress-related health problems including hypertension, loss of appetite, abdominal pain, and increased susceptibility to viral and bacterial infections (Woods, Hall, Campbell, & Angott, 2008). The mental health consequences of intimate partner violence and abuse include: anxiety disorders, postpartum depression, and posttraumatic stress disorder (Kendall-Tackett, 2005; Urquia, O'Campo, Heaman, Janssen, & Thiessen, 2011; Woods et al., 2008). When the abuse takes place during pregnancy, it is associated with additional potential complications including: uterine rupture, increased maternal and fetal mortality and long-term sequelae (fetal growth restriction, preterm delivery, and low birth weight) (El Kady, Gilbert, Xing, & Smith, 2005; Janssen et al., 2003; Murphy, Schei, Myhr, & Du Mont, 2001).

Despite these health consequences, pregnant women are reluctant to disclose abuse. Lutz et al., (2006) reported that barriers to disclosure during pregnancy included: fear of partner retaliation, fear of being reported to child protection services, and a desire to maintain a positive public perception of a normal family. The desire for a normal family cannot be overstated. Wuest and Merritt-Gray (2008) interviewed a community sample of women who stayed in relationships that were previously violent, but that had become non-violent. They

reported that the women in their sample did not want the relationship to end; they just wanted an end to the violence.

When women go to a shelter, one must not assume that the woman has left the relationship. Stork (2008) found that women sought shelter from intimate partner violence and abuse for many reasons that were linked together over long periods of time. The decision of whether to stay or leave an abusive relationship is not based on a single event, but rather a sequence of events. Stork's work adds to the limited research about how women actually make decisions to stay or leave an abusive partner, but neither Stork nor Wuest and Merritt-Gray addressed pregnant women's decision-making. Further research into women's decisions to stay or leave an abusive intimate partner relationship during pregnancy would add much needed information that nurses and other health care providers could use to construct interventions to support pregnant women during the decision-making process. In the next section, I discuss how using a feminist lens helps me to understand the woman's position.

Feminist Lens

In this study I wanted to explore the tension between the developmental tasks of pregnancy and the feminist notion of how power and control influences women's experiences of intimate partner violence in pregnancy, specifically the decision to stay with or leave their male partner. Thorne and Varcoe (1998) suggest that researchers using a feminist approach need to "… draw upon and apply knowledge about perspective and bias, using reflexivity and critical scholarship as mechanisms to make explicit their interpretive claims" (p. 491).

Because feminism can mean different things to different people I will begin by outlining how I used feminism in the current study. When I first began to write my research proposal I reviewed the literature related to feminism, and feminist standpoint was a good fit for what I was proposing to do because it focused on women's experiences as told from their own perspectives; it would enable multiple dimensions of the experience to be explored and to challenge taken-for granted assumptions of the experience (Naples, 2003). I was not aware of feminist intersectionality. Since I have been writing up my findings, there has been a shift in the intimate partner violence research literature to endorse this perspective (Kelly, 2009; Rogers & Kelly, 2011). The explosion of research in this area has resulted in both a deeper understanding of the complexities of the experience of leaving an abusive partner, and recognition of women's strengths. I will explore how this shift in thinking has evolved in Chapter 6. In the next section I discuss my use of violence and abuse terminology in the study.

Violence and Abuse Terminology

The research and practice fields use numerous terms to describe women's experiences of violence and abuse. In my review of the literature I have used the terminology that each author has chosen. The variation in terminology likely reflects the wide variation in the disciplinary perspectives of researchers in this field (i.e., criminal justice, counselling, public health, mental health, and community-based advocates) (Kilpatrick, 2003). It is problematic, however, because it leaves the reader with the impression that terms are sometimes used interchangeably. It is beyond the scope of this dissertation to explain all of the

differences between the terminologies; instead I wish to acknowledge that there is an ongoing debate about which term to use.

The World Health Organization (WHO) uses the United Nations (UN) definition of violence against women: "as any act of gender-based violence that results in, or is likely to result in physical, sexual, or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life" (2010). This is a very broad definition that includes the meaning of a variety of terms that have been used in different countries. Intimate partner violence, family violence, domestic violence, woman abuse, battered woman, wife abuse, wife assault, spouse abuse, and spousal violence are all terms used to describe a pattern of abuse of a woman by her partner, family members, caregivers, or others with whom she has intimate, romantic, or familial relationships (Graffunder, Noonan, Cox, & Wheaton, 2004; Society of Obstetricians and Gynaecologists of Canada [SOGC], 2005). Intimate partner violence has been defined as a pattern of coercive behaviour designed to exert power and control over a person in an intimate relationship through the use of intimidating, threatening, or harassing behaviour (Shoffner, 2008).

I have used the term "intimate partner violence and abuse" to describe the phenomenon I studied. To clarify how I used the terms of violence and abuse in my study, I will first define violence, and then explain how the terminology of violence and abuse is used in the literature. Johnson and Ferraro (2000) reviewed the literature on domestic violence from the 1990's and suggested that two themes

need to be addressed by current researchers. The first theme involves making distinctions about the context of the violence. Addressing these distinctions helps to clarify the theoretical and practical understanding of the nature of partner violence and assist in the development of more sensitive and comprehensive theories. Secondly, issues of control have been conceptualized predominately in terms of men trying to control women. Particularly in the feminist literature, the interplay of violence, power and control in relationships is complex.

Both of these themes have been addressed in the later work of Johnson (1995, 2006). Johnson (2006) found that battering takes different forms in intimate relationships, ranging from intimate partner terrorism to common couple violence. Johnson and Leone (2005) identify four types of individual partner violence based on the dyadic control context of the violence: (a) intimate partner terrorism, (b) situational couple violence, previously called common couple violence, (c) violent resistance, and (d) mutual violent control. The first two types are not defined by the nature or the frequency of violent acts but solely in terms of the level of control within the relationship in which they are embedded (Johnson & Leone). In formulating his typology, Johnson (2006) reviewed the research on intimate partner violence from various sources, including shelters, police and law enforcement, feminist literature, and family therapy literature. Intimate partner terrorism refers to the attempt to dominate one's partner and to exert control over the relationship by using power and control tactics; violence is one of these tactics (Johnson & Leone). Situational couple violence is not embedded in a pattern of controlling behaviour; rather a conflict results in an argument or a situation

escalates to violence (Johnson & Leone). Intimate partner terrorism is perpetrated almost exclusively by men, whereas violent resistance is found almost exclusively among women. The two types of violence are not defined by the nature or frequency of violent acts, but in terms of the relationship-level of control in which they are embedded, i.e., the context (Johnson & Leone). Violent resistance is seen when the individual is violent but not controlling, but the partner is violent and controlling (Johnson, 2006). Mutual violent control is rarely seen, but is when both the individual and partner are violent and controlling (Johnson, 2006). While these last two categories are useful for theoretical discussions the terms are difficult for clinicians to operationally define and measure; consequently the terms do not translate well in the practice or research settings. This inability to operationalize the terms has been demonstrated by Frye, Manganello, Campbell, Walton-Moss, and Wilt (2006), who in an analysis of a subset of data collected for a case control study of femicide, did not find a clear cut distinction between the different categories of intimate partner violence.

Sharps, Laughon, and Giangrande (2007) define perinatal violence as "...violence that occurs before, during, or after pregnancy, or up to one year postpartum (the childbearing year) and is committed by an intimate partner: spouse, ex-spouse [or] boyfriend ..." (p.105-6). They acknowledge that "although this definition does not include emotional and financial abuse outside the context of physical and sexual violence, it has utility because intimate partner violence is conceptualized as a risk factor for other health problems regardless of disease or syndrome" (p. 106). Perinatal intimate partner violence can be conceptualized as a

risk factor for maternal, fetal and infant health disparities (Peterson et al., 1997). Recent critiques by Kilpatrick (2003) and Tjaden (2004) have highlighted that defining violence as violent acts, such as physical assault, sexual assault and threats of physical and sexual assault, misses out on the very concerning behaviours of stalking and psychological and emotional abuse. "By broadening the definition of violence against women to include stalking and psychological and emotional abuse and by examining the interrelationship among these components of violence and abuse, we will be better able to explain the conditions under which violence and abuse against women are likely to occur, especially in the context of intimate relationships" (Tjaden, p. 1247). Using a broad definition, that includes both violence and abuse takes into account the variety of physical, sexual and mental behaviours that are used by male partners to control their female partners.

I chose to use the phrase "intimate partner violence and abuse" to refer to all forms of intimate partner abuse, including but not limited to violence. I did not want to inadvertently exclude women who were experiencing emotional or verbal abuse who may not have volunteered for the study if they thought that I only wanted to include women who were being physically or sexually assaulted.

Intimate Partner Violence and Abuse

Current research indicates that spousal violence involves multiple violent incidents, rather than a discreet incident (Statistics Canada, 2006). Women suffer more emotional consequences than men as a result of spousal violence (Statistics Canada, 2002). According to the General Social Survey (GSS) on Victimization,

653,000 Canadian women experienced intimate partner violence in 2005-2006 (Juristat, 2007). Using data from Edmonton, Ratner (1993) found the incidence rate of wife abuse was 10.6% and psychological abuse was 13.1%. In Ratner's study, nearly all the physically abused wives were also psychologically abused.

Some women who experience intimate partner violence and abuse seek shelter in various community agencies and leave the relationship. The Canadian statistics on women who seek shelter from abusive relationships are a compilation of women who have fled abusive relationships and women with mental health needs who are experiencing a housing crisis. This compilation makes it difficult to have a clear picture of the number of women who are making decisions to stay with or leave an abusive partner. Furthermore statistical reports do not distinguish pregnant and non-pregnant women in shelters. The Alberta Children's Services *Women's Emergency Shelter Program Review* (2006) reports that 5,998 women and 5,488 children were accommodated in 2004; the number of pregnant women is not reported.

Research over the past 20 years had documented the increased risk for violence in pregnant women (Campbell, 2004; Gazmararian et al., 2000; McFarlane, Parker, Soeken & Bullock, 1992; Rhatigan, Moore & Street, 2005). Measuring the true prevalence of intimate partner violence in the pregnant woman population is complicated by variations in definitions and reporting strategies. Using data from the British Columbia lower mainland Janssen et al. (2003) reported a prevalence rate of 1.2% for exposure to physical violence by an intimate partner during pregnancy. Burch and Gallup (2004) analyzed the data

collected from domestic violence prevention and treatment programs and found that both the frequency and severity of male initiated violence against women were twice as high when the women were pregnant. Using data from Saskatchewan, Muhajarine and D'Arcy (1999) reported that 5.7% of women reported experiencing physical abuse during pregnancy in the second trimester, and 8.5% of women reported experiencing abuse within the 12 months preceding the interview in the third trimester. Saltzman, Johnson, Gilbert, and Goodwin (2003) examined the prevalence and risk factors for physical abuse in 16 states and found that pregnancy was not the risk factor for intimate partner violence, but the majority of women experienced a continuation of the abuse, while new abuse (that started in pregnancy) was less common. More recent research (Campbell, et al., 2006) has identified that pregnant and postpartum women whose partners' exhibit controlling behaviours are potentially more at risk than women whose partners are verbally abusive, but women, themselves, did not recognize that they were at greater risk. Further research is needed to assist health care providers in understanding how these differences are played out in the lives of pregnant women.

Purpose of the Study

The purpose of this research study was to generate a description of how women make decisions about staying or leaving an abusive intimate partner relationship when the violence and abuse takes place during pregnancy.

Overview of Chapters

In this chapter, I outline the knowledge that guided development of the research purpose. I also present current definitions of intimate partner violence and abuse, and justify my use of the term intimate partner violence and abuse for the purpose of this study. In Chapter Two I review two bodies of literature: women's experiences of violence and abuse during pregnancy and decision-making about whether to stay in or leave an abusive intimate partner relationship. The section on violence and abuse during pregnancy includes implications of intimate partner violence and abuse for women's health and the health of their unborn children, and current knowledge of maternal role theory. I integrate and critique these two bodies of literature and identify logical gaps that framed my research question. Chapter Three provides a description of the methods I used to conduct this study. Chapter Four provides a description of the research findings. In Chapter Five, I relate the findings to the current literature. Finally, in Chapter Six, I outline implications for clinical practice, education, research, and social policy.

CHAPTER TWO

Introduction

In this chapter I review two bodies of literature: women's experiences of intimate partner abuse during pregnancy and decision-making about whether to stay or leave an abusive intimate partner relationship. The section on abuse during pregnancy will include current knowledge of feminist standpoint theory, maternal role theory and implications of intimate partner violence for women's health and the health of their unborn children. There is very little literature on the decision to stay or leave an abusive relationship during pregnancy so this section will also include literature on this topic in other populations. I will integrate and critique these two bodies of literature and identify logical gaps that framed my research question. The chapter concludes with my research question.

Women's Experiences of Intimate Partner Abuse during Pregnancy

Over the past 20 to 30 years there has been a growing body of research on intimate partner violence and abuse but relatively few studies involving women who experience violence and abuse during pregnancy (Sharps, Laughon, & Giangrande, 2007). I looked for literature that had addressed whether women decided to become pregnant thinking that it might make an abusive situation better ("He won't hurt me if I am pregnant"), but could not find any studies in this area. Most studies of pregnant women who experience intimate partner violence and abuse have focused on the abusive behaviours with little discussion of other dimensions of the relationship, such as communication, or other forms of conflict resolution. For example, Cloutier et al. (2002) studied the relationship between

socio-demographic factors and satisfaction with their relationships among abused women. They found that the most frequent type of abusive behaviour was verbal aggression, followed by minor violence, then by severe violence (Cloutier et al.).

Campbell et al. (2006) explored the context within which conflict occurs in abusive intimate partner relationships before, during, and after pregnancy. They found that almost half the women described their relationships as not abusive, even though they reported experiencing behaviours that would be defined as abuse on standardized abuse screening instruments. The researchers identified role expectations –the way the couple conducted themselves - as a factor in whether the women interpreted what happened to them as abuse or not. While this study aids in our understanding of how women perceive the conflict in their intimate partner relationships during and after pregnancy, the findings were obtained through screening in outpatient settings and thus were limited-by the setting and the screening questions. Nevertheless, this study demonstrates that abuse may be perceived in different ways by health care professionals and the women who experience the abuse.

The study of violence between partners over the past 40 years has changed from a dichotomous analysis between men and women, where men are the perpetrators and women are the victims to a more complex interactive perspective (Eisikovits & Bailey, 2011). In a study of therapists who worked with heterosexual couples who had experienced partner violence, the researchers found that the gender-related controversies were still being reflected in both the self-perceptions of male and female therapists and of their clients. Of significance was

the lag in knowledge translation, where the therapists were offering care that reflected the dichotomy between the genders, rather than the present day understanding of more blurred gender positions for both men and women (Eiskovis & Bailey). Feminist standpoint theory can be used by nurses to better understand women's gender role in their relationships and to understand how this this role influences the decision to stay in or leave an abusive intimate partner relationship during pregnancy.

Feminist Standpoint Theory

Feminist standpoint theory is a useful analytical tool to engage in discussions about pressing political issues, particularly those facing women who are oppressed or marginalized. Hawkesworth (1999) states the strength of feminist standpoint theory lies in its use as an analytical tool with which to "confront the contentious assumptions most deeply entrenched in our conceptual apparatus, fostering sustained critique of problematic assumptions that impair an objective grasp of the complex issues confronting contemporary political [and social] life" (p. 153). One of the main criticisms that feminists have of traditional scientific knowledge is that it tends to be written by men and reflect dominant male social values. Sandra Harding (2003) questions the notion that there is only one reality. She suggests that to represent the human experience accurately society needs to consider a variety of perspectives, male and female, rich and poor, as well as people of colour and those who have different political and religious beliefs than the mainstream culture.

Feminist standpoint perspectives can enable the researcher to bring out the perspectives of women's experiences; both shared and different experiences. Using a feminist lens will enable appreciation of how differences in pregnant women's experiences influence their decision making in intimate relationships to be appreciated. I would argue that a feminist perspective allows for a greater variety of individual experiences to be envisioned and appreciated. This appreciation enables a broader view of the context of the experience and subtle changes in behaviour. Specifically this study will use feminist standpoint theory to examine pregnant women's decision making to stay in or leave an abusive intimate partner relationship. It will enable the woman's viewpoint of her decision-making; that is, how she evaluates how important it is for her to have her partner accept the pregnancy and provide her with emotional support. Little has been written about this part of the experience from women's own perspectives. Feminist standpoint theory can enable the context of the lived experience to be explored, in particular, how men's and women's social roles have evolved over time, and continue to change within the context of societal and personal definitions of maternal and paternal roles. The experience of "double binding" brought to light by Lutz et al. (2006) is similar to women's experience of "the outsider within". Feminist standpoint theory offers a way for the woman who is "the outsider within" to tell others about her experience. Harding (1987) identifies that women occupy an "outsider within" position that affords a social location from which particular experiences of culture, poverty, or violence may bring into focus questions and issues that are not visible or legitimate within the conceptual

frameworks, cultures, or practices of dominant institutions or culture. In order for the voice of the woman who lives the experience of the "outsider within" to be heard she needs to "... create a hybrid space, a social location from which her standpoint can be in dialogue with but not assimilated into more dominant perspectives" (Lenz, 2004, p. 114). The practice of the researcher as privileged person speaking for or on behalf of the less privileged person reinforces the oppression of the group spoken for and interferes with the researcher's ability to reveal social and political truths or realities that are not apparent to someone more fully assimilated into dominant ideologies. "Feminist theorists working from standpoint epistemologies can, by considering the complex circumstances in which marginalized people experience oppression, produce analyses that are both sensitive to individual perceptions and cognizant of the wider social forces that organize experience " (Lenz, 2004, p. 100). To understand women's lives feminist researchers recognize that a variety of methodological techniques are necessary to eradicate sexist bias in research and find ways to capture women's voices that are consistent with feminist ideas (Campbell & Wasco, 2000).

In a review of contemporary feminist literature in nursing Plummer and Young (2010) identify "…a shared set of common epistemological features, including valuing women's lived experiences as a legitimate source of knowledge, appreciating the influence of context in the production of knowledge, respecting the role of reflexivity in the research process, rejecting traditional subject-object dualisms, and attending to gender, power, and transformative social action" (p. 307). The production of knowledge in the social sciences is shaped by the culture

and society in which we live. In order to create knowledge that is more complete and less systematically biased toward one group or the dominant group's views, we need to ground each view of the social world in the standpoint from which it is created and to engage in active dialogue among those developing the picture from different social positions (Sprague, 2005). One of the strengths of standpoint epistemology is how it can assist researchers to understand and respond to the relationship between knowledge and power. In feminist standpoint, knowledge is shaped by the social context of the knower. The essence of feminist standpoint theory lies in its focus on the multiple dimensions of women's lives. This focus can enable the researcher to better understand the lived experience of pregnant women who experience intimate partner violence who come from different socioeconomic, cultural and religious backgrounds but have in common the experience of being abused by an intimate partner.

According to Longino (1993) the strength of standpoint theory lies in its ability to help reframe the terrain in which epistemology is done so that the knowledge is less removed from the actual conditions in which we strive to produce knowledge. Feminist standpoint theory was initially developed in response to debates surrounding Marxist feminism and socialist feminism in the 1970s and early 1980s. "In reworking Marx's historical materialism from a feminist perspective, standpoint theorists' stated goal is to explicate how relations of domination are gendered in particular ways" (Naples, 2007, p. 580). Feminist standpoint theory is a broad categorization that includes diverse theories including: Nancy Hartsock's (1983) *feminist historical materialist perspective*,

Donna Haraway's (1988) analysis of *situated knowledge*, Dorothy Smith's (1987, 1990a, 1990b) *everyday world sociology*, and Patricia Hill Collins's (1990) *black feminist thought*. Sandra Harding (1986) is credited with creating the category of feminist standpoint theorists as a general approach that argues for the importance of situating knowledge in women's experiences. Standpoint theorists raise important questions about the way power influences knowledge in a variety of fields. In response to Susan Hekman's (1997) assessment of feminist standpoint theory Nancy Hartsock, Patricia Hill Collins, Sandra Harding, and Dorothy Smith all emphasize that feminist standpoint theorizing is designed to investigate how power works rather than some apolitical or abstract "truth". Harding points out that it is the relation between power and knowledge, rather than how to justify the truth of feminist claims to more accurate accounts of reality, that is of concern to feminist standpoint thinkers.

Much of the early research about violence against women has been informed by a feminist ideology, feminist were able to revolutionize the way people think about violence against women (Tjaden, 2004). Naples argues that women's standpoint should not be equated with women's viewpoint or actual experiences, but rather standpoint refers to a way of conceptualizing reality that reflects women's interests and values and draws on women's own interpretations of their own experiences. Similarly, Hartsock (1983) identifies that women's lives provide a related but more adequate epistemological terrain for understanding power. "Women's different understanding of power provides suggestive evidence that women's experience of power relations, and thus their understanding, may be

importantly and structurally different from the lives and therefore the theories of men" (Hartsock, p. 151). This is an important viewpoint that can add insight into the lives of women who experience intimate partner violence by enabling women's experiences to be understood within the context of social influences on the women's lives, in particular the power difference between the woman and her male partner. Rather than view standpoints as individual traits, most standpoint theorists attempt to locate standpoint in specific community contexts with particular attention to the dynamics of race, class, and gender.

This view of standpoint will guide me for data collection and analysis, so that I can remember to contrast my experience as care provider with the woman's experience of living with abuse. The idea of a standpoint as the view that can be constructed from a specific social location is revealed in Sandra Harding's analysis of the elements of a standpoint. Sandra Harding (1998) provides one of the clearest ideas of a standpoint as a view that can be created from a specific location in her analysis of the elements of a standpoint. Harding (1998) identifies 4 elements that contribute to constructing a standpoint: (a) actual location in nature; (b) interests with regard to that location; (c) discourses which provide tools for making sense of the location; and (d) position in the social organization of knowledge production. She illustrates how these elements come together to inform a standpoint by using it as a framework to analyze how gender creates distinctive standpoints for constructing knowledge. Firstly, all people are located in specific places in a nature that is heterogeneous and socially organized. Secondly, different locations in nature – different bodies and different places in

the environment – create differences in people's interests and desires. Thirdly, people vary in their access to discourses that Harding (1998) refers to as metaphors, models and narratives that they can use to interpret their experience. The fourth element of a standpoint relates to its position in the organization of the production of knowledge. "Harding's four-pronged specification of physical location, interests with regard to that location, discourses that provide tools for making sense of the location, and the social organization of knowledge production is a template for analyzing any standpoints as places from which to build an understanding of the social world" (Naples, p. 70). Harding (1986) and Smith (1992) argue for starting standpoint analysis from the lived experiences and activities of women that have been left out of the knowledge production process, rather than start inquiry with the abstract categories and a priori assumptions of dominant social institutions.

Although pregnancy and the transition to parenthood are normal developmental, emotional, and cognitive processes, the associated changes may be viewed as new stressors that could destabilize intimate partner relationships (Lutz, 2005b). Hobel, Goldstein and Barrett (2008) suggest that researchers need to take a broader long term view of these stressors in light of individual-level traits and experiences (e.g., perception of stress, resilience, and commitment to the pregnancy), and community-level stressors (e.g., safety, access to resources) that may influence abuse.

Anderson (2009) conceptualizes gender as a multilevel system of difference and inequality that involves cultural beliefs and the distribution of

resources at the macro level, patterns of behaviour, and organizational practices at the interactional level, as well as self-identities at the individual level. Anderson's resulting multilevel theory of gender has three components (identity, interaction, and social structure) that can aid understanding about the role that gender plays in abusive relationships. "Understanding the gender dynamics of partner-perpetrated abuse requires (among other things) theorizing gender in terms of the expectations and accountability for performances of hegemonic masculinity and normative femininity familiar from ethnomethodological accounts of gender" (Brush, 2009, p.1428). Anderson (2010) also suggests that in order to understand how conflict, power, and violence influences individual and family members it is important for family counsellors and other researchers to move from focusing on individuals and to look at the relational connections between adult partners, parents and children. These suggestions lend support to my decision to explore the connections between the woman, her partner, and their child. I explored with women how they described their decision making around staying or leaving their abusive male partners.

In the next part of this chapter I discuss the normal developmental tasks of pregnancy and how I think these tasks are challenged by the experience of intimate partner violence and abuse.

Maternal Role

The development of what it means to be a mother is the primary developmental task of pregnancy. Maternal role theory was developed in the 1970's and 1980's to address questions related to women's and families

experiences of pregnancy, childbirth, and early parenting. Two of the most well-known theories are Regina Lederman's theory of *Psychosocial Adaptation in Pregnancy* (1984, 1996; Lederman & Weis, 2009) and Ramona Mercer's theory of *Becoming a Mother* (1986, 1995, 2004, 2006).

Psychosocial adaptation to pregnancy. Lederman's (1984, 1996) theory of *Psychosocial Adaptation in Pregnancy* focuses on labour and delivery as a key element of the pregnancy experience by assessing prenatal dimensions of maternal development. The seven dimensions on which maternal development are measured include: (a) the woman's acceptance and adaptation to pregnancy, (b) her development and formation of a parenting relationship with her developing child, (c) her past and present relationship with her own mother, (d) her relationship with her husband/father of the pregnancy, (e) her knowledge and preparation for the events of labor, (f) her anticipation of how she will cope with her fears involving pain and loss of control during labor, and (g) the way(s) she copes with her fears of loss of self-esteem during labor (Lederman, 1984, 1996; Lederman & Weis, 2009). These dimensions were identified using a set of standardized questions developed by Lederman with two groups of women, at two different points in time, in the United States. Lederman developed standardized sets of questions to obtain information in these areas. I think there are two problems with Lederman's conceptualization of maternal development. First, although labor and delivery are important, it is only a part of the pregnancy experience. Second, the use of standardized questions could inadvertently restrict the communication between nurses and mothers. The use of the standardized

questions sets up a pattern of communication that is led by the nurse. In this situation, the woman may be reluctant to raise any concerns, such as violence or abuse that may not be included in the questions. Even though Lederman and Weis updated the theory in 2009 based on research with military families, they did not address intimate partner violence as an influence on the couple's relationship during pregnancy.

Becoming a mother. Mercer's work (1986, 1995, 2004, 2006) builds on research about the maternal role that has evolved over the past thirty years from Rubin's (1961, 1977, 1984) work on maternal role attainment. This evolution has led to an understanding that rather than attainment of maternal role at a set time, maternal role is a more individual experience that occurs at different times for different women; meaning that becoming a mother is a dynamic and non-linear process rather than a static experience (Mercer, 2004).

Mercer's theory of becoming a mother is a middle-range theory that links research and practice, and is situated within the systems theory of Bronfenbrenner with its nested circles of microsystem, mesosystem, and macrosystem (Meighan, 2002; Mercer, 1986, 1995, 2006). According to Mercer, maternal role attainment/becoming a mother is a process that involves four stages:
(a) anticipatory – begins in pregnancy, includes the psychological and social adjustments to pregnancy; (b) formal – begins with the birth of the infant, includes learning and taking on the mother role; (c) informal – begins as the mother makes her new role fit with her existing lifestyle; and (d) personal - occurs when the woman internalizes her role and experiences confidence and competence

in the maternal role (Meighan, 2002; Mercer, 1995). Progression through the stages is influenced by social support, stress, family functioning, and the relationship between the mother and her intimate partner (Meighan, 2002; Mercer, 1995). Maternal role attainment/becoming a mother is achieved within the microsystem through the interactions of the mother, infant, and father.

Mercer was influenced by Rubin's work in the 1960's and 1970's, in which she described maternal identity. Rubin's (1975) research on the maternal experience identified that "the maternal tasks are profoundly influenced by the qualitative relationship of husband and wife" (p. 59). She emphasized the importance of the father in maternal role attainment by stating that he helps to "diffuse tension in the mother-infant dyad" (Mercer, 1995, p. 15).

> Acceptance of the coming of a child requires an awareness of the personal sacrifices and the willingness to let go of some ego-satisfying pleasures…. A man who is aware of his wife's acceptance of the self-deprivations and dangers in childbearing and in childbirth in order to give him and their union a child has a profound experience in joy and humility. He works harder to provide for and to protect his wife and coming child. A woman who is aware of her husband's appreciation, reordering of priorities and efforts in husbanding readily forgoes the pursuit of the now trivial pleasures and objectives and binds in with greater love for her husband in the maternal tasks of pregnancy (Rubin, 1984, p. 61).

Based on Rubin's work, Mercer described maternal identity in relation to four tasks and six basic assumptions (Meighan, 2002; Mercer, 1995). The tasks were: (a) ensuring safe passage for self and baby, (b) seeking acceptance of and support for self and baby, (c) "binding-in" to her infant (similar to attachment), and (d) giving of self. These tasks are based on six major assumptions:

1. Maternal role attainment/ becoming a mother (acquisition of a mother's *core self* as a mother) through lifelong socialization. Perceptions of herself as a mother and how her infant's responses to her are influenced by her life experiences.
2. Perception of self as a woman is influenced by socialization, innate personality characteristics, and her developmental level.
3. The infant demonstrates the mother's competence in the maternal role through growth and development.
4. The infant is an active partner in the development of the maternal role by both affecting and being affected by the maternal role.
5. The intimate relationship the mother shares with the father of her baby contributes to role attainment in a way that cannot be duplicated by any other support person.
6. Maternal identity and maternal attachment are interdependent.

Mercer (1995) also highlighted that only the male partner can fulfill the father role. Within this discussion it becomes apparent that the mother's relationship with the father of her infant begins in pregnancy and is intertwined with the woman's experience of becoming a mother. Other research on the male

partner's experience of becoming a father, acknowledged the shift in thinking about the father role begins in pregnancy, rather than after the birth of the child (May, 1978). Previously it was thought that the male partner did not become a father until after the baby was born. May's research on including the male partner in prenatal classes helped nurses to understand how the male partner can be involved in supporting his female partner, the mother of the unborn child.

The mother – father relationship has important meaning for the woman as she moves through the stages of becoming a mother. Ptacek (1999) found that having a child increases a woman's dependency on her male partner, and for him, it can become a point of leverage by which he exercises control over her by threatening to harm the baby. It is possible that women who are in emotionally or physically abusive relationships with the father of their unborn child experience ambivalence or conflicted feelings that can interfere with their ability to progress through the stages of maternal role attainment of becoming a mother, but few studies have addressed this aspect of women's experiences. Further research could enhance health professionals' understanding of how to support women's decision-making in abusive relationships.

Mercer's theory has been a standard component of education for maternity nursing since its development, and thus provides a theoretical context that informs the way nurses engage in therapeutic communication with women who are pregnant. Mercer's approach differs from that of Lederman in that the nurse encourages the woman to raise her own concerns, and does not rely on

standardized questioning approach. *Becoming a Mother* places the woman's experience and decision-making within the context of the woman's own life story.

Mercer's (2004) research has been used to study partner relationships. For example, Sank (1991) used Mercer's theory in her dissertation to study prenatal role attainment for Black American mothers and fathers. She found that fetal attachment was more important for fathers than mothers, and that self-concept was the best predictor of parental role attainment for both fathers and mothers. A major recommendation of her study was that health care practitioners should be working with both parents to help them gain the knowledge and skills necessary to attain their respective roles. Although Sank found that maternal role attainment is linked to paternal role attainment, she did not examine issues of violence in intimate relationships. Researchers in Australia, Emmanuel, Creedy, St. John, Gamble & Brown (2008) interviewed women following childbirth and found that maternal role development is complex and can be adversely affected by older maternal age, relationship issues related to short-term partner relationships or being married, and inadequate social support. These researchers found that social support was the most important factor influencing maternal role development in childbearing women. This finding is significant in light of the changing social profile of childbearing women who may postpone first births, who have increased participation in the workforce, and variations in family patterns where women may be a single parent or in a cohabiting relationship (Emmanuel, et al.). This study shows that individual social circumstances also have the potential to influence women's experiences of becoming a mother.

The research on intimate partner violence and becoming a mother acknowledges that the stress of living with an abusive partner can lead to health issues for the woman and her unborn child, but to date there has not been research on how this stress influences a woman's decision making and how she enacts her role as a mother. More recently maternal role attainment has been explored with mothers of medically fragile infants (Miles, Holditch-Davis, Burchinal & Brunssen, 2011; Holditch-Davis, Miles, Burchinal & Goldman, 2011). These researchers examined which components of maternal role attainment influenced the quality of parenting for medically fragile infants and found that interventions are needed to help mothers develop confidence and competence in their maternal role. They found that women who did not develop confidence were at risk for not bonding with their infant and this could be a potential marker for child abuse. Their findings give us insight into the process of becoming a mother, showing that different stresses can influence how women take on the maternal role.

Critique of Mercer's theory. Mercer's theory implies that at some point "becoming a mother" can actually be attained. Walker, Crain, and Thompson (1986) critiqued Mercer's (1986) theory. They agreed that becoming a mother was indeed a process but questioned whether this role was actually ever attained, and argued that one evolved as a mother as one's children grow older. I agree with this critique, but I also think it is important, to remember that Rubin (1961, 1967, 1984) and Mercer's (1986, 1995) work reflected the values of the time in which it took place. Rubin (1984) and Mercer's (1986, 1995) research occurred at the same time as the women's liberation movement (consciousness raising) was

advocating for women to have more equal roles in their marriages and society (Naples, 2003). The women's liberation movement brought a focus to the roles of women both inside and outside of the home, to dual roles of wife and mother (inside) and worker (outside). This consciousness raising enabled women to take on the role of paid worker outside the home, but the role of wife and mother was also present. Mercer's (1986, 1995, 2004) work helped to build awareness about the components of the maternal role and the developmental tasks of pregnancy, and it highlighted the importance of the woman focusing on the fetus and on planning for one's life as a new mother. Sometimes Mercer's theory of becoming a mother has been incorrectly interpreted as a baby-centric nursing theory by midwives (Parratt & Fahy, 2011). They have focused their critique on earlier versions of Mercer's theory (1981), rather than the updated version (2005). Koniak-Griffin (1993) reviewed the literature on maternal role attainment from the 1960s to the 1990s, she identified that although the research had found behavioral and affective dimensions of maternal role attainment, it had been limited by the focus on the early postpartum period. Helping mothers to identify their competencies has been shown to enhance positive infant nurturing and development and should be a priority for nursing care from when the woman confirms the pregnancy throughout the first 18 months of the child's life (Koniak-Griffin, Logsdon, Hines-Martin, and Turner (2006).

Neither Lederman nor Mercer directly addressed how the context of violence and abuse affected women's achievement of the developmental tasks of pregnancy, but I think they still provide an important theoretical background

against which to explore women's decision-making about whether to stay or leave an abusive partner during pregnancy. I will discuss this point further in Chapter 5.

Binding/binding-in/double binding. Although the concepts of binding, binding-in, and double-binding provide a starting point for understanding the experience of pregnant women, and new mothers who experience violence and abuse, I do not think they adequately reflect the disruption in the development of the parenting roles associated with abuse. Normally, binding-in implies that each parent is also supporting each other in the development of their roles as parents, but this phase may be missing in an abusive relationship.

As noted above, the third developmental task of maternal role focused on binding-in as the mother attachment relationship with her fetus. Landenburger (1989, 1998) studied intimate partner violence and extended the notion of binding to include the partner. She found that the abusive partner competed with baby for the mother's attention. Lutz et al. (2006) put these two ideas (binding-in and binding) together and identified a phenomenon they called double-binding. Double-binding is characterized by the woman binding-in to her fetus while at the same time binding-in with her partner. In the context of the abusive relationship, double-binding may give rise to conflict, as the woman feels torn between her baby and her partner.

> Double binding-in refers to the simultaneous and often conflicting psychological and social process of binding-in to the unborn child and binding-in to the abusive intimate partner that women experience as they

> engage in the developmental tasks of becoming a mother while living in an abusive partner relationship (Lutz et al, p. 123-4).

Landenburger's (1989, 1998) midrange nursing theory of the process of entrapment in and recovery from an abusive relationship provides some additional insight into the dilemma posed by double-binding. Her study focused on the abusive intimate partner relationship, but did not look at pregnancy. She noted that during the early stage of the abusive relationship, the woman is trying to build a loving and long-term partnership and generally tries to ignore or minimize the beginning signs of controlling behaviour by her partner. As the abuse escalates, the woman sees herself as putting up with the violence to preserve the relationship. During this stage the woman may experience depression, low self-esteem, substance abuse, and posttraumatic stress disorder (PTSD). If the woman is able to disengage from the relationship, she actively seeks help to end the abuse and sometimes the relationship, and from Lutz's perspective (2005a, 2005b) one could say that the binding-in with the partner stops, at least temporarily. The woman's help-seeking may shift from family and friends to more formal systems, but this is also a time when she is at risk of harassment from the abuser (Campbell & Campbell, 1986). During the final phase of the recovery process, the woman works through her experience of abuse. During this stage the woman may continue to experience mental health sequelae from abuse such as PTSD, even though she is no longer being abused or harassed (Davies, Ford-Gilboe & Hammerton, 2009). Frequent symptoms of PTSD include anxiety, hypervigilence, stress-related physical symptoms, and sleeping problems (Campbell & Campbell,

1986). Kendall-Tackett (2005) also suggests that the chronic stress associated with abuse increases the individual's risk for illness in the form of irritable bowel syndrome, depression, and sleep disturbances as a consequence of chronic inflammation.

Lutz et al. (2006) suggest that further research should explore theoretical issues related to pregnancy and motherhood, such as becoming a mother and violence related constructs such as double-binding. "Becoming a mother assumes a positive, supportive, intimate partner relationship, yet pregnancy and being in an abusive relationship often coexist and present competing behavioural demands and social expectations for women" (Lutz et al., 2006, p. 119). I think that although double-binding does capture the idea that the mother is trying to have a relationship with her baby and her partner at the same time, it is problematic because it does not include development of the parental roles of the mother and the father, which is one of the central problems with intimate partner violence and abuse. Double-binding also fails to account for some of the contextual pieces related to becoming a mother, such as the woman's own personal history in her family of origin and the history of her relationship with her partners (past and present).

Father role. Although both Mercer and Rubin said that the father was needed in order to support the mother in the development of the maternal role, neither author addressed the development of the father role. In Sandelowski and Black's (1994) secondary data analysis of interview data with expectant couples they found that couples "… engaged in a process that typically involved first

being oblivious to the biological fact of conception, and then suspecting, considering the evidence for seeking to confirm, and finally accepting the fact of pregnancy" (p. 604). In my master's study of adolescent pregnancy, I found that young women passed through stages as they confirmed their pregnancies: (a) suspecting the pregnancy, (b) confirming the pregnancy, (c) making decisions about the pregnancy, (d) living the reality of the pregnancy, and (e) experiencing a changed life (Banks, 1993). I found that the father of the baby (husband/boyfriend) was also involved in these steps. His engagement or lack of engagement (no longer in relationship or denies paternity) in the process of acknowledging the pregnancy impacted the woman's experience of acknowledging the pregnancy. No specific studies were found discussing the role of the male partner who is abusive as he transitions to the father role in pregnancy. However, a research group in Sweden (Edin, & Högberg, 2002; Edin, Lalos, Högberg, & Dahlgren, 2008; Edin, Högberg, Dahlgren, & Lalos, 2009) published a number of articles from interviewing professionals (counsellors and midwives) who had worked with couples who experienced intimate partner violence. Their most recent study (Edin, Dahlgren, Lalos, & Högberg, 2010) interviewed 9 women who were receiving care from a midwife and revealed that the women had experienced severe intimate partner violence during pregnancy. While their research is helpful for understanding how the women "kept up a front" (researcher's emphasis) for the health care professionals, and the men were characterized as both ordinary and deviant it does not shed light on the decision making process the women used.

Couple roles. Mercer and Rubin are relatively silent on the transition to parenthood. Lutz and May (2007) noted that there is some literature on parenthood after birth, which documents a decline in marital satisfaction in the first year after birth. More recent studies have examined the impact of pregnancy, birth, and the postpartum period on the couple relationship (Lutz and May). Of most relevance has been the research on the male partner's experience (May, 1978; Hall, 1991) and the transition of the couple relationship in their adjustment to their parenting roles (Kalmuss, Davidson, & Cushman, 1992). It is an accepted view that all couples experience transient increases in emotional distress and decreases in personal well-being and marital satisfaction as they become parents (Lutz & May). Further research into the mother's relationship with the father of her unborn child can help health care professionals understand how the couple copes with changes in their roles and how abuse may impact their intimate partner relationship. Of relevance to this research is how changes in the couple's relationship influence the decision-making process of the pregnant woman in an abusive relationship.

This section has reviewed literature on becoming a mother also known as maternal role attainment. I have argued that the developmental tasks of pregnancy emphasize the mother wanting a relationship with the father of her unborn child and discussed the difficulties that abuse places on this process. I think these conflicting aspects of the relationship have important implications for how women make decisions to stay or leave an abusive intimate partner relationship.

Implications of Intimate Partner Violence and Abuse for Well-being

A variety of studies have investigated the health implications of abuse during pregnancy (Murphy et al, 2001; Woods, Hall, Campbell, & Angott, 2008). Intimate partner violence and abuse has pervasive impacts on women's lives, from the early days of dating relationships through pregnancy and new parenting roles through to later life in the senior years. Research over the past 20 years has found that women of all ages, cultures, and socioeconomic groups experience violence in their lives (Campbell, 2004). Harrykisson, Rickert, and Wiemann (2002) examined the abuse of young mothers and found that pregnant women may experience escalating levels of violence during pregnancy and during the 18 months following delivery. Gazmararian et al. (2000) found that violence commonly occurs during pregnancy and may be associated with unintended pregnancies. Ruzzo and Pirlott (2006) found that abortion can be a marker for intimate partner abuse, but focusing on it as a marker is problematic because it distracts attention away from the main issue – the violence and abuse. Woo, Fine and Goetz (2005) sampled an urban, racially and socioeconomically diverse population, and found that 17.2% of women concealed pregnancy terminations from their partners. The domestic abuse was twice as high in this group and may have adversely affected open communication with partners. But of concern, is that a subset of women did not tell their partner about the pregnancy because of their fear of personal harm.

Because of the identified risks for harm to the mother and fetus, efforts have been directed at screening for abuse during pregnancy. However, screening

for abuse does not address the "unique contextual circumstances" imposed by pregnancy (Lutz et. al., 2006, p. 118).

Clinical sequelae of Intimate Partner Violence and Abuse. Stark (2000), a social researcher, reported that "the clinical sequelae of domestic violence were first revealed by medical research which showed that an initial episode of partner assault is typically followed by further injury and by an evolving configuration in which relatively minor physical problems, isolation, and increasingly complex psycho-social problems are interwoven" (p.985). Among battered women, an "adult trauma history" is accompanied by a history that includes medical problems linked to violence, intimidation, and control. Identified medical and social problems include miscarriages and abortion, alcohol and drug abuse, sexual assault, increasing isolation, poverty, attempted suicide, child abuse, and mental illness. Stark also suggests that a pattern of intervention by health and social service professionals that is characterized by neglect, minimization, inappropriate medication, pseudo-psychiatric labelling, and punitive interventions also contributes to "battered woman syndrome" (p. 985).

> Work with battered women outside the medical complex suggests that *physical violence may not be the most significant factor about most battered relationships.* In all probability, the clinical profile revealed by battered women reflects the fact that they have been subjected to an ongoing strategy of intimidation, isolation, and control that extends to all areas of a woman's life, including sexuality; material necessities; relations with family, children, and friends; and work (Stark, p. 986).

The male partner uses sporadic, even severe, violence with the female partner as an effective control strategy. The unique profile of the 'battered woman' arises as much from the deprivation of liberty that is implied by coercion and control, as it does from violence and resultant trauma (Stark).

> Reconstructing a woman's experience through the prism of coercive control helps everyone involved in the case, including the survivor of the assault, appreciate the central paradox of battering – that women who are highly intelligent and mentally healthy in other respects function, within the context of the batter's power, in what appears to the outsider to be a dependent, even self-destructive manner (Stark, p. 1025).

These perspectives are reflective of the research that has taken place over the past 30 years. A new emerging area of research is women's use of violence and differences in defining gender roles (Flinck & Paavilainen, 2010; Johnson 2006). Although this research is controversial, it is agreed that the consequences of violence between men and women show that women are more likely to be injured than men, more likely to be sexually assaulted than men, more vulnerable to post traumatic symptoms, less financially independent, and usually are more tied to child rearing responsibilities (Eisikovits & Bailey, 2011).

Responses of the Health System to Intimate Partner Violence and Abuse.

Even though health care professionals have acknowledged that intimate partner violence and abuse is a serious health issue for women there continues to be an inadequate response (Tower, 2007). The reasons for this inadequate response are multifaceted and complex. Tower conducted a review of the literature on

screening for intimate partner violence and found that health care professionals lack knowledge about intimate partner violence, have attitudes and beliefs that decrease the likelihood of women disclosing current violence and abuse and prevent them from responding in an effective manner, and cite time constraints as limiting effective responses. It is disconcerting that women described how health care professionals were disinterested, sometimes ignored the women's complaints, offered unhelpful advice, or openly doubted the women's experiences (Bacchus, Mezey & Bewley, 2003; Chang & Martin, 2001; Chang et al., 2005; Chang et al., 2006).

MacMillian et al., (2009) carried out a large randomized controlled trial in the Canadian context and found that there was not sufficient evidence to support screening all women for intimate partner violence and abuse in health care settings. One of their concerns was the inability to prove that screening did not cause more harm than good for women. They found that women preferred self-report approaches over face to face questioning. Their findings are contrasted by Svavarsdottir (2010) who found that abused women in Iceland preferred to disclose physical abuse in a face-to-face interview. Consequently, I think that helping women who experience intimate partner violence and abuse needs to be addressed in a broader way rather than focusing on screening in outpatient and clinic settings.

A common response has been to medicalize and label women's experiences with a medical diagnosis similar to a chronic health condition. The medical diagnosis is important because it may provide access to services for

women who develop stress-related disorders such as PTSD, but it could be problematic if it obscures and discounts the context of the of women's lives. Labelling can also lead to shame, stigma, and discrimination against this group of women, which ironically serves to further isolate the women and hide the identity of the perpetrators (Tower, 2007), and could be used by abusive partners to gain access or custody of children. Researchers can address this misplaced viewpoint by expanding the research agenda to focus on the women's experiences of their own lived realities.

Decision-making about Whether to Stay or Leave an Abusive Intimate Partner Relationship

In this section, I will review the current research on women's decision-making in abusive intimate partner relationships. The process women in abusive relationships use to make decisions to stay or leave their partner has been studied from several different angles, including moral theory (Belknap, 1999), stages of change (Burke et al., 2001; Burke et al., 2004; Kramer, 2007), and decision-making models (Stork, 2008). Most of the decision-making research has focused on women who are already mothers. Only the work of Lutz et al. (2006) focuses on deciding to stay or leave an abusive relationship during pregnancy. As a result I will discuss key articles on deciding to stay or leave and abusive relationship regardless of when it takes place, and then I will discuss how I think pregnancy further complicates this process.

Decision-making in context. Decision-making is a very complex process. In the intimate partner violence and abuse literature decision-making has been

theorized in various ways, depending on the professional background of the researcher and the focus for interacting with women who have experienced intimate partner violence and abuse (Anderson & Saunders, 2003; Kim & Gray, 2008; Lerner & Kennedy, 2000; Rhodes & McKenzie, 1998). In this study, I was interested in how decision-making is influenced by the woman's previous experiences (context). Rhodes and McKenzie (1998) found that no single decision-making theory explains why battered women stay in abusive relationships. "[I]t becomes clear that neither personal or violence demographics have clear predictive validity in determining whether a woman would remain with or leave a violent partner, and that a single personality trait or group of characteristics may not be found that can explain the tenacity of a battered woman in remaining with her violent partner" (p. 396).

Factors affecting the decision to stay or leave an abusive relationship

The science of decision-making is based on philosophy and economics where it was developed to provide rules that people should follow given their beliefs and values (Stork, 2008). Psychologists further adapted the knowledge of decision-making to create optimal models that could be used to study decision-making as a process (Stork). Stork studied women's decision-making about whether to stay or leave an abusive relationship by constructing a model which showed how the woman gradually acquires the knowledge and skills to leave an abusive relationship. The strength of the study is the recognition that each woman's decision-making is influenced by a multitude of factors including: (a) decision events, (b) generation of options, (c) influences on option generation,

(d) decision factors (commitment, experience, time horizon, and nature of violent events), and (e) components that influence a sequence of decisions (number of decision events, decision outcomes). Stork suggested that

> ...aggregated data of battered women's experiences can help us note patterns, structures, and common features in decision models as well as junctions and features that are highly individual to make better sense of the ways women organize their lives around violence with intimate partners (p. 2).

Thus the decision to leave is highly complex and ranges from removal from an abusive situation by the police to deciding to leave on one's own terms. Stork based her model on the belief that women's decision-making is influenced by their commitment to the relationship, which is an important feature of the decision to seek shelter from intimate partner violence and abuse. Commitment is the basis for demonstrating the role of time and experience, and the consequent change in beliefs about the relationship, and for making the decision to seek shelter. This model is helpful in enabling researchers and clinicians to better understand how women make decisions to seek shelter from an abusive partner. Similarly, Haggerty, Kelly, Hawkins, Pearce, & Kearney (2001) found women's beliefs about abuse severity, danger, and their ability to control abuse cannot be fully comprehended by exploring the discrete acts they experience. While Haggerty et al. highlight the need for further research to identify factors that influence women's beliefs; there remain gaps in our understanding of how the relationship with the male partner and pregnancy influence the woman's decision-making.

Socio-cultural values

Kelly (2009) found that battered Latino women engaged in a complicated risk-benefit analysis in which they balanced the socio-cultural expectations related to being a mother against the abuse they experienced. "Balancing" required that they appear to be a "normal" family when in public, despite the abuse occurring behind closed doors, and, at the same time, guard the safety of their children. Three key areas were identified: managing the abuse, making decisions to stay in or leave the abusive relationship, and disclosing their abuse to health care professionals. Focusing on their maternal role was a primary influence for the mothers as they strove to prioritize, protect, and provide for their children; focusing on their mother role enabled the women to develop coping strategies despite the abuse. While Kelly's research helps to explain how Latino mothers focus on their mother role in making decisions to leave an abusive partner, it is focused on the mother balancing the needs of her children with those of her abusive partner. Her research does not explain the decision-making that begins in pregnancy.

Beliefs about separation and divorce. Belknap (1999) said that for some abused women, the decision to stay or leave an abuse relationship is essentially a moral conflict related to beliefs and values about separation and divorce. The woman feels morally conflicted between her own needs and the needs or values of her family. "Women in this study described the decision to leave or stay as a conflict between the threat to self if they stayed and a threat to relationships with others [friends, family] if they left" (p. 403). "Understanding how the context of

an abusive relationship influences and coerces a woman's decisions is necessary to assist the woman in making health and life-preserving choices" (Belknap, 1999, p.403). The findings from this study provided important background information for me as I analyzed my data. I will address this point further in Chapter 5, but this study raised an important question for me around the extent to which women stayed in unsafe relationships because they were encouraged to do so by those who were important to them. Belknap's work provides an important addition to our understanding of the context in which women make the decision to stay or leave an abusive relationship. The decision is about more than just the maternal role; it may be heavily influenced by the social context within which the woman lives her daily life. This social context includes the people (family, friends, health care and service professionals) who either offer or withhold support, knowingly or unknowingly.

Safety issues

Campbell (2004) reported that while battered women were aware that they may be killed by their abusive partners, the danger assessment tool has revealed that women almost always underestimate their risk of harm from their partners. Indeed, one of the strongest risks for femicide in abusive intimate partner relationships occurs when women take deliberate action to sever a dangerously abusive relationship (Campbell). Many women will remain with an abusive partner because of the fear of life-threatening consequences should they attempt to leave (Merritt-Gray & Wuest, 1995, 1999).

The context of intimate partner violence research has been broadened to include alcohol and substance use, and includes a large body of research that is beyond the scope of this review, except to acknowledge that the associated increased risks may play a role in the woman's decision-making to leave an abusive male partner due to concerns for the safety of herself and her unborn child or infant. Use of alcohol and/or substance abuse by the abusive male partner is associated with increased risk of injury and death for the woman (Humphreys, Sharps, & Campbell, 2005).

Challenges related to co-parenting

Researchers have begun to document the challenges women face in co-parenting their children with a partner who previously was abusive to the woman and possibly the children. Kurz (1996) studied a random sample of women and found that many women experienced violence both during and after the ending of their marital relationships. She noted that violence was a significant factor in the women's decisions to leave their partners to protect themselves and their children. Kurz states that future researchers need to examine the influence of violence on woman's decision-making about whether to stay or leave a violent intimate partner relationship. "We must learn to see violence wherever it occurs and to understand the full extent of its consequences" (Kurz, p. 79).

The decision to leave a partner following abuse has long term consequences for everyone in the family (Hardesty, 2002). Recent research has addressed the co-parenting relationship after divorce (Hardesty, Khaw, Chung, & Martin, 2008). The authors examined the co-parenting relationships of 25

divorced mothers who had experienced violence during their marriages and found that the current relationship was influenced by how well the former husbands were able to separate their parental and spousal roles (Hardesty et al). In another study, Hardesty and Chung (2006) found that joint custody and cooperative co-parenting are often unsafe for women who leave violent partners because the man used the co-parenting relationship to continue to make threats and emotionally abuse their former partner.

Power and Control

Davies, Ford-Gilboe, and Hammerton (2009) examined the patterns of intimate partner violence and abuse among women who had recently left an abusive partner. They found that the women's risk of abuse and harassment after leaving was shaped by relations of coercive control. In order to better understand the social structural factors that shape the relations of power and control in intimate violent heterosexual unions, Davies et al., conducted a longitudinal prospective survey. They acknowledged that a notion of the idealized family is found within the context of how women think about intimate relationships. "Women negotiate intimate relationships within the broader context of gender ideologies that romanticize and make invisible male power and privilege" (Davies et al, 2009, p. 27). While their research is helpful in furthering our understanding of how women leave abusive relationships they did not address the decision-making process women use to leave the relationship. They suggest that the dominant belief system of harmonious family of mother, father and children is perpetuated by social policy, such that women are not encouraged to consider the

possibility of finding themselves in an abusive relationship even though it is a "disturbingly common experience" (Davies et al, 2009, p.27). As a consequence, when women find themselves with a violent partner, they have difficulty recognizing and acknowledging the abuse, and figuring out what to do about the violence.

There is a lack of awareness that intimate partner violence and abuse is embedded within the broader arrangements of power and control and as a result, the dominant perspective is a tendency for society to blame women and for women to blame themselves. Thus women can face major challenges when they interact with large bureaucratic institutional systems (like health, education, justice, police, and social services) that have inherent socially constructed biases about family and gender roles. Davies et al (2009) suggest that in order to better understand the dynamics in abusive relationships further research is needed to address how systematic gender inequalities make disentangling from abusive partners challenging and often dangerous. This knowledge is critical to understanding how women make decisions to leave an abusive partner. Understanding the context in which violence and abuse occurs is vital to my study in order to understand the context in which women live and how their decision-making is influenced by these circumstances. This knowledge helps to redirect our attention from focusing only on the woman's behaviour and linking it to the contextual aspects of her living situation that impact both her becoming a mother, and her relationship with her partner, the father of her unborn child.

Davies et al. (2009) acknowledge that feminist scholarship has moved the field of woman abuse beyond previous individual and family based models of violence. They argue persuasively that intimate partner violence emerges out of the social context that surrounds people's lives. This is important because it shifts our focus away from individual explanations, and encourages research aimed at recognizing and understanding the culture that simultaneously perpetuates and hides male partner violence against women. Davies and colleagues examined the relationships among gender inequality, relations of power and control, and patterns of violence after leaving. "Leaving brings up simultaneous and complicated feelings for women. For example, women may feel some continuing sense of love for their former partners, grief at the loss of their dream for their safety, and worry as they negotiate the unchartered waters of a new life" (p. 30). Leaving is not a discrete event, but is characterized by breaking psychological, emotional and physical connections (Lutz, 2005a, 2005b). While these researchers have helped to clarify factors that impact women's experiences of intimate partner violence and abuse, still unclear in our understanding of the decision-making process is how pregnant women incorporate these factors into their decision-making to stay or leave.

*Degrees of conflict***.** Johnson and Leone (2005) explored whether different types of violence had different effects on the decision to stay in or leave an abusive relationship. They developed a typology that describes the degrees of violence in the couple's relationship, and found that the consequences for women who experienced intimate partner terrorism were different than for women who

experienced situational couple violence. Women who were subjected to intimate partner terrorism were attacked more frequently, experienced violence that was less likely to stop, were more likely to be injured, exhibited more symptoms of PTSD, used more prescription medication (e.g., pain killers, tranquilizers, and antidepressants), missed more work, and were more likely to leave their husbands to seek their own residence, when compared to women who experience situational couple violence (Johnson & Leone).

Although family therapy research has shown that there are different degrees of conflict and violence in abusive relationships, there is still a bias in health care research toward epidemiological studies that quantify the numbers of women who are abused. While this kind of research is helpful for documenting the incidence of violence, it does not offer direction for how the situation might be changed. In contrast, research by Bacchus, Mezey, and Bewley (2003), Bell, Goodman, and Dutton (2007), Merritt-Gray and Wuest (1995, 1999), Wuest and Merritt-Gray (2008) provide a view of abused women's lives through the eyes of women who are living the experience. In these studies women identify concrete examples for how things could be changed, such as the woman becoming more assertive and setting limits on what she would accept in the relationship, and accessing other resources or getting a job so that the woman is not financially dependent on her male partner. "Above all, collaboration with victims is likely to be most effective when it adopts a longitudinal perspective and considers both the short-term and long-term consequences of various approaches to pursuing safety" (Bell, et al., p. 426).

Coping skills for staying and leaving. Sleutel's (1998) review of the qualitative research on women's experiences of abuse focused on the perspective of battered women and examined accounts of their experiences in abusive relationships to understand how they cope, why they stay, and how others can help. In her review, Sleutel characterized leaving an abusive partner as a process where the woman identified herself as battered and sought help; this process involved multiple strategies that were contingent upon children's needs, housing availability, and beliefs about religion and marriage. The process of terminating the relationship usually involved leaving and returning several times before leaving for good. Leaving was complicated by court mandated visits of children to their father and loss of the dreamed relationship. Wuest and Merritt-Gray (2008) found that women wanted the violence to end, but were not about to leave the relationship. This is in direct contrast to many programs offered by health and social service agencies that have focused on helping women to leave abusive relationships.

Making decisions to stay or leave an abusive relationship is influenced by the woman's coping strategies. Sabina and Tinsdale (2008) studied three types of problem focused-coping strategies (i.e., amount of help seeking, pursuing a protection order, and staying away from the abuser) that women living in violent intimate partner relationships used to cope with their current abuse. They found that women's enactment of their coping strategies and decision-making about staying in or leaving an abusive relationship were influenced by their general health, employment status, and sources of social support. Sabina and Tinsdale in

their examination of the abuse characteristics and coping resources as predictors of problem-focused coping strategies among battered women, highlight that early research "found that women were deficient in coping skills" (p. 438). Their central critique is that locating the problem in women rather than in the environment is a problem with the society, rather than the deficient personal characteristics of the woman. This is an important perspective that draws attention to the problem needing to be seen as a broader societal problem rather than an individual problem.

Balancing Love and Abuse. Lempert (1996, 1997) found that women vacillated between alternating contradictory realities – theirs and their abusers' reality. Women who experienced intimate partner violence and abuse struggled with the simultaneous acts of love and violence within their relationships. The women spoke of their ambivalent feelings of loving their husbands, but wanting the violence to stop (Lempert, 1996). Lempert's (1996) study highlighted how women struggled with complex multidimensional relationships that included violence, but also include significant acts of love and affection. "By contextualizing abused women's help seeking processes within the simultaneity of love and violence, this analysis rejects the simple binary of abusive relationships and illustrates the multi-dimensionality of the interactions and the complexity of interactions and informal helpers" (Lempert, 1997, p. 306). While Lempert's (1996, 1997) research sheds light on women's conflicting emotions of loving their partners, it also shows the fear that abused women feel. Lempert also showed that even the threat of abuse can be used to intimidate and control a partner and

contributes to understanding of the conflicting emotions an abused woman may experience. These findings were also confirmed by Anderson and Saunders (2003) who conducted an extensive review of both qualitative and quantitative research on women's experiences of leaving an abusive partner and found that women typical undergo several shifts in their thinking about abuse before they are able to permanently leave their partners. They also found that some women's psychological health can worsen after they leave the relationship; this paradoxical finding has important implications for how women are supported in their decision-making. Bell et al. (2009) examined the implications for women's emotional well-being on the dynamics of staying or leaving a violent intimate partner relationship. They found that the women who were "in and out" of the relationship fared worse than women who either stayed or left. Women identified the following reasons for not leaving: limited economic resources, fear of retaliation from the abuser, emotional attachment, or worries about family and community responses (Bell et al., 2009).

Summary

In this section I have reviewed literature on decision making among women living with intimate partner violence, and the factors that influence this process. The most important point is that decision making is dynamic and unpredictable. Although most authors acknowledge that decision making takes place within the societal context of people's lives, very few authors consider social contexts that include violence and abuse. There are differences in how feminist standpoint theory is used by researchers to analyze experience. In this

study I used the approach explicated by Nancy Naples (2003): "…standpoint as embodied in social identities, as a communal or relational achievement, and as an axis point of investigation" (p. 66). Using feminist standpoint theory helped me to better understand how pregnant women, who experience intimate partner violence and abuse, made decisions whether to stay in or leave an abusive intimate partner relationship based on each woman's own interpretations of their experiences, while also acknowledging the social influences on their lives.

Linking the Literature on the Experience of Intimate Partner Violence and Abuse and Decision-making

When the literature on intimate partner violence and abuse and the literature on decision making are put together the tension experienced by women becomes more obvious. On the one hand the woman is trying to attain the maternal role, and on the other hand she is living the reality of intimate partner violence and abuse. The dominant belief system is of an idealized happy family composed of mother, child, and father. As well, societal norms dictate that couples are committed and loving toward each other in their intimate relationships (Lutz, et al., 2006). The reality for women who experience abuse in their intimate partner relationship during pregnancy stands in sharp contrast to these views of society. Unfortunately, abuse may happen at any time in a relationship, but researchers have found that it is common during pregnancy (Campbell, 2004; Gazmararian, Petersen, Spitz, Goodwin, Saltzman & Marks, 2000; Janssen, Holt, Sugg, Emanuel, Critchlow & Henderson, 2003; McFarlane, Parker, Soeken & Bullock, 1999; Rhatigan, Moore, & Street, 2005). Thus, studies of the reality of

the violence and abuse as seen among those who live in abuse shelters, who attend emergency departments for care, and who surface within the criminal justice system, show that intimate partner violence and abuse is primarily directed toward the female partner and is characterized by coercive control by the male partner (Bell, Goodman & Dutton, 2007; Wuest & Merritt-Gray, 2008). It is not surprizing therefore, that sometimes women find themselves with a violent partner, but have difficulty recognizing, acknowledging, and figuring out what to do about the abuse (Davies, Ford-Gilboe & Hammerton, 2009).

Lutz (2005a, 2005b) found that leaving is not a discrete event, but one that is characterized by a break in psychological, emotional and physical connections that build over time. This is supported by other researchers who have found that women often leave many times before ending the relationship with their abusive partner (Davies, Ford-Gilboe & Hammerton, 2009; Merritt-Gray & Wuest, 1995, 1999; Stork, 2008). Current research indicates that the decision to leave is an interrelated piece of the experience for abused women that has not been fully understood. When a woman who is experiencing violence and abuse becomes pregnant, the developmental tasks of becoming a mother get added to an already complex decision-making process about how to manage the abuse.

Gaps in the Literature

The main gap in the literature on women's experience of abuse during pregnancy is that the literature on the developmental tasks of pregnancy does not adequately address the challenges to these tasks that occur when abuse is part of the intimate relationship. Beginning work has been done in this area by Lutz

(2005a, 2005b). Lutz and her colleagues' (2006) work was based on two previously collected data sets and thus was limited to a secondary analysis. Secondary data analysis is limited by the lack of opportunity to ask the participant how his/her experience is similar to or different from the experience that comes from the analysis, or to seek clarification about questions that arise during analysis. In my study I had the opportunity to ask my participants direct questions to clarify how their experiences were both similar to and different from our current understanding of the double binding phenomenon identified by Lutz et al. (2006). I was particularly interested in how women made choices for "safe passage for herself and the baby" (a developmental task of pregnancy), and how she made choices about her relationship with her partner.

Part of the developmental task of seeking safe passage for the unborn child is promoting acceptance of the developing child by the father. "Incorporated into the father's acceptance of the baby is the maternal dream of having an ideal, loving, supportive family, and home" (Lutz et al., 2006, p. 122). These authors suggest that women who are abused during pregnancy often try to create the appearance of a welcoming, stable and loving environment for the infant to conceal the partner's abuse, and project an optimistic future for the family, or maintain their hope that the abuse will stop. There is limited research on how women negotiate the maternal tasks of pregnancy within the context of an abusive intimate partner relationship. Consequently, little is known about how a woman executes her maternal tasks and becomes a mother while making decisions about

her relationship with an abusive intimate male partner who jeopardizes the family unit, her own safety, and that of the her unborn child.

Lutz (2005a, 2005b) used Mercer's (1995) theory to explore issues of intimate partner violence and abuse among new mothers. Later work done by Lutz et al., (2006), also based on Mercer's (1995) theory, incorporated research about the developmental process of becoming a mother with the process of being in an abusive relationship. Integration of these perspectives was used to understand women's behavioural responses to intimate partner violence and abuse during pregnancy. Integration of these two perspectives is an important step in broadening our understanding of the behavioural dynamics exhibited by pregnant women in abusive relationships. "Becoming a mother assumes a positive, supportive intimate partner relationship, yet pregnancy and being in an abusive relationship often coexist and present competing behavioural demands and social expectations for women" (Lutz et al., 2006, p.118).

While all parts of the role are important in order for the mother to become competent, I am particularly interested in the role the mother's intimate partner plays in her ability to achieve the maternal role. This has implications for how social and health programs work with women who are in abusive relationships. Examination of the role the abusive male intimate partner or father of the unborn baby plays in the woman's development of her maternal role may help to illustrate the conflict a woman feels when she is physically or emotionally abused by someone that she considers pivotal to becoming a competent mother. Researchers have found that the woman's struggle to come to terms with this conflict is played

out in her ambivalence about leaving her partner, her hope that the abuse will stop, and her focus on trying to make the relationship work (Lutz, 2005a, 2005b; Merritt-Gray & Wuest 1995, 1999; Wuest & Merritt-Gray, 2008; Wuest, Ford-Gilboe, Merritt-Gray & Lemire, 2006).

The experience of mothering after leaving an abusive relationship has been discussed in other contexts (Irwin, Thorne, & Varcoe, 2002; Dhillon, 2009, Tamas, 2011). This literature is vast and beyond the scope of this proposal. But I do want to comment on Irwin, Thorne and Varcoe's approach to dismiss psychological theory such as Lederman (1984) or Rubin (1984) as being too rigid and inadequate for articulating the mothering experience. The danger is that we are left with a void, while the research is being conducted, that fills with many different descriptions of mothering. We miss out on key areas that can help health professions communicate with women and families and each other about core pieces of the mothering experience while continuing to build the theory to reflect current experiences of mothering and becoming a mother. Irwin, Thorne, and Varcoe worry that "…there is a tendency to "pathologize all of a woman's day-to-day mothering challenges as a product of that violence" (p. 48). But without a basis of understanding of how all women grapple with the developmental tasks of becoming a mother or the mother role we are limited in our ability to discuss with clients and other health care professionals what women are doing and thinking as they become mothers – this piece is essential to ground the experience, then we can add in intimate partner violence and abuse and understand the complexities of the lives of women, their children, and families.

There is a real danger in essentializing experience, i.e., breaking it into parts or items we search for in another's experience, that takes us away from seeing the whole experience in the context it is lived. For example, by focusing on the woman's decision making to leave her abusive partner from the angle of being a mother it appears the woman puts her child first. If we focus on her trying to leave an abusive partner, it appears her child suffers because all her attention is focused on the abusive partner. While both scenarios illustrate part of the woman's decision making, in fact as nurses we need to consider both scenarios as part of a complete story, in order to understand the complexity of the lives of the women, their children, and the families we care for.

Although Mercer (1986, 1995, 2004, 2006) has made changes to her theory as knowledge has evolved, her theory remains focused on the maternal role and how women take on the role within the socially defined role of mother. She has tried to use the concept of maternal role attainment/ becoming a mother to refer to the maternal role. Sometimes maternal identity, a term borrowed from Rubin, has been substituted for maternal role attainment. This has led to some confusion about the concept of maternal role attainment/ becoming a mother (Meighan, 2002). In my study, I used the phrase "becoming a mother" to refer to the maternal role, i.e., the woman's experience of becoming a mother. I acknowledge that Mercer's theory of becoming a mother does not account for all aspects of how women view their role as mothers, particularly employed mothers. The theory of becoming a mother, however, is a helpful framework or backdrop for understanding the conflict that a woman may feel as she grapples with her new

role of mother. However, this work has not been taken up within a feminist perspective. I think by adding feminist standpoint theory I will be able to broaden my viewpoint and take into account different ideas of how women define their roles and relationships. Feminist standpoint theory adds to the discussion by bringing a lens that moves away from focusing on stereotypical maternal roles, and challenges us to think of women's experience within the current context of socially mediated behaviour. My study provided an opportunity to broaden my viewpoint and take into account different ideas of how women define their roles and relationships. Particularly, my study allowed me to explore the differences between the ideal view of becoming a mother and the daily reality of becoming a mother in context of violence and abuse.

Specifically, this study examined how pregnant women made decisions to stay or leave an abusive intimate partner relationship. It illuminated the woman's perceptions of her decision-making experience; that is, how she evaluated how important it was for her to have her partner accept the pregnancy and provide her with emotional support. Little has been written about this part of the experience from women's own perspectives. Feminist standpoint theory can enable the context of the lived experience to be explored, in particular, how men's and women's social roles have evolved over time, and continue to change within the context of societal and personal definitions of maternal and paternal roles.

While medical care of pregnancy has evolved to be able to care for both women and fetuses with complex health needs, there are still gaps in our understanding when our clients present with complex social problems such as

abuse. Although both Lederman and Mercer explore the woman's relationship with her husband, neither has addressed the very real issue of intimate partner violence and abuse during pregnancy. In order for nurses and other health care professionals to use maternal role theory with women and families, the missing piece about intimate partner violence and abuse during pregnancy and early mothering needs to be addressed. I proposed to address this missing piece by conducting an interpretive description of women's decision-making about whether to stay or leave an abusive partner during pregnancy.

Summary

This chapter has reviewed the literature related to two key areas: women's experiences of intimate partner violence and abuse during pregnancy and decision-making about whether to stay in or leave an abusive intimate partner relationship. The section on violence and abuse during pregnancy has included current knowledge of maternal role theory and implications of intimate partner violence for women's health and the health of their unborn children. Although much has been learned about abuse in intimate relationships, the literature does not yet adequately address the challenges that occur when abuse takes place during pregnancy. Further knowledge and understanding of the complexities that the abuse experience adds to pregnancy is needed, particularly in relation to how pregnant women make decisions about staying in or leaving an abusive intimate partner relationship.

The purpose of this qualitative study was to begin addressing this gap in the literature. Specifically I wished to generate a description of pregnant

women's decision-making about staying with or leaving an abusive intimate partner relationship. This study was designed to provide a foundation for my research program. My overall goal is to learn more about how the experience of violence and abuse influences a woman's ability to meet the developmental tasks associated with pregnancy, her own understanding of her competencies of pregnancy, and to use this information to design nursing interventions that support women at this difficult time.

Research Question

The research question was: How do pregnant women describe their experiences to stay or leave an abusive intimate partner relationship?

CHAPTER THREE

In this section I outline the design, sample, setting, data collection, and data analysis components of my study.

Research Design: Interpretive Description

The research question in this study focused on the development of a description of how women make decisions to stay in or leave abusive relationships during pregnancy, and ways in which nurses could potentially support the women during their decision-making. Interpretive description is particularly well suited to this type of research question because it goes beyond "pure" description, and "...seeks to discover associations, relationships and patterns within the phenomenon that have been described" (Thorne, 2008, p. 50), which could then be used to guide nursing practice (Thorne, Reimer Kirkham & O' Flynn-Magee, 2004). Interpretive description is informed by the key axioms of naturalistic inquiry and is underpinned by the following three philosophical assumptions:

1. Clinical nursing practice consists of multiple constructed realities that can be studied only holistically; this is based on the assumption that reality is complex, contextual, constructed, and ultimately subjective.
2. The inquirer and the "object" of inquiry interact to influence one another, such that "the knower and known are inseparable".
3. No *a priori* theory can encompass the multiple realities that are likely to be encountered during the research; rather the theory must emerge from

> or be grounded in the data (Thorne, Reimer Kirkham, & O'Flynn-Magee, 2004; Thorne, 2008, 2009).

"With a philosophical alignment with interpretive naturalistic orientations, interpretive description acknowledges the constructed and contextual nature of human experience that at the same time allows for shared realities" (Thorne, et al., 2004, p. 5). Interpretive description studies use small samples and use data collection methods such as interviews, participant observation, and document analysis to render a coherent and meaningful account of the experiential knowledge.

> Interpretative description attempts to make visible the commonalities inherent in such complex phenomena as the intricate dynamics of human relationships and the psychological twists and turns that characterize human experience. It also seeks to reveal their variations as different people experience similar situations in different ways (Thorne, 2008, p. 216).

Interpretive description differs from other qualitative descriptive approaches in that it assumes nurse investigators want more than a description. Simply stated, interpretive description provides direction in the creation of an interpretive account that is generated on the basis of informed questioning, using reflective and critical examination that can guide and inform clinical practice (Thorne, et al 2004). The design strategies of interpretive description borrow from grounded theory, naturalistic inquiry and ethnography, while the data collection methods borrow from phenomenology (Thorne et al, 2004). Reflecting an

awareness of expected variations, the samples are purposively and often theoretically generated (Thorne, et al, 2004).

Interpretive description is unlike other qualitative designs such as grounded theory or ethnography, where the primary objective is theory development, and this may be viewed as a limitation. Given the early exploratory nature of my work, however, I chose interpretative description because it fit my research question and because I thought it would provide a solid foundation upon which to build my research program and my clinical practice. Interpretive description helps the researcher develop a coherent conceptual description that taps thematic patterns and commonalities believed to characterize a phenomenon, while at the same time accounting for inevitable individual variations (Thorne et al, 2004). The products of interpretive description provide a backdrop for nursing assessment, planning, and intervention strategies, in keeping with recognized nursing standards of evidence, logic and ethics (Thorne, et al, 2004). The disseminated research report is accessible to the practice discipline for the purpose of informing clinical reasoning, extending available insights for practice decisions, and helping to make sense of the eccentricities and variations that occur in the real world of health care (Thorne et al, 2004).

Interpretive description is a method for generating knowledge pertaining to clinically derived phenomena, within an applied disciplinary domain, such as nursing. It departs from the conventional methods designed for disciplines whose object is theorizing, and addresses a distinct need for inquiry approaches where certain kinds of clinical problems or populations warrant inquiry that describes

and interprets patterns of experience, action, or expression. As such, it is "atheoretical" but with explicit recognition that the nature of the problem derives directly from a set of ideas and structures about practice disciplines that may have theoretical elements but are not themselves theory (Thorne, 2008, p. 68).

Thorne cautions against confusing theory-driven research with research that is structured in such a manner so as to account for and acknowledge a disciplinary orientation. The problem with "theory building" disguised as clinical research, in her view, is that the researcher will be drawn to observations that confirm their own perspective, rather than acknowledge the observations that do not support the theory (Thorne, p. 69).

Thorne (2008) notes that when interpretive description is used for disciplinary knowledge development, the researcher needs to "own up" to their disciplinary heritage and situate their question within it. In order to situate the question within the disciplinary heritage, interpretive description requires sufficient grounding in the discipline to be able to discern its scope and boundaries, its angle of vision on problems of concern, and its philosophical underpinnings in relation to what constitutes knowledge.

> Thus, an important element in the forestructuring of any study is to consider its disciplinary nature, to consider the manner in which it aligns itself with the knowledge and practice of the discipline, and to sort out how that will be made apparent within the research design and eventual write-up (Thorne, 2008, p.67).

According to Thorne, Reimer Kirkham, and MacDonald-Emes, (1997) what is known about a phenomenon, whether it is formal research or clinical knowledge. is considered foundational forestructure. This foundational forestructure helps to build an analytic framework. "[I]n contrast to traditional descriptive research, in which a formal conceptual framework would be required, an analytic framework constructed on the basis of critical analysis of the existing knowledge represents an appropriate platform on which to build a qualitative design" (Thorne, et al. p. 173). The analytic framework is used to orient the inquiry, provide a rationale for its anticipated boundaries, and make explicit the theoretical assumptions, biases, and preconceptions that will drive design decisions (Thorne, et al). Because it represents a beginning point rather than an organizing structure for what is found in the inquiry, the researcher will be challenged to think about how the pieces fit together as the inductive analysis proceeds (Thorne, et al.). Consequently, stating the analytic framework at the beginning of the research provides a solid basis upon which the design logic and interpreted meanings within the data may be judged (Thorne, et al).

Interpretive description has been formulated for the pressing questions that we currently face in clinical nursing. The value of interpretive description results lies in the insights, which it can provide to the clinician that may facilitate provision of appropriate support from health professionals (Payne & McPherson, 2010). Interpretive description has been used by others to study issues related to health care communication (Thorne, Con, McGuinness, McPherson, & Harris, 2004), the maternal role (Payne & McPherson), intimate partner violence (Irwin,

Thorne & Varcoe, 2002), and decision-making (Thorne, Patterson & Russell, 2003).

The real value of interpretive description in relation to my study is in the frame it provides for learning more about women's experiences of making decisions to stay or leave an abusive partner during pregnancy and then interpreting these findings for nursing practice. Thorne (2008) "suggests that there is inherent value in careful and systematic analysis of a phenomenon and an equally pressing need for putting that analysis back into the context of the practice field, with all of its inherent social, political, and ideological complexities" (p. 50).

It is important for the researcher to think about his or her assumptions about these complexities prior to beginning any study. My assumptions are currently rooted within the literature about the developmental tasks of pregnancy. I have offered a critique of this framework earlier in Chapter 2. In Chapter 5, I integrate my assumptions and my study findings in my discussion of how I think my study extends current thinking about these developmental tasks for women who have experienced intimate partner violence and abuse.

Sample and Recruitment

I used a purposive sampling approach to recruit the women for the study. A purposive sample is one in which participants are selected based on specific characteristics expected to assist in the collection of data needed to answer the research question (Thorne, 2008). Given my interest in describing the tension related to staying or leaving an intimate partner who is abusive, I recruited women

who were at least 18 years old, and who were currently living in one of two shelters in a large metropolitan area for women who had recently experienced violence or abuse, who had experienced the violence or abuse during pregnancy, and who were currently not pregnant. In planning for the interviews, I discussed with my supervisors, how women who had experienced violence and abuse during pregnancy, but were not currently pregnant would have an ability to reflect back on the meaning of their experience and talk about it in greater depth than women who were currently pregnant, thus taking into account the turning inward to their own experience that happens for women according to the developmental tasks of pregnancy. Women unable to read or speak English were excluded.

Following ethics approval, I presented the study proposal to the director and community health nurse at a local women's shelter. I introduced the purpose, research question, methods for recruitment of participants, and data collection, and answered any questions. Following approval by the shelter administrator, participants were recruited using posters (Appendix A). I put up posters in the shelter to invite potential participants to speak to a shelter staff member if they were interested in participating. The shelter staff then gave potential participants a postcard (Appendix B) and a letter (Appendix C) about the study. The postcard provided my contact information and requested that potential participants contact me if they were interested in hearing more about the study. The woman called and left a message on a dedicated research information line. I called the woman back and arranged to meet at a mutually convenient time and place at the shelter. When I met with each woman, I answered any questions about the study, and

obtained written consent (Appendix D). Each woman who contacted me was eligible for the study and agreed to be interviewed.

I started advertising in September 2010, but (by October 31, 2010) no women had agreed to participate. When I met with the shelter staff to explore this problem, they mentioned that researchers in previous studies had offered an honorarium. I thus submitted a revision to the Health Ethics Research Board in which I requested to permission to offer participants $30.00 per interview. Once permission to offer an honorarium was received in late November 2010, I met with shelter staff and advise them of this change in my study. I delayed recruitment activities during December 2010 due the holidays and the potential stress it might add to the women's lives if they tried to talk about their experiences during a time that was already stressful for them. In January 2011 I introduced the study to a group of women in the shelter, who were meeting in a support group with a Community Health Nurse from the shelter. I met with the group on two different occasions to give the women a chance to meet me, and provide an opportunity for the women to directly ask me questions about the study. In these instances I gave the women the postcard (Appendix B) and a letter (Appendix C) about the study. Recruitment was still going slowly so I requested permission from the Health Research Ethics Board to recruit participants from a second shelter population, and this permission was received in Feb. 2011. In the second shelter I attended a meeting with the shelter staff and they spoke to potential women about my study. Interested individuals were asked to call and leave me a message with their contact information on the dedicated research line

set up for my first shelter population. Identical procedures were used with both groups of women for explaining the consent and taping the interviews.

Participants were eventually recruited from two shelters for women who experienced domestic violence and abuse. Both shelters were affiliated with the Alberta Association of Women's Shelters. A sample size of 10 to 15 women was estimated consistent with interpretive description. In reality I recruited 8 women. I interviewed 2 women twice, and the remaining women once for a total of 10 interviews. Because of the nature of qualitative research it was hard to predict exactly how many women would need to be interviewed to achieve in-depth understanding of the process women use to make decisions to stay or leave an abusive intimate partner during pregnancy. According to Thorne (2008) an "interpretive description can be conducted on samples of almost any size" (p. 94). An important step for the researcher deciding on a sample size is to determine the subset of the theoretical whole "population" that will be engaged and the strategies that will be used to locate and involve the sample (Thorne). In consultation with my supervisory committee I chose to draw my sample from a shelter population to address safety and ethical issues for the women and myself as a researcher.

From within this group, I was interested in recruiting a subset of women who could provide me with a complete detailed description of their experience of being abused during pregnancy. This approach to sampling is called purposeful sampling (Mayan, 2009). Purposeful sampling is the explicit selection of participants based on their knowledge of the information required, their

willingness to reflect on this knowledge, and their ability to talk about their experience in detail (Mayan, 2009). With this in mind, I recruited women in the shelter who spoke English, who were at least18 years of age, and who had experienced abuse during a pregnancy. Each woman had a story to tell, and some elements of their decision-making were similar, while other elements of the decision-making were different.

As the study progressed, I anticipated that I would change to theoretical sampling (Thorne et al, 1997; Thorne et al, 2004). Theoretical sampling is a sampling strategy that is used to ensure that one speaks to individuals with potentially different experiences of the topic under investigation (Thorne, 2008). In theoretical sampling the researcher seeks out participants because of their ability to talk about their experience as it relates to the emerging description (Richards & Morse, 2007). It was difficult to know who these participants would be until some data had been collected. I anticipated, however, that the decision to stay or leave an abusive relationship might be partly informed by beliefs and values related to ethnicity, and so I thought about the possibility of recruiting women from various ethnic groups as the study progressed. Fortunately, women from several different ethnic groups volunteered at the outset of the study, and so I did not have to recruit them explicitly. Interestingly, the stories of all the women in my study were remarkably similar. I also thought it might be important to recruit women who had had more than one pregnancy, but did not need to recruit these individuals explicitly as the women who volunteered included those with both one child only and two or more children. Theoretical sampling in interpretive

description is used to uncover knowledge that can help inform clinical practice rather than developing a formal theory as in grounded theory research, consequently, the full scale of analytic depth is not required. Instead the researcher during data collection is mindful of the evolving data analysis and interpretation and explicitly seeks maximal variation of the relevant phenomena that is the central focus of the study (Thorne, 2008).

Data Collection and Analysis

My initial plan was to interview each woman twice. In reality I found that some women needed to have two interviews in order to tell their stories, while others preferred to be interviewed just once. As I gained experience with interviewing in the researcher role and let go of my interviewing style used in clinical encounters I was able to convey an openness and willingness to just listen and hear what the woman wanted to share. I found it helpful to start by using phrases such as "I would like to hear your story". "I'd like to hear about your experience of making decisions to leave your relationship; whatever you feel comfortable sharing with me." I was fortunate to have several women who were articulate and able to talk about their experiences with very little prompting from me – I felt truly honoured to have been able to hear their stories and to be able to learn from their experiences.

Because I had ethics approval to conduct up to two interviews with each person if necessary, I was able to go back to earlier participants and ask about new areas I found in later interviews. Irwin, Thorne and Varcoe (2002) suggest the second interview can be used to share the preliminary analysis and add depth

to the analysis by having the women clarify the evolving interpretation of the women's experiences. When I first started the interviews I thought the women would talk about their relationship with their partners in planning the pregnancy, but most of the participants did not plan their pregnancies. Nevertheless, they were able to reflect on how their relationships changed over time. It was this change of the relationship and the women's admissions that they did not realize their relationships were abusive that enabled me to ask other participants about how they made decisions. I also realized how important the crisis (precipitant event) was in helping the women to recognize that the relationship was abusive and initiate decision making.

I had developed some initial guiding questions for the first interview (Appendix E) but I was flexible and respectful of each woman's own pacing during the interviews. In reality I initially asked a few broad, open-ended questions as part of an interview process that included setting the tone and seeking information, and then I just let the women talk. In a few instances I asked further questions to clarify the women's experiences. Interview questions were used to ask the participant to describe and reflect upon her experiences of making decisions to stay in or leave an abusive intimate partner during pregnancy. I used my position as interviewer to listen, to observe with sensitivity, and to encourage the woman to respond to the questions and share her thoughts and feelings that were triggered by the questions.

I conducted the interviews at a mutually agreed upon time with each woman. My plan was to conduct the face to face interviews in a safe location for

both the woman and me, at either the shelter or an interview room at the university. I was able to interview each woman at one of the shelters. Although, I had planned to offer the women the choice to participate in the research by face to face interview or telephone interview, all the interviews were done face to face. I did not do any telephone interviews. I anticipated that the interviews would be an hour to an hour and half in length, in reality the interviews ranged from 45 minutes to 90 minutes. The interviews were tape recorded and later transcribed.

All the first interviews and second interviews were conducted in person. I had planned in anticipation that some women would chose to participate by telephone interview, and that I would respect the woman's choice as long as it was safe for her to participate. In reality I did not need to address issues related to telephone interviews. The second interview provided an opportunity for the participant to confirm or clarify the researcher's presentation of the women's experience as described in the initial interview and to respond to the researcher's analysis (Irwin, Thorne & Varcoe, 2002). Authors on interviewing (King, & Horrocks, 2010; Kvale & Brinkmann, 2009; Olson, 2011; Spradley, 1979) discuss how it is best to have the person being interviewed feel comfortable and that the researcher is truly interested in what they have to say, and I did strive for this atmosphere in my interviews with the women. During the interviews I was cognizant that baring's one's soul and telling a stranger about the details of one's life when one felt vulnerable and scared could leave the interviewee feeling weakened and even more vulnerable. I tried to achieve a fine balance between being interested and encouraging and helping the interviewee to feel empowered

and strengthened by sharing her story. I showed respect to the women by using pauses as an opportunity for the woman to reflect on her experience and for her to feel grounded prior to responding to the question and sharing her perceptions.

Demographic information was collected from the participants at the end of each interview (Appendix F). I found that leaving the demographic questions to the end of the interview enabled me to build rapport with each woman by allowing her to share what she was comfortable sharing at her own pace, this approach was particularly important for the women who had had children apprehended by the Child and Family Services Authorities.

Data generated by the interviews was augmented by recording field notes of my observations related to incidents and perceptions arising from the interviews, consistent with qualitative methods (Richards & Morse, 2007; Mayan, 2009). The field notes were written in a notebook as soon as possible after each interview in order to minimize the potential for memory loss and misinterpretation. I had anticipated that I might tape record my field notes, but I found it easier to just sit and write field notes after each interview was completed. I also kept a research journal (Thorne, 2008) about my impressions of the interview and questions that arose. Under the section describing the development of the description, I will discuss how the research journal was used to compliment the memo writing process.

I followed my plan to interview women and to code and analyse data concurrently. Morse, Barrett, Mayan, Olson, and Spiers (2002) described how collecting and analyzing the data concurrently forms a mutual interaction between

what is known and what one needs to know. By asking analytic questions of the data, the researcher ensures that she is developing a solid and significant piece of research. "The active approach to inquiry is driven by the identification of questions that force the researcher to think, to confirm, and to pursue every avenue" (Richards & Morse, 2007, p.13). Duffy (2004) highlighted how allowing time to elapse between interviews was important for allowing the interview to inform, develop and focus subsequent interviews. I planned to transcribe the interview tape following the interview, thinking it would allow me to be immersed in the data. But I am a slow typist and I found it was better to use a transcriptionist so that the process of transcribing the tapes did not compete with my time for reflection and analysis. I did not use NVivo 8 software to assist me with data management. Advantages of this software include support for management of large volumes of complex data that can be text, audio, or visual files; and flexibility in retaining context while developing codes and categories. In reality I found it was easier to code the interview data using coloured post-it notes. The data coding was done by identifying patterns, following intuitions, and retracing "a line of logical reasoning among and between pieces of data" (Thorne, et al, 2004, p. 14). As well, I wrote memos about questions or ideas about how the data link together. For example, when a woman talked about trying to keep things calm in her household so that her husband will not be physically abusive to her, I reflected and wrote about how the woman appeared to have felt about being abused or treated disrespectfully when she was pregnant. I considered and documented my thoughts about questions such as: Did this experience make her

wonder about how her husband would treat her after the birth of the baby? Did she worry about how he would treat the new baby? In my memos I reflected on the woman's answers, were they what I expected? How were they different than I expected? As I conducted further interviews I wrote about how the answers were similar or different.

Analytic Approach

According to Thorne (2008) an interpretive description is constructed by the researcher through both witnessed and lived interaction. At the beginning of the analytic process the researcher draws on theoretical knowledge, clinical pattern observation, and the scientific basis within which all studies of human health and illness phenomena are generated (Thorne et al., 2004). Thorne et al. (2004) caution that while the researcher can draw from the analytic framework used to frame the design, sample, and early analytic decisions, too much reliance on this framework can hinder the analysis process. Instead, the researcher needs to also consider possible alternative conceptual emphases in the richness of the data. This meant that I needed to be open to information that appeared outside of the preliminary theoretical scaffolding (Thorne et al., 2004). In the present study I started with the developmental tasks of pregnancy and the notion of double-binding (theoretical scaffolding), but as I collected data through interviews with women who have lived the experience of making decisions to stay or leave an abusive partner during pregnancy, I was open to hearing how their experiences were similar and different both to the scaffolding and to each other's story. The women talked about not realizing they were in an abusive relationship until after

they had left their partners. This was new information that did not fit with the preliminary theoretical scaffolding. I needed to search out alternative linkages, exceptional instances, and contrary or negative cases as a mechanism for broadening rather than narrowing the conceptual linkages (Thorne, et al, 2004). During this phase of the analysis I sought guidance from my committee members to ensure that the analysis went beyond the beginning analytic framework and extended the findings, and would have clinical relevance. In my first and second round of analysis I identified 10 to 14 themes. Themes with common threads were combined. For example, themes related to realizing the power to leave and struggling to separate from their ex-partners were combined and relabelled "moving forward as a single parent".

Data coding. Thorne, Reimer Kirkham and O'Flynn-Magee (2004) describe the analytic process of data coding as starting with the preliminary theoretical scaffolding and gradually distancing one's self from it as "alternative conceptual emphases and intrigues arise" (p. 10). In this study I used Thorne's (2008) suggestions for coding data. In her book, Thorne cautioned against coding line by line or in too much detail as it can derail the analysis. Following Thorne's suggestions I reviewed the transcription while listening to the interview tape to get a sense of the whole experience and the parts (bits) of the experience that had meaning for the participant. Then coding was used to sort and organize information into a manageable form. Thorne (2008) described coding within inductive research as an active process that allows the researcher to

> ...experiment with trying different angles of vision from which to gaze upon the whole complicated collection of data bits so that you can begin to appreciate the implications of each of the available options for handling, grouping, and reconstructing pattern within them (p. 147).

Once the data bits have been organized into various groupings, then the researcher needs to make sense of what relationship the various groupings have to one another, this leads to inductively building a coherent whole out of the iterative reasoning process (Thorne). The next step in development of the description is memo writing which links coding to the writing of the first draft of the analysis. During this part of the analysis I used coloured post-it notes to display the key elements of the experience. I then moved the post-it notes into groupings to help me see what the memos and draft writing would look like. After writing the initial draft I once again reviewed the transcripts and revised the draft copy of the analysis.

Development of the description. Making analytic notes or memo writing is used to elaborate on the codes and to raise the codes to conceptual categories or the next level of analysis. The analytic notes allow the researcher to ask increasingly complex questions about what it all means (Thorne, 2008). I used memo writing throughout this study as I developed my codes at all levels. I wrote memos early in my coding as a means to document where I was deriving my codes from. These memos and notes were used to capture my thoughts as I developed my coding scheme. As I did more in-depth analysis and moved into conceptually categorizing the data, I wrote more analytic statements to help me

think through the categories as I was developing them. Thorne has suggested using a blank notebook to enter dated collections of thematic lists, pose questions, and jot down emerging patterns that the researcher wants to track. In conceptualizing or transforming the data, the findings will reflect an interpretive maneuver within which the researcher considers what the data pieces mean individually and in relation to one another; what various processes, structures, or schemes might illuminate about those relationships; and what order and sequence of presentation might most effectively lead the eventual reader toward a kind of knowing that was not possible prior to the study (Thorne).

Thorne (2008) describes qualitative findings as being on a continuum with a topical survey or inventory of topics being at one end, and moving to a higher level of abstraction, conceptual or thematic description, and then interpretive explanation, the most fully integrated qualitative analytic process, at the other end. Therefore a small, interpretive descriptive study can generate a thematic summary or conceptual description. Prior to beginning the study I acknowledged that I could not predetermine whether the present study would be a thematic summary or conceptual description until I started interviewing the women in the shelter. In Chapter Four I present a conceptual description of women's decision making to leave an intimate partner during pregnancy.

I used a research journal to capture my initial impressions and questions about how the women described their experiences. This writing was different from memo writing in that it contained my reflections, and thus enabled me to track my reflections. Thorne (2008) identified that carefully documentation of the

nature and substance of the researcher's ideas about the phenomenon and what is happening subjectively and conceptually as the research engages "becomes a core element informing your inductive analytic process" (p. 109).

I anticipated using theoretical sampling to help me to identify additional participants or events to fill the gaps that arose as I moved into analytic coding. In reality, by chance the women who volunteered for the study each shared a different perspective. So while I was mindful of using theoretical sampling, I did not have to seek out other participants. The participants who volunteered provided data that enabled me to extend, refine, and fully develop the categories during analysis. During sampling and analysis I was aware of how theoretical sampling could be used to help the researcher to sharpen the concepts and deepen the analysis.

In interpretive description, Thorne (2008) discourages the use of the term "data saturation" but notes instead that cessation of data collection should occur when there are no new variations in the phenomenon under investigation. During the data collection phase and interviewing I was able to hear several women share their stories, and I was able to appreciate that I could cease data collection because the interview data did not offer new direction, and no new questions arose for me. I decided to stop data collection when the key concepts emerging in from the data had been verified repeatedly across most participants. Integration and extension of the theoretical findings occurred through writing memos.

As discussed in this section, interpretive description offers qualitative researchers a way to frame their questions that arise from clinical practice. I have

described how I followed the identified key strategies of interpretive description: (a) simultaneous collection and analysis of data, (b) data coding process, (c) memo writing aimed at the construction of conceptual analyses, (d) theoretical sampling to refine the researcher's emerging ideas, and (e) integration of the research findings.

Rigor and Credibility

Although interpretive description is a relatively new research method, Thorne (2009) has taken steps to address concerns for credibility in each element of the research process. She has identified four domains of credibility that need to be addressed: (a) epistemological integrity, (b) representative credibility, (c) analytic logic, and (d) interpretive authority. In addition, criteria for evaluation in the applied practice disciplines are identified: (a) moral defensibility, (b) disciplinary relevance, (c) pragmatic obligation, and (d) contextual awareness. These elements fit well with the verification strategies for reliability and validity developed by Morse, Barrett, Mayan, Olson, and Spiers (2002). Verification refers to the mechanisms the researcher uses during the research process to contribute to the reliability and validity, and thus the rigor of the study (Morse et al.). Rigor can be addressed by building it into the research process. Verification strategies include: investigator responsiveness, methodological coherence, theoretical sampling and sampling adequacy, active analytic stance, and saturation. These strategies are built into the research process and, when used appropriately, provide the researcher with the direction for analysis by moving

between the macro and micro perspectives, constantly checking and rechecking, so that the findings develop from a solid foundation (Morse et al.).

In this section I will explain how I addressed the four domains of credibility identified by Thorne (2008): (a) epistemological integrity, (b) representative credibility, (c) analytic logic, and (d) interpretive authority. *Epistemological integrity* refers to a defensible line of reasoning that the reader can follow from the assumptions made about the nature of knowledge to how the research process is explained (Thorne, 2008). This has been reflected in my literature review and statement of the research question. The second domain of *representative credibility* was achieved by making the complexities visible through the analytic process (Thorne, 2008). I addressed this component of rigor by comparing my findings to what is in the literature and by discussing my ongoing data collection and analysis with my committee. I showed how I used *analytic logic* by being clear about the interpretive lens that I used. I used verbatim accounts from the data to reflect my findings. The fourth domain of *interpretive authority* was reflected in what is referred to as the "thoughtful clinician test" (Thorne et al, 2004). For the thoughtful clinician test, other nurses who have expert knowledge of the phenomenon are asked to read the interpretive description of the study. Ideally, if the study is well done, the expert will find the claims plausible and confirmatory of their "clinical hunches" and at the same time the description will illuminate new understandings of the phenomenon. For the purposes of this study, I addressed *interpretive authority* through discussion with members of my supervisory committee at various points in time during the research process. Also

when I successfully publish in research journals interpretive authority will be further addressed.

Additional criteria, identified by Thorne (2008), for evaluation in the applied practice disciplines, such as nursing include: (a) moral defensibility, (b) disciplinary relevance, (c) pragmatic obligation, and (d) contextual awareness. The criterion of *moral defensibility* was reflected in how I conducted the interviews. It behoves us as nurses to think critically about how we ask questions and the meaning the questions have for those in our care. In the end, the reader or user of the research is the judge, as Thorne (2008) states:

> A sound critique of qualitative research beyond the surface level of adherence to a set of evaluative criteria will therefore inevitably reflect deep questioning as to why we select certain questions to ask, how we claim the knowledge gained will further certain kinds of meaning, and what might be the implications of acts based on what we have come to believe through the process of research (p. 230).

My passion for clinical practice is reflected in the reason for my research question that has *disciplinary relevance* ... "to try to expand knowledge that has the potential of making a difference" (Thorne, 2008, p. 233). Thorne (2008) suggests that putting the research products to use should be the goal of every researcher. "When an interpretive description is done well, it not only documents what patients tell us, but it digs below the surface of those telling to uncover elements of the experience that may help us think entirely differently about the difficulties that they encounter in our care contexts" (p. 237). I reviewed my analysis with my

supervisors to make sure the interpretive description reflected the interview participant's experiences. I anticipated that the analysis would offer the women deeper insights about their lives. The *disciplinary relevance* of the research was demonstrated by laying the ground work for future research studies and by contributing to nursing and health care knowledge about pregnant women's decision-making for staying in or leaving an abusive intimate partner relationship. In Chapter Five I compared my findings to other related studies in nursing. The third criterion, of *pragmatic obligation* refers to considering how the research knowledge might be used in practice; I have discussed this in the literature review. I think the findings from this study could inform the development of programs and/or policies for women, children, and families who experience intimate partner violence and abuse. The fourth criterion, of *contextual awareness* required that I take into account how my own perspective could influence the research results. I wrote field notes and wrote in a research journal about how my own thoughts and feelings influenced my perspective and discussed my ideas with my committee.

Ethical Considerations

Prior to starting the initial individual interview with each participant, I discussed the purpose and procedures of the study including the process for informed consent with each potential participant. I reviewed the procedures to ensure confidentiality and addressed any questions the participant asked. Once all the questions and concerns had been addressed to mutual satisfaction, I obtained an indication from each woman about her willingness to proceed with the

interview and obtained signed consent (Appendix D). The formal consent to participate in the study and permission to use the obtained data was reaffirmed verbally with the woman upon completion of the individual interviews.

I used accepted procedures for ensuring confidentiality of data. Only code numbers were used to identify recorded interviews and transcripts. Recorded interviews, transcripts, and notes were kept in a locked file cabinet separate from the consent forms and code lists. Data may be used for another study in the future with prior approval from the appropriate ethics review board. When the study findings are reported, published or presented, no identifying information will be included that might identify the participants, this was explained to each participant when the consent was signed.

Ellsberg, Heise, Pena, Agurto, and Winkvist (2001) acknowledge that studies of painful subjects such as domestic violence face the challenge of how to support participants to speak openly about intimate aspects of their lives. The onus is on the researcher to create an atmosphere of trust and to be respectful of the autonomy and protection of vulnerable people (Fontes, 1998; Ellsberg & Heise, 2002). "Investigators must examine how they support the abuse of power by consciously or unconsciously using privilege, gender, coercion, or intimidation in their approach to participants" (Langford, 2000, p.135). I drew on my previous clinical and research experiences, and my understanding of feminist standpoint to guide the relationships I established with my participants. I recognized their vulnerability and worked hard to establish relationships that were respectful and open, and that were based on trust. During the interviews I acknowledged that

participating in research can be both helpful and difficult. Hlavka, Kruttschnitt, & Carbone-Lopez (2007) found that cumulative effect of violence over the life course has a significant relationship to women's disclosure of sensitive issues, and so I tried to listen attentively and carefully to allow the interview process to become participant-oriented and to provide women the freedom to disclose as much of their stories as they wished to share with me. In a study on training interviewers for research on sexual violence, Campbell et al (2009) found that the survivors wanted the interviewers to show warmth and compassion. This is consistent with my experiences as a sexual assault nurse examiner and community health nurse, and in the interviews in my study I tried to show compassion and to encourage the women to talk freely while also respecting their choice not to answer some questions. For the two women I interviewed twice I also asked if there was anything that they wanted to share with me or ask me about since the last interview; my goal was to reinforce that I was interested in hearing their stories.

Sullivan and Cain (2004) emphasize the importance of being sensitive and aware of the safety issues for conducting research with women survivors of intimate partner violence.

> It is critically important to take all precautions possible to minimize the risk of women with abusive partners being assaulted as a result of participating in research. This involves considering such issues as how to first contact women about participating in the research; where data collection will occur; how to protect women's safety before, during, and

> after data collection; and how to safely locate women over time in the case of longitudinal research (p. 604).

I acknowledge that women who experience intimate partner violence and abuse are vulnerable and at increased risk for further violence and abuse. By inviting women who were already seeking help in a shelter, I was working with participants who had access to both psycho-emotional and physical support through the shelter. I arranged with the shelter staff to ensure that that if any participants in my study wanted to talk further about their experiences with a counsellor, this service would be available at no cost. I clearly stated in my written consent form and as a preamble to the interview that the participant could refuse to respond to any questions they would prefer to not discuss. The women were informed that they could stop the interview at any time, or request information be erased from the tape recorded interview, with no questions asked.

Conclusion

Interpretive description is a qualitative methodological approach that has been specifically designed to fit the kind of complex experiential questions that nurses ask, "... it provides a logical structure and philosophic rationale for design decisions in qualitative inquires" (Thorne, Reimer Kirkham, & O' Flynn-Magee, 2004). I have described how I used interpretive description in my study of pregnant women who are making decisions about staying in or leaving an abusive intimate partner relationship. I expected that this approach would help me articulate the similarities and differences in women's experiences by focusing on the context – the multiple dimensions of women's lives. Understanding this

experience from the woman's perspective has implications for how health care professionals, especially nurses provide care to women. It also has implications for how the social determinants of health can affect health policy and care for women, children, and families. Interpretive description can take the researcher deep into the phenomenon without isolating it from its social location, enabling the researcher to gain intimate knowledge of the phenomenon. The notion of a multiplicity of perspectives and multiple realities forces the researcher to construct layered analyses and to attend to varied ways both the researcher and the participants construct meaning in their lives. Interpretive description enabled me to provide a rich and thick detailed description by defining the essential properties and relationships as I went deeper into the studied life of women who had experienced intimate partner violence and abuse during pregnancy, and connected it with the larger social issues that impacted their decision-making about staying in or leaving an abusive intimate partner relationship. I anticipated that by incorporating women's perceptions of how they acquire the maternal role and the developmental tasks associated with becoming a mother would enable me to get to a deeper level of the experience and relationship issues so that I could explore with the women how they made decisions to stay in or leave an abusive intimate partner relationship.

In the next chapter, I present the findings from the women's own lived experiences of making decisions to stay or leave and abusive partner during pregnancy.

CHAPTER FOUR - FINDINGS

In this chapter I outline the findings of the study. First, I describe the characteristics of my sample. This is followed by a discussion of the contextual factors that shaped the results of my study. Then I provide a description of the major themes that emerged from the accounts the participants in my study provided about deciding whether to stay or leave a partner who abused them during pregnancy.

Sample

My sample was comprised of 8 women. Seven of these women were currently living in a shelter for women who had experienced intimate partner abuse and violence. This was not a short term emergency shelter, but a supportive program where the women received counselling and lived for 6 months to enable them to make changes in their lives. One woman had recently transitioned from a shelter to second stage transitional housing. Two women were interviewed twice, and the other 6 women were interviewed once, for a total of 10 interviews.

Over half of the sample of women identified themselves as being of Aboriginal descent. Two women were of Asian and south east Asian ethnicity. None of the women were working at the time of the interviews. As a consequence of being in stable housing, they also received income assistance that enabled them to focus on getting help for themselves and provided a stable home for their children. While two of the women had university education, and another woman had post-secondary training, the majority of the women had left high school before completion, and most had limited marketable skills for work. An advantage

of the supportive housing was the support with child care, and assistance with completing their education or applying for job training. This was also a limitation of the study, I did not reach women who had the financial resources to leave their abusive partners and set up a new household, these women might have shared a different perspective about their decision making to leave their abusive male partner in the context of pregnancy.

For approximately half of the sample, this was not their first abusive relationship during pregnancy. Two of the women described previous abuse during pregnancy with a different partner. Some of the women left and went back to their partners during their pregnancies. Several of the women went to shelters during their pregnancies and then reunited with their partners near the time of their baby's birth, so that their baby would have a father, and to test to see if the relationship was over. Some of these women told me they were hopeful the baby would change the relationship so that their partner would not be abusive. However, at the time of the interviews all the women had left their abusive male partners.

All the women in this study had suffered 1 or more pregnancy losses. The women had from 1 to 5 children living with them. Two of the women had some of their children living in the care of other family members; the care arrangements were court mandated. Both of these women were currently caring for their youngest child, a baby. The babies were 6 to 9 months of age during the interviews. While none of the women were pregnant at the time of the interviews, all the women had experienced intimate partner violence and abuse during one or

more previous pregnancies. Some of the women had gone to shelters multiple times. For women who had been in a shelter more than once, they were able to talk about the challenges they had lived through, but sometimes the interview did not follow chronological order as their experiences would flow into one another. It proved difficult for them to separate out their pregnancy experience from their mother role when their partner was abusing them in pregnancy and their other children were watching.

Additional characteristics of the participants are shown in Table 1.

Table 1

Demographic Characteristics of Study Participants

Age	Number of pregnancies	Pregnancy loss	Ethno-cultural Background	Educational Level	Employment Status	Income	Current Relationship Status
35	8	1	First Nations	Some High School	Homemaker	>$25,000	Separated
28	2	1	First Nations	Some College	Homemaker	>$25,000	Living apart/ Single
33	5	1	Caucasian	Some College	Homemaker/ Unemployed	$26,000-35,000	Separated
23	4	3	First Nations	High School graduate	Homemaker	>$25,000	Separated
23	3	2	First Nations	some High School	Homemaker	>$25,000	Single
40	2	1	South East Asian	University Graduate	Homemaker	>$25,000	Separated
26	8	4	Métis	Some College	Homemaker	>$25,000	Separated
46	4	1	Asian	University Graduate	Homemaker	>$25,000	Living apart

Overarching Features of Participants' Lives

Feminist standpoint theory enabled the context of the women's lives from their viewpoints to be explored. The results of this study must be viewed from the standpoint of several overarching features of the lives of the participants. Understanding these features is important because they aid in the interpretation of the themes that were identified in the interviews. The three features of confusion, concealment, and endurance influenced how the women made decisions and circulated in the background of the nine themes. These features sometimes clouded or slowed the women's decision making processes. For example, when a woman felt confused by the abuse in her relationship she had difficulty seeing herself as able to parent her baby or to become a single parent. The woman would sometimes focus on what she could do to make her partner happy and not abusive; she would focus on just getting through her days, by enduring. Some women used concealment to put on a front that everything was okay in the relationship, in order to avoid closer scrutiny by community health nurses and maternity care providers. In the next section I describe the three features and then the nine themes separately, but in reality the woman's experience is much more complex and the features and themes overlap so that engaging the woman in conversation it would be difficult to pinpoint where the woman is in her decision making, but if the woman was to reflect back on her experience these features and themes would be more evident to a careful listener who was equipped with an understanding the decision making process.

Confusion

One may think that abuse is so obvious that a woman would know whether or not she was abused, but this is not the case. From the women's viewpoint they hoped the abuse would stop. They blamed themselves for the problems in their relationships. They focused their energy on trying to make their partners happy, and making their relationships work. I cannot overstate how important this feature was, and it may contribute to the reasons why women do not acknowledge the abuse or seek help.

The women talked about how hard it was for them to recognize the abuse/mistreatment in their relationships. Several things contributed to this problem. First, some participants said that when they first met their partners they found them charming. He seemed interested, and showed kindness to her, her friends, and family, and so it was hard to reconcile this past behaviour with the current abusive behaviour. Second, some participants grew up in homes where they had witnessed intimate partner violence and abuse toward their own mother by her partner. In this sense, abuse seemed normal. Thus when abuse happened in the relationships with their own partners, it took a while for them to recognize that abuse was neither normal nor acceptable. It was only after reflection and looking back that the confusion cleared and they could recognize that they had been abused. Some of the women I interviewed had been in several relationships with abusive partners, they had gone through 2 or 3 abusive relationships and still not thought of themselves as abused, it was only with the counselling they were

receiving in the shelter that they were able to understand and acknowledge that they had been abused in their most recent and past intimate partner relationships.

Concealment

Fear and worry plagued every step in the decision about whether to stay or leave an abusive relationship in pregnancy. While the women in my study felt angry about the abuse, they were afraid to show their anger, because they were afraid their partner would retaliate by physically abusing them, or doing other things to control them like stopping their credit card, or leaving them without food to feed themselves or their other children. They were also worried that even if they did try to tell someone about the abuse, no one would believe them. One woman of South Asian ethnicity tried to ask her family for assistance; she was encouraged by her parents to stay with her abusive husband and try and make the relationship work, thus reinforcing her need to conceal the abuse.

Endurance

In order to survive the abuse, the women in this study all learned to "endure" their abusive relationships. This enduring enabled the women to survive despite suffering both emotional and physical abuse. Endurance required that the women withdraw from others and focus solely on their own experiences. Although endurance thus isolated these women, it was important because it helped them to come to terms with the tension, and develop the strength required to make decisions about their relationships, particularly the decision to leave their abusive partners.

Thematic Analysis

I identified nine themes in the accounts provided by my participants. The themes are linked to one another, and taken together, these themes show aspects of the experience of abuse that come before the decision to leave and help to explain why some women, particularly those who are pregnant, may endure abuse for a long time before deciding to leave the relationship. I have listed the nine themes below briefly and then provide more detail about each one. While I have presented the themes to illustrate the complexity of the women's decision making, it is important to note that the thematic analysis is not meant to reflect linearity or unidirectionality. The numbers that follow the quotes refer to the number I used to identify the participant in my study.

The nine major themes included:

1. Trying to make it work: Women work/spend their energy to "try and make the relationship work" in the hope their partner will change his abusive behaviour.

2. Binding in to partner: The man threatens or uses violence and abuse (including verbal, emotional, and physical) to control the woman.

3. Loss of self-esteem: The women experienced loss of self-esteem – they stayed with their abusive partners because they did not feel they could live without them.

4. Fantasy life: The women talked about their dream/fantasy that life would get better after the birth of the baby.

5. Crisis: A crisis/precipitant event occurred that provided an opportunity to reflect on the violence and abuse.

6. Testing to see if the relationship was over: The women continued to hope that their partners would change his abusive behaviour, several women went back to their partners near or following the birth to see if it was possible to continue the relationship.

7. Desiring peace and happiness: The women wanted peace and happiness in their lives and the lives of their children.

8. Moving forward as a single parent: The women talked about their realization that they could provide a safe and loving home on their own without their abusive partner.

9. Making a better life: The women began to experience a changed life and they talked about how their changed lives influenced their decision-making. The women hoped to make a better life for themselves and their baby/ children.

Trying to Make it Work

The women were initially hopeful their partner would change his abusive behaviour. They reflected back on the beginning of their relationships and wanted their lives to be like it was at the beginning of their relationship. This hope lasted a long time, often through many episodes of violence and abuse. For example, one woman said:

> We were friends for a while at first, and then we started dating. This guy just made me happy, he made me laugh. If I ever needed help, he was there for me. He just seemed like a really fantastic guy, and I didn't bring any of the negative stuff. If anything, I got to leave the negative stuff

> [from previous relationships] out and I just had fun with him. So that made me hopeful. (6)

Another woman related how she tried to sort out the abuse in the context of her pregnancy:

> I went to all my appointments with my partner, and my Dr. was asking if I needed anything. But I was scared. My sisters encouraged me to leave. I always knew about the shelter. When you are in a relationship, you do not want to get in trouble so you do things to keep things quiet, [no conflict]. It felt like danger to me, to tell about the abuse. I was not strong enough, and I was too scared to tell. (7)

Even though this woman knew she could go to a shelter, she continued to conceal the abuse in her relationship while she tried to figure out how to tell others about the abuse. She also harboured a romantic notion that things would get better and her partner would stop being abusive.

The women tried to change their own behaviour to make the relationship work. They made excuses for their partner's bad behaviour, and they took responsibility for the problems in the relationship. For example, one woman said:

> I thought before when it's just me being the abused one, you're knocked down so much, you're like, I'd rather be in this relationship than be alone, and I thought I could work on it. (6)

Another woman shared:

> I thought, okay, I will do my best. I will tell him I have the problem, and I told him I have the problem: I need to see the marriage counsellor. We

> should go and see the counsellor together and then solve the problem. Maybe they have the way that we can work together, and then we can still keep our relationship taking care of the kids (10).

Other women reflected on how the relationship turned out much different than they had thought it would when they first began the relationship. One woman said:

> If I knew that this type of situation could end up happening, could end up occurring in my life, I wouldn't want to be in it; I wouldn't want to date or be involved with a person that can put me in that kind of situation. I never knew anything about it ... I didn't want to see it, I didn't want it to happen, but I was kind of oblivious to the whole situation. Like I didn't even know what to look for, I didn't know what key signs were about abusive relationships. (9)

The women talked about how they saw their lives and how they perceived others were judging them. For example:

> It's not like I ask "Are you going to hit me? I want to be with you". (3)

Another woman shared how her own childhood had not prepared her, in the following:

> Growing up my mom and dad were always abusive. Like my dad used to beat my mom a lot when they were drinking, and I'd be the one running in the snow to go and get the cops, or hiding my sisters or brothers so nobody would get hurt. .... Just coming from an abusive place, it is like I look for it. I don't know why. (2)

This statement provides a key insight into the woman's beginning reflection; while she recognizes that she was abused, she cannot yet comprehend why the abuse is happening to her.

Another woman related how an early pregnancy loss made her think about her relationship. Although she had three children, her very first pregnancy had been a loss as a miscarriage. After I turned the tape off she told me a story of how her very first pregnancy had resulted in a miscarriage. They had gone for a motor bike ride. The motor bike broke down during the ride. "He made me push it back, a very long way. The next day I started bleeding." The bleeding got heavier and resulted in a miscarriage. There were many ups and downs in the relationship, while she tried to figure out how to make him not fight with her (10). In the interviews the women talked about trying to make the relationship work. Early on in their relationships they were in love with their partners and wanted to work on maintaining this deep emotional connection in their relationships. The verbal, emotional, and physical abuse slowly crept into their intimate relationships. One woman shared her feelings in the following:

> When you love somebody, it doesn't just shut off; you love them and you want to be there for them and save them. It's kind of sad, because you sit there and say 'It's not their fault, it's not their fault, and sometimes you will even take on the blame, saying it's my fault, kind of thing. (6)

She went on to further explain:

> I thought it was my fault for a while, so I thought maybe if I just listened to what he's telling me to do, or do what he says, then it will be okay. I

> thought maybe I'm being too strong of a woman and I don't know, I was just trying to be obedient. (6)

The contrast in how the woman viewed her partner's behaviour and her own feelings and responses is illustrated in the following:

> He was an alcoholic, so it was more fury, and actually he would take a sledge hammer to my vehicle; like that is how the violence started, like it wasn't against me. So, even when that started, I thought, I'm not in an abusive relationship, because he's an alcoholic, and I have to help him with this. I have to help him control his anger and get help with his drinking. And he's not coming after me; he's coming after my vehicle or my phone or my property. I didn't think I was in an abusive relationship, I just thought, either I had the choice I could leave or I could help him, and I really cared about him. (6)

She tried to rationalize why she needed to stay with her partner despite the abuse in the following:

> I thought it was more because of the alcohol, it wasn't him. I thought this is a substance abuse problem, so it's not his fault.... I really though, okay I need to stand by him. This is my man. Either I could just leave this guy and move on and I could lose somebody that I'm going to marry someday, or else I could stand by him and show him that I'm going to help him and that I really love him. (6)

Another woman talked about how conflicted she felt:

> I felt that it was more for them [children] than anything else. Because, although me loving him and them loving him was a pro, it was also a con; it was something that was also bad. I knew that I loved this person, but I figure he can tell me he loves me as much as he possibly wants to, but it wasn't so.... it was like he constantly was always going to be the same person, he was never willing to actually change. (9)

Although the woman hoped her partner would change his ways. She also tried to change her own behaviour in order to respond to her partner's abuse and to bind in to the relationship.

Binding-in to Partner

The male partner tries a number of different approaches to exert his power in the relationship. When I listened to the women's stories I had a sense that the male partner started with every day things and as the tension built between the couple he tried harder to exert his control. While at the same time the woman is focused on trying to make the relationship work and to bind-in to her partner in preparation for the birth of her child. Emotional, verbal, and physical abuse and violence are used by the man to control the woman. One woman said:

> My first pregnancy, it was a lot of emotional abuse; it wasn't very physical, but it was a lot of words, and what he said to me. (7)

The abuse could also be verbal as this woman shared:

> At that time, I was 26 years old when I married him: before that I knew him for 3 years. And I wanted to leave him, but every time, he said if I leave him he's going to commit suicide.... and he has said to everybody

> that we are living together, - but we were not living together – so he told everybody that I'm almost married, so I couldn't leave him. Because in my culture, when we have a deep relationship like that, it's so difficult to marry another person, and he was threatening that's he's going to commit suicide. (8)
>
> When the woman was pregnant he started calling her names. She felt he disrespected her:
>
> "He would say things like: "you are a cow, you will deliver a calf". (8)

Sometimes the abusive partner controlled the woman by withdrawing assistance and support. For example, one woman talked about how her partner ignored her symptoms in the following:

> I had a lot of vomiting – morning sickness. It was extreme; I had to get an IV. .... I wanted to have contact, a visit [from my family]. He said No, you are not the first woman who got pregnant. There are so many women who have delivered babies, so you have to go through this. And I remember one day, I was vomiting and I was dehydrated, and he had a friend, a girl who was in the medical college at that time ... She said, you bring her and we will give her an IV. He didn't take me there. He said, if I take you there, nobody's going to stay with you. I said, I will die like this, and then he said No, if I stay with you, who is going to earn money? I cannot leave work to go with you. He said, you drink a lot of water, and then you won't dehydrate. .... Later he took me to the Dr. and he had to pay money. He

> was complaining about paying money. He said I told you pregnancy is hard. (8)

Not all women had this experience, but this woman's story illustrates how her partner used control to minimize her symptoms and refused to take her to the hospital.

For another woman the partner exerted control by destroying the participant's property early in the relationship. She said:

> He had a temper, but it was more like he would take a sledge hammer and he would destroy my vehicle, or he would destroy my phone, it was things like that, but he wouldn't really come and hit me. Like, he would shove me, and I thought I'm not black and blue, so I don't belong in a shelter. (3)

Later on the violence and abuse escalated to physical violence toward the participant, as in the following quote:

> But when I got pregnant that's when he started choking me. He would punch me in the face. He wouldn't ever touch my belly. He would say, "It's an alien in there". (3)

Pregnancy motivated the women to question their situation and to try to regain some control over their lives, as evidenced by the following:

> Once you are pregnant, it kind of gives you a little bit of your power back. Like, you realize, 'I love this baby' and it kind of snaps you out of how low your abuser is putting you down. (6)

After the baby was born she reflected on her experience in the following:

> ... if it was just me, and she didn't come along, I probably would still be in that relationship. They [the abuser] have so much control over you, and it's just you, you're not having to worry about another – like, your child, another little person who is being brought into this [relationship]. ...knowing that I'm going to be the caregiver of her and she's looking up to me to keep her safe, then that's what really got me to go [to leave]. (6)

In her reflection I can hear the tension between her trying to bind-in to her partner and her realization that her baby needs her too, trying to bind-in to the baby.

Another form of control was the male partner's insistence that the woman focus solely on her abusive partner's needs, such as cleaning the house or preparing meals for him. The male partner was using control to compete with the baby for the woman's attention. For example, one participant said:

> I felt like his slave – there to clean his house – not loved [for being me].(1)

Another woman shared:

> Even though I had morning sickness ... I had to cook for him; every morning I had to cook his breakfast and make his lunch. I had to do all the housework; he didn't help with anything. (8)

Sometimes the partner extended this control by timing the woman as she engaged in various activities such as going to the store or going for the mail. For example, one participant said:

> I was on time limits when I went to the store, or shopping for groceries. I don't know why I stayed. I think I was scared to live by myself. I have never lived by myself before [coming to the shelter]. (1)

In another interview a woman related how her male partner would call home to see if she was at home as a way to check-up on her and keep track of where she was.

The women explained how they questioned the reason for their partners' control and abuse. For example, one participant said:

> I knew it wasn't my fault – because that's how I felt. I knew it wasn't my fault, but you try to put it on maybe if I did this or that, then things would be better.... maybe I should have done the dishes when he told me to. (3)

In this example, "maybe I should have done the dishes when he told me to" is a simple statement, but it shows the energy spent on trying to understand experience and give it meaning. The example provides insight into the woman's decision-making. While she could verbalize that the abuse was not her fault, and she was searching for ways to make things better, she had not yet realized that she did not need to take all the responsibility for what was wrong in the relationship or for her partner's abusive behaviour. Although the woman hoped her partner would stop his abusive behaviour, she also tried to change her own behaviour in order to respond to her partner's abuse and because she wanted him to be present for the birth – she was trying to bind-in, a developmental task of pregnancy.

Another woman related how her partner tried to control her:

> He stopped letting me sleep in the bedroom, so I was sleeping on the couch, and he would lock the bedroom door, so that I couldn't go in. That's where my laptop was. So he didn't want me to look at my email and stuff. He even changed my computer passwords. (5)

For some women the control extended to their prenatal care. For example, one woman said:

> I stopped caring about my baby. I stopped going to my appointments because I didn't have any support. He didn't want me to talk to my family anymore, so I didn't, so I felt like I didn't have their support, I didn't talk to them, like he was really controlling. (5)

Another woman shared:

> When I was pregnant I wasn't allowed to leave the house. (6)

For the pregnant woman "not being allowed to leave the house", meant that not only was she controlled by her partner, she could not attend her prenatal appointments.

The women felt they had limited resources with which to support themselves, which meant that trying to escape the control was complicated by the realities of no job, no money, and no way to support themselves. For example:

> I needed him – like, financially I needed him. (7)

Sometimes the controlling behaviours used by the male partner to control the woman began subtly and built in the increase in the use of force and threat of force. The woman did not recognize how the controlling behaviours were impacting her self-esteem when she was living with her partner as she was focused on trying to bind in with him.

Loss of Self-Esteem

The man's attempts to control the woman had the effect of wearing down the woman's self-esteem, as well as her emotional connection to the fetus.

Some women talked about how their partner betrayed their trust by dating other women while the woman was pregnant, and then telling the woman about it, which further lowered their self-esteem. The women tried to work out the differences in their relationships by sharing their feelings with their partners. One woman, who had left a previous abusive relationship, explained her approach to this new relationship in the following:

> I would get intimidated a little bit, or I wouldn't talk, I wasn't open, and then he would be like, "Why are you acting like that?" I'd say honestly, I was taught to keep my mouth shut, and that I'm just trying to avoid conflict and all that.... I would just tell him what would happen ... he would [previous partner] he would lock me in the bathroom, he would punch me in the face and all kinds of stuff, and this is the one thing I really hated, was he would argue – because men are bigger than you [women], he would corner me, and I couldn't move, and he'd be right there, and I was literally cornered, and I said – that sense of entrapment around me, that is what was the worse, because I'd be panicking. (6)

Her partner also used fear to control her and it was a struggle to maintain her positive sense of self-esteem. For example,

> Even if I was crouched down on the floor, he still got me there; it was more of an advantage if anything. So when I told this to my son's Dad, he actually, I guess, stored it in his mind, going "I got a weakness on her". So he started off where, if we argued, he would come towards me, and then I would start – without even realizing it. I'd start backing up; it was just my

> automatic reaction, if you're coming towards me, I'm going to back up ... one day I was in the shower, and he had me cornered, and I just dropped into the tub and I just started screaming, and he went like 'holy cow'. I guess I freaked out. I said, don't ever do this to me again, you're cornering me. I literally just couldn't handle it ... It gave him power. If guys know what your weakness is or how to catch you, they'll – well not all, but the abusive ones will use that as a negative. (6)

This woman had learned a lot about abusive behaviours and how the man controls the woman in her counseling sessions at the shelter. She was able to identify the controlling behaviours her previous partners had used on her, but it was a revelation to her, she had not understood what was happening when she was in the midst of the abuse. Similarly another woman shared about her experience:

> I was 7 months, and then, I don't know, I think something clicked, and I thought, I don't deserve this. There was a lot of fighting whenever he was under the influence. It's like he – I don't know, like he turned into somebody totally different. (4)

Another woman shared how having an unplanned pregnancy had added stress to their relationship and under minded her self-esteem:

> I get pregnant …. Then he wants me to do an abortion because he don't want the kid with me; he want to break up. I says I don't care that I'm going to be staying with him or not, but I'm going to keep the kid, my baby. He said, you make things worse. The easy thing is to just go and do an abortion and end it. … Then he told me, okay, we will try and work

> things out. And I go back to staying with him. … I don't know how to solve this problem. I want my baby, but I want more for her life. I don't know how to tell my family. I don't know how to tell my friends. I don't know how to survive. … Thinking back now, I am doing better, I am better off [having left] (10)

Her confusion about the relationship and how to resolve the conflict with her partner are reflected in her account.

The women talked about how when their self-esteem was at a low point it was hard to envision how their lives could be changed. There was a tension present; their lives were different than what they had imagined or fantasized being pregnant and preparing for the birth of their child would be like.

Fantasy Life

One woman reflected on how she was hopeful her partner would change his behaviour:

> ... with this guy, I think I left four times before it was final – or maybe even more. Like, I went to a shelter three times before I finally left the last time, but I'd keep going back, and it was because I kept – because I did love him, and there was hope, there was always hope. I thought getting pregnant - it wasn't planned for us, but when it did happen, I thought that that would change everything. Once he had a child - he doesn't have kids – he'll realize what love is and he's going to love me for this, and he's going to want to change and it's going to fix things. (6)

Upon further reflection, she related how this experience had influenced her decision-making:

> Because, I thought once the baby's here, he'll change. This will make us a family. This is going to be our saviour. But it actually it got worse after she was born, the controlling part, especially. So that's when I decided to leave for good. (6)

Some participants talked about becoming embarrassed about the violence and abuse because it was becoming clear that their dreams of a "happy family" did not match their actual daily life. They tried to minimize the abuse to decrease the shame and pain. One woman shared:

> I wanted people to think that we were good; I tried to hide it, like, 'Oh no we're fine, we're fine. But he wasn't shy about it; he hit me in front of people. (6)

Participants were still working hard to present a public image that the relationship was "fine" but in their private lives they realize that the relationship was abnormal. Despite this realization, they were still intent on trying to find some way to make the relationship work. For example, one participant said:

> There was still a part of me that wanted that family. But, I wanted to prove to my family, that I could be a good wife. That I could have the same thing ... 'cause they probably knew how the relationship was ... I felt like I didn't have their support in leaving him or staying with him. (7)

For women who were pregnant, maintaining the family unit was particularly important because the women wanted their unborn child to have a father, and for the child to grow up knowing their father. For example:

I stayed because I didn't want my kids to grow up without their Dad, because that's how I grew up. (1)

Crisis or Precipitating Event

While some of the women were trying to sort out their feelings, a crisis or precipitant event occurred. Often this meant that the police were called and the woman was taken to a shelter. The crisis highlighted a disconnection between the participant's public and private lives. Up until this point, some women related that their partner could be a smooth talker outside the home, be very charming, sounding as if he was very caring, but at home he would be verbally abusive and mean-spirited, sometimes inflicting pain and physical abuse on the woman. Once the crisis occurred however, the violence and abuse that happened privately became public. The crisis could take different forms, for example:

> The first time I ever heard of a crisis shelter, a woman's crisis shelter, was when I was actually put in one. I was placed in one by the police. That was back when I found out I was pregnant with my daughter. I was about 2 months pregnant, and I didn't know I was pregnant, and my ex had come home from drinking, freaking out on me, and he beat me severely, to the point where my neighbours were concerned. They called the cops and the cops ended up taking me and putting me in a crisis centre. (9)

This woman's account reflected a crisis where others were concerned for her safety, this wasn't always the case. Another woman arranged with friends so that she would have support when it came time for her to deliver. She had complications in her pregnancy and she was concerned that her partner would leave her alone at home with no way to get to the hospital or help might not come in time and the baby might die as reflected in the following:

> I told that lady, "I'm very scared, and he said that I have to get ready to do a home delivery." And I said, "I am very scared. I will die." I said "We will both die." Then she had spoken to her husband, and they said I could stay with them. (8)

In both instances the crisis brought others to help the woman with her pregnancy, but the tension she was feeling in the relationship with her partner remained. She still wanted him to be present for the birth of the baby. For the first woman we can hear her reflections of being a mother and how it influences her decisions around a new pregnancy. The second woman's experience reflects her preparing to become a first time mother.

Testing to see if the Relationship was Over

After the crisis the man would often be contrite, act remorseful and the woman would feel guilty and take him back, they would become friendly and spend more time together. But then he would fall back into his previous patterns of being verbally and emotionally abusive, and in fact sometimes the physical abuse would escalate after this reunion. This pattern was related in the following woman's story. In the following quote one participant discussed this process.

The quote also includes some other themes, which illustrate how the woman's account reflects her standpoint as an embodiment of her social identity:

> I was thinking, "I can't do this all by myself. I need someone here. My family is an hour away. What if something"—you know, I kind of used that as an excuse to bring him back, to reconnect with him. And still there was always that "Maybe he did kind of learn his lesson. Maybe he really wants to do this." I learned from counselling and stuff I was a big romanticizer. I was always, like, "We're going to be this, and we *will* be that, and we'll do these things together." I didn't really look at the *now* and what was going on now. Because if I looked at what was going on now, I'd have to face the reality. So I got a hold of him. I called his mother, I told her I wanted to talk to him, he came out the next day to my new place we had a talk. I told him I really missed him and that he really missed us and things were going to change, he didn't want to hit me, he didn't like the way we were treating each other. Then we decided, "Yeah, let's do this. I think we can do this." I told him I really loved him, he told me he loved me, his family. Then I had my son…then he really didn't want to find work right away, he was very lazy, he always wanted to go gambling, go to the casino, so I always gave him our money—'cause I didn't want to fight, I didn't want to be the one to cause a fight 'cause I knew he would get upset. So he started drinking a lot again, started gambling. *[pause]* Then when he would come home drunk, it was like I had to face him; you know, I was there waiting for him with my kids, and

> I had to—face him, and it was, like, "What am I doing? I got out of this how many times already, and I'm just right back to where I was. (7)
>
> For another woman the testing came after the birth of the baby. She shared how she tested the relationship in the following:
>
> …after having the baby and she was just 6 weeks old, that's the day I left …. He had gone out drinking and came back at 4 o'clock in the morning …. He was trying to hold the baby. … like, his body is shaking and he's trying to hold the baby. That kind of got us fighting. ….That's the day I left. I'm like, this is crazy. He'll end up dropping her. He can't even admit it. …. I just realized, "Oh, my gosh, I have to get out of here. (6)

Later on she shared how hard it was to stay away from her partner.

> It's really hard, 'cause you think about, well, it is the dad, yet I know that I did the right thing when I left and we are going to be fine. You go through those stages where you're just, like, "I still love him", and I still have hope that he'll change, and I want him to see the baby, because she is growing up. …. But there are ways to do it where if he really wants to see her, he could go ask for visitation through court and it could be set up. …I have to realize that he hasn't changed. (6)

The women began to realize that their partners were not going to change their behaviours and as mothers-to-be and new mothers they needed to focus on their new roles.

Desiring Peace and Happiness

These experiences made the women think about what they wanted for their own lives and their babies. The women related that after everything they had lived through in the abusive relationship with their partner all they wanted was to have peace and happiness in their lives to raise their baby and children. For example, one woman said:

> I really wanted to be happy, because I was tired of being unhappy, it was really hard ‘cause I was really emotional when I was pregnant. Then I had to leave him right after she was born. (5)

Another woman shared:

> I think you need to ask yourself what you really want. Do you really WANT to leave? Are you happy? (7)

It was an emotional experience for the women to share their thoughts about their decisions to leave. For example, one woman said:

> There is a better life out there. There is a happier life out there. When the time is right maybe you will meet the right guy. The worst abuse is emotional or mental. Bruises can go away, but the abuse from mental is worst. If you don’t deal with the emotional abuse it is a scar that will be there forever if you don’t deal with it. (1)

Later on she shared:

> If they (women) really want to succeed or lead a better life they need to go. Just go. It is plain and simple and you have to go. It is not worth it. It’s a

> cycle, that's what I learned, (sic) it's a cycle that you have to not let your kids see that. (1)

Another woman talked about how writing helped her to work through her feelings:

> It helped when I write about stuff like that, it helps me to think like I'm a fighter, I can be a fighter, and I will be a fighter, and I won't let this – I won't let this sort of thing bring me down anymore. (9)

Here she presents her feeling in a poem, To Be a Fighter, which she wrote prior to sitting down to talk with me in the interview:

> The challenge in life is to be a fighter.
>
> The fighter does not dwell on defeat, but accepts it as another step towards ... [her] future.
>
> Our challenge is similar.
>
> We do not dwell on our pasts.
>
> We stare defeat in the eye and say 'we are stronger than ever'
>
> And we will not go down in pain and agony
>
> We shall surpass and grow from love and strength within,
>
> For we are fighters. (9)

Moving Forward as a Single Parent

As part of thinking through what they did want their lives to be like, the women thought about how they were parenting their babies. Thinking about being a mother, the women realized that it would be better to be a single parent rather than continue in an abusive intimate relationship with their male partners.

Realizing that it would be better to be a single parent, rather than trying to maintain their relationship with an abusive partner was an important step in the women's decision-making. The women took into account that they could provide a safe and loving home on their own for their children. One woman explained, "once your baby is there you realize that your maternal instincts are stronger". (3)

The women also talked about feeling guilty for not leaving the abusive relationship sooner. In particular, the women with more than one child talked about how they felt bad that their children had witnessed the abuse of their father towards their mother when she was pregnant. One woman whose partner was verbally and physically abusive to her wrote a poem to give herself strength for those days when she felt herself wavering in her decision to leave her partner, and thinking about going back with him. She wrote:

> Heavenly Father, I come to you as humble as I know how.
>
> I confess my sins, those known and unknown.
>
> Lord, you know I'm not perfect and I fall short every day of my life, yet you are still there for me.
>
> I just want to take time out and say thank you.
>
> Thank you for your mercy.
>
> Even though I have more bills, than money,
>
> I thank you for my home, my car, my food, my life, my children, and everything I do have.
>
> I realize this life I'm living is full of trials and tribulations, full of ups and downs,

But I thank you for not putting more on me than I can bear to handle.

And when she felt tested she reminded herself:

> The next time you get ready to complain, tell the Devil you are a blessed child of God, and you have more to be thankful for than to worry about. We all must go through the storm to appreciate the sunshine. (9)

The women talked about how their decision-making to leave their abusive partners was influenced by both their determination to be a single parent, and to not force their children to watch their mothers being abused. For example, one woman shared:

> I wanted something more for my kids. I wanted them to have a life that I didn't know. 'cause I grew up in an abusive family, and I didn't want them to see the things I seen (sic). I didn't want them to have to feel that pain and that stress". (9)

Making a Better Life

When the woman realized that they needed to leave their abusive partner in order to make a better life for themselves and their children, the next step was using their power to leave. There comes a time when the woman realizes that she is worth more and that she doesn't have to live with abuse and violence, she has the resources and support to enable her to leave. For example:

> The whole leaving part, it was very difficult. It was a decision I knew I had to make on my own, that nobody could help me decide. (9)

There is a sense of disbelief that she is actually out of the relationship after the woman leaves. One woman said:

> I think that is what stresses a lot of women out. And where they are going to end up next. I think women; they just give up and go back to their relationships. That is just from my experience. From this last time I don't want to go back, I'm terrified that I will end up giving up and that I will lose my baby and go back to my old ways. (1)

Realizing that they could leave their abusive relationships and a make a better life for themselves and their children was powerful, and it helped to sustain the women for the struggles ahead.

In the following example, the woman relates how her own childhood experiences influenced her decision-making:

> ...seeing what she [my own mother] went through and what she had to deal with helped me a lot to make the decision to leave my children's father. Because after seeing everything she went through, and realizing I'm heading in the same direction, I thought to myself, 'I'm not going to allow my children to see their mother the way I seen my mother get abused. (9)

She strongly felt that a child should never have to witness their father beat their mother, this was related to her own emotional trauma, and strongly influenced her decision-making, as illustrated in the following:

> I've seen my Dad do so many horrible things to my Mom. It was like he [pause] it must have made him feel like a bigger man, but he would make us watch him beat my Mom, and that is something you –even as a young child, there's some things you never forget [sighs] Just thinking about it makes me so mad, and I just want to say it helped me to realize, I'm not going to let

> my children see that.... even though I love him, I'm not going to allow him to hurt me anymore. (9)

The reality hit very close to home for this mother because she had run away from home, when she was a teenager as she couldn't cope with seeing her mother being beaten by her father. Later on she related:

> A lot of the pros [for leaving] were the fact that my children needed something better, they needed something different. They don't need to see their mother being hurt, they didn't need to feel like they were insecure, and they didn't need to feel belittled. (9)

She shared how despite her hope that her partner would change and become a good father, she needed to focus on her children's needs.

> I know a lot of women say they need a father – the kids need a father and stuff like that, or they always make excuses about how much they love their partner and how much things can change, and 'we can make it better' or 'we can work on it'. (9)

But the reality was that her partner was physically abusive to her when he was drinking or using street drugs, and he drank whenever he got paid. She reflects on her experience in the following:

> If a man can look you in the eye and tell you he loves you, he shouldn't raise his hand to you. If a man can tell you he loves you and loves your children he shouldn't be hurting them in any sort of way. It doesn't matter how little bit of pain it is, it is still pain, and it still hurts. As long as you can

> recognize it when it first starts, then I'm sure that you can also be the person to change that. (9)

Her partner tried to reunite with her after she left. Her resolve is evident in the following quote:

> I love him, but he made his choice to leave us and I'm not taking him back – he's asked but I'm a stronger woman than that. (9)

Having made her decision, the woman still questioned if it was the right decision:

> Sometimes things do change; sometimes there is that little bit of hope; there is always that little bit of hope in every single woman that the man they love will change. But most of the time, you cannot – women need to realize that you cannot change a person if they are not willing to change, and even if it hurts you as much as your heart's desire to give them up, sometimes giving them up is better. And not just for you, it's better for your whole family. (9)

She went on to explain how the abuse affected her own family, stating you've got to look at the bigger picture.

> It's not just you and your children, it's the people around you, that love and care about you. I didn't realize until after I had left how much the abuse that I was going through affected my brothers, it affected my sisters, and it affected my mother. (9)

Another woman shared:

> So here I am leaving and I'm pregnant with my second child, and I'm feeling bad, feel like I did something very wrong, like I shouldn't have gave up on him, I shouldn't have gave up on the relationship. (7)

One woman related that after she left she realized that she had been focusing on his needs over her own needs.

> I thought it was not the end of the world if I was not with him. Like there is a whole world out there. My whole world had revolved around him, I bought him everything, supported his habits, made sure there was food in the house, kept it clean. In the end I was the one who wasn't worth a dam.(1)

It was not an easy decision to leave their partners, and the women had to give up their notion of hope that the man would change. For example:

> I wasn't sure what I wanted. I think, I was holding onto [the hope of] him changing. But you can't help someone who does not want to help themselves. I have been to a lot of workshops and sometimes I forget to use my tools. I don't know. You can't change someone who wants to be drunk all the time or high. (1)

Sometimes it takes more than one time of leaving and going to a shelter to be able to separate, as illustrated by the following woman's comments:

> I came to a shelter; I didn't get help with resources or anything like that. So I ended up going back with him. (1)

Another woman related a similar experience even though she gave her partner another chance to test the relationship:

> We'd broken up many times, and each time we'd come back together, it's bad for both of us. We were both worse with jealousy and abuse,

> emotionally and mentally. He gets worse and worse every time we got back together. (5)

As I listened to the women's stories, I could hear how the confusion seemed to intensify their struggle to leave. Some women talked about how hard it was to let go of their dream of a happy family with their abusive partner. In the other women's stories I could hear them searching to make sense of the abuse by the man they loved; in fact this searching happened as the women were enduring and trying to make sense of the relationship.

Having made the decision to leave their partners, the women began a new journey of life as a single parent on her own. In each woman's story, I could hear her balancing the hope for a new life with her baby/ children with her uncertainty how things were going to turn out, but determined that it would be better than the experience of abuse and violence that they were leaving behind.

The women discussed how happy they were to be making a new life with their children. They acknowledged that it was not their responsibility to change someone else; that person needed to want the change themselves. They acknowledged that their ex-partners did not want to change. One woman said:

> I have cried a lot, I have tried so hard; I did my best. I don't need to see him again. He was just destroying - he destroyed me and my child. (8)

Another woman related:

> I had enough. It was either leave or lose my baby to Child Welfare. Or try and make a new life for us. (1)

It wasn't always easy to live the consequences of the decision. For example one mother discussed the conflict she now felt:

> I feel like a bad Mom if I keep him away ... I have to wonder if he is ever going to change. I'm not going to change him; he'll change when he wants to. (5)

Thinking about the new life she was making for herself and her child and children helped the women stay committed to their decision. For example:

> I think I will have a better life. Now that I look at it, I wasn't getting anywhere. I wasn't getting ahead. I wasn't getting help from anywhere. (1)

Interestingly the desire for a better life sometimes leads to another abusive relationship. Several women gave accounts of having gone through the whole decision process many times, each with a different abusive partner. In other cases the woman was able to maintain her dream of a new life on her own.

Description of Deciding to Stay or Leave

In this chapter I have presented the analysis of the interviews I collected about how pregnant women made the decisions to stay or leave an abusive intimate partner relationship. The analysis provides a rich description about how pregnant women make decisions about staying or leaving an abusive partner relationship. The three contextual features of confusion, concealment, and endurance circulate in the background of the woman's thinking, sometimes clouding her weighting of the positive and negative aspects of the relationship, and consequently influence how the woman makes decisions about staying with or leaving her abusive intimate male partner.

The women had a sense that the relationship was not working. They tried harder to make the relationship work in the hope that their partner would change his behaviour, but they could also tell, often through the control and dropping self-esteem, that there were some things about the relationship that were not normal. Their pregnancies, however, helped them construct a fantasy in which they dreamed that life would be better after the baby came because the baby would help them create a family with their partner. This fantasy was shattered by a crisis in which the woman left the place where she and her partner lived, often with the help of police who had been called by a neighbor. Once removed from the physical environment the women could begin to see that the problems in the relationship were not all their own fault and that their partners were not going to change; it was not something the women could help the men to do. The men needed to want to change themselves. At this time the women also began to see that a different life was possible and that both parents were not necessary. Sometimes they were able to leave the relationship at this point but this was not always the case. Participants talked about returning to their partner following a crisis, testing the relationship, still hopeful that they could make the relationship work.

There came a time, however, when the women said ”I’ve had enough”, often because of fear for the emotional and physical safety of their children, and the women decided to leave the relationship. Sometimes it took months or years for a woman to make the decision to leave her partner. The picture was complicated, because the women felt they had limited resources with which to

support themselves. But the women were hopeful that living their lives as a single parent without the abusive partner would be better for themselves and their babies.

The belief that the relationship will work, when bolstered by the desire to create a family with a new baby, is strongly supported by the beliefs and values of society. The pregnancy initially helps to create a fantasy that the unborn child will help the woman and her partner create a family in which the abuse will no longer be present. When a crisis occurs, however, women have an opportunity to consider a different life and some choose to change their situation, while others return to the relationship. The transition to a new life, however, as exciting as it may be, is also full of challenges and some women may find it too difficult and may return to their abusive partners.

In Chapter Five I link these findings to the current research literature and show how my study helps to address existing gaps.

CHAPTER FIVE

Introduction

In this chapter I discuss my findings in relation to the gaps I identified in Chapter 2, and also discuss new ideas from my work not previously identified in the literature.

In Chapter 2, I reviewed two bodies of literature: women's experiences of intimate partner abuse during pregnancy and decision-making about whether to stay or leave an abusive intimate partner relationship. I identified 2 main gaps. The abuse literature does not address how pregnancy affects the decision to stay or leave the abusive relationship or how abuse affects the developmental tasks of pregnancy. The main findings of my study were that early in the abusive relationship, the pregnancy seemed to be a deterrent to leaving the relationship, but as the abuse progressed, the pregnancy seemed to be a motivator for leaving. Also, during the early phase of the abusive relationship, the tasks normally associated with binding-in are replaced by a phenomenon identified by Lutz et al. (2006) as double-binding. Once the women left their abusive partners, the double-bind was broken and they moved into binding-in, but without the support that would normally be provided by the partner.

In Chapter 2, I noted that beginning work had been done on abuse and pregnancy by Lutz (2005a, 2005b), but her focus was on prenatal care, not on the decision to stay or leave the relationship. Lutz and her colleagues' (2006) research was based on two previously collected data sets and they found that women experience a phenomenon they called double-binding. Lutz's work is helpful for

understanding the pieces about prenatal and postpartum care in the context of intimate partner violence and abuse. Our current understanding of the double binding phenomenon is that the woman is torn between her relationship with her abusive partner and her preparations for her role as a new mother. This period of time is challenging for an abused woman because her attention is focused on making choices for "safe passage for herself and the baby", while also trying to maintain her relationship with her abusive male partner, who she loves, but who is a threat to both her and her baby. This is consistent with the developmental tasks of pregnancy, and it is important to remember that binding-in is not time specific, but occurs over a time span from pregnancy through the first year of life after the birth. My research builds on this previous research by contributing knowledge about the decision making to stay with or leave and abusive partner during pregnancy, when double binding is supposed to occur.

Limitations

I started this research project with questions about how the developmental tasks of pregnancy would influence a woman's decision making about staying with or leaving an intimate partner due to violence and abuse. While Lutz (2005a, 2005b) has written about this issue, previously there was relatively little written from this unique perspective. The intent of my research is to provide an interpretive description that will deepen our understanding of women's decision making to stay with or leave an abusive male partner during pregnancy. This intent is consistent with Thorne's description of using interpretive description to obtain a more refined understanding of the patient's standpoint. "In the health

field … many studies are designed for the explicit purpose of uncovering [a] more refined understanding of health problem from a particular standpoint of the patient" (Thorne, 2008, p. 243). This intent is also consistent with Naples (2003) description of feminist standpoint theory's contribution to the analysis of experience by exploring social identities, such as becoming a mother, and the relational aspects of social identities, such as mother role, father role, and couple roles. In this foundational project I am drilling down to a very narrow focus of women's experience of making a decision to stay or leave an abusive partner during pregnancy. I acknowledge the following limitations: to address issues of safety for the participant and the researcher, and pragmatically because this was an unfunded dissertation project, I chose to interview women who had gone to a shelter. Two major concerns are raised with a shelter population, on the one hand the shelter population is more likely to have experienced severe abuse, and secondly the shelter population is a small subset of all women who experience intimate partner violence and abuse. I recognized that this sample would not be representative of all women who make a decision to stay or leave an abusive partner during pregnancy. I anticipated the trade-off would allow me to gain an in-depth understanding of some women's decision making that would acknowledge the context of the developmental tasks of pregnancy. One advantage of interviewing women from a shelter is the support the women were receiving from the shelter staff; I think this support made it safer and easier for them to speak about their experiences. In addition, I did not have the opportunity to interview women who stayed with a partner who had been abusive in the past but

who changed his behaviour and was no longer abusive. While two of the women I interviewed were parenting one child, most of the women had several children and had had previous abusive relationships; as a result it was difficult for them to separate out their experiences of abuse. As they shared their stories it was evident that previous experiences of abuse and the most recent pregnancy experience were entangled.

I acknowledge that this is a relatively small sample of women, but all the participants had experienced intimate partner violence and abuse during a previous pregnancy and were able to provide detailed descriptions of their experiences and the themes were remarkably consistent. Nevertheless the sample was small, particularly given its ethnic diversity. I ended recruitment because the themes were consistent and the recruitment had taken much longer than expected. The recruitment of more Caucasian and South Asian participants would have made it possible to explore issues related to ethnicity in more detail. As well, for a larger scale study other dimensions of diversity (e.g. socioeconomic status, women not in the shelter, time since leaving the relationship) would have made it possible to explore how these factors may influence women's decision making within the context of their living story.

In the following sections I discuss the interpretive description I developed and show how it demonstrates the tension that is present in women's lives as they try to balance their needs to seek safety for themselves and their unborn child while trying to have a relationship with the father of their child, an abusive intimate partner.

Overarching Features

I identified three overarching features: confusion, concealment, and endurance that circulated in the background and sometimes clouded the women's decision making.

Confusion

According to Landenburger's (1989) process theory of abuse, abused women were confused about what was happening in their relationship. Thus it took the women awhile to realize that there was something about the relationships that made it difficult for the developmental tasks of pregnancy to proceed. While Landenburger did not interview pregnant women, these findings are consistent with those of my study. The women I interviewed talked about how confused they felt by the abuse from their male partners during pregnancy. They wanted to have a relationship with their partners because they loved them and because these partners were the fathers of their unborn children. This desire for a relationship seemed to contribute to the confusion and make it more difficult to see the abuse for what it was. This was reflected in the participants' choice to describe their current relationship status as separated, which may have been a reflection of the confusion they felt about permanently severing the relationship with their partner.

Stork (2008) also reported confusion among women who were in the process of leaving abusive relationships. She suggested that women may not have articulated or even mentally formed their goals; "…more likely women are trying to figure out what is happening, what might be an appropriate or possible

response, even whether the situation is one in which a response or decision is possible" (p. 33). Stork highlights the woman's confusion and searching:

> Living with the unpredictable behaviors of partners may require specific measures just to cope and try to get through. Over time, actions may reflect the desire to make sure that the future does not look like the past, yet that desire is continually punctuated by conflicting needs and trade-offs (Stork, p.33).

Concealment

The participants in my study all talked about how hard they worked to conceal the abuse in their relationships. While they realized that something about the relationship was not "right", they hoped that if they didn't acknowledge the problems and just tried harder, they could make the relationship work. The concealment, however, triggered intense emotional turmoil and tension. The women I interviewed reported fear, worry, embarrassment, shame, and self-doubt as they tried to conceal the abuse they were experiencing. Lutz and her colleagues (2006) also talk about how women dealt with conflict in their intimate relationship by working harder on the relationship, ignoring warning signs, and hoping things would get better.

The decision to conceal the abuse had implications for care seeking. Lutz (2005a, 2005b) described these implications as "living two lives"; she noted that women closely guarded the secrets about what was actually happening in their relationships but tried to present a positive image of herself to others as a capable, pregnant woman. Similar to the women in my study, the women in Lutz's study

talked about feeling that they were not living up to the societal expectations of having a partner/father for her baby, and were consequently ashamed and embarrassed about the abuse. In my study the women also talked about fear that others would find out about the abuse and try to take their children away.

Endurance

The women in my study endured abuse while they searched for a way to make the relationship work. "Enduring" was exhausting work because it required the women to be constantly vigilant, always "on the look-out," for ways to keep the relationship going. Kearney (2001) used a grounded theory approach, to analyze 13 qualitative research studies and synthesized a middle-range theory of women's experience of domestic violence. She found that endurance was a common feature of the abusive relationship. "Within cultural contexts that normalized relationship violence while promoting idealized romance, these women dealt with the incongruity of violence in their relationships as a basic process of enduring love" (p.270). Kearney found that women passed through four phases in response to the shifting definitions of their relationships. The four phases included: (1) discounting early violence for the sake of their romantic commitment (This is what I wanted"), (2) progressed to immobilization and demoralization in the face of increasingly unpredictable violence that was endured by the careful monitoring of partner behavior and adapting or stifling their own behavior, (3) the women shift their perspective that redefined the situation as unacceptable ("I've had enough"), and (4) the women moved out of the relationship and into a new life ("I was finding me") (Kearney, p. 270). Reflecting

back on these findings in relation to the women in my study, I can see many similarities. Although Kearney did not focus on pregnancy, the women in my study described experiences that were similar to other women who were being abused by their intimate male partners. Both the participants in my study and those in the studies reviewed by Kearney were committed to their relationships and did not recognize the violence. They endured the violence and abuse, trying to find ways to change the relationship, but eventually realized that they needed to leave the relationship, and make a new life for themselves and their children.

In Kearney' study (2001), *Enduring love*, was the basic social process by which women sought to reconcile internal and external conflicts within abusive relationships. Kearney used enduring as both an adjective and a verb to reflect the women's attachment to their partners or their obligation or their commitment despite ongoing abuse. The verb form of enduring connotes an intense focus on surviving in the present. In my study the women focused on surviving the abuse in their intimate partner relationships in the hope that their partner would change or the relationship would change after the birth of their child.

Kearney's conceptualization of enduring is similar to the definition developed by Morse and Carter (1996) in which they described enduring as "… an intense focus on surviving in the present…" (p.47), and as "…the ways the individual 'gets through' extraordinary physical or physiological assault or stressful conditions and remains intact" by (Morse & Carter, p. 47). They go on to explain that everyone has the capacity to endure, and that we do not know what we are capable of until the time comes. Enduring is a response that is reflexively

implemented when one's physical or psychological integrity is threatened; it is demonstrated when the individual has no choice but to get through the situation (Morse & Carter). This conceptualization of endurance is consistent with the experience described by the women in my study; they noted that they endured physical abuse and emotional abuse. It was not a matter of conscious choice on their part. "Thus, choosing between getting through a situation (and not emotionally disintegrating), or not getting through a situation is not premeditated, although circumstances may enhance one's capacity by motivating one to endure (e.g., "I had to do it for the children [baby]") (Morse and Carter, p.48).

One of the key points of enduring is that although the person is aware of the event they have not cognitively processed the event. "When the level of knowing is limited to awareness without full comprehension, the person enters the stage of enduring. Over time, the reality of the situation begins to 'sink in', and the incomprehensible becomes more real" (Morse & Penrod, 1999). The person's energy is devoted to suppressing emotions to hold on and remain in control (Morse & Penrod). The Domestic Violence Survivor Assessment (DVSA) was a tool developed for counseling women in domestic violence relationships that drew on Landenburger's theory of entrapment and recovery by incorporating the cognitive states of battered women (Dienemann, Campbell, Landenburger, & Curry, 2002). "Enduring encompasses the period when a woman recognizes that abuse is occurring, but remains committed to the relationship and tries to control the violence and focus on the good aspects of the relationship" (Dienemann, et, al, p. 222). One disadvantage that counsellors found when using the tool, was the

temptation to assess the situation based on the counsellor's extensive experience working with abused women rather than from the women's view of her own situation. The women that I interviewed initially described their hope that their partners would change, and the various ways they tried to make the relationship work. Some women even went back to their partners after their babies were born to see if their partners would change and if the violence and abuse would stop. It is possible that these women were focusing on the task of binding in to their partner and consequently enduring helped them to work through this stage of their relationship and to cognitively process the event. Some of the women related that they were able remain in the relationship because of support from other family members or the police. I will discuss this further in Chapter 6.

Deciding to Stay or Leave and Double-Binding

In Chapter 4, I described how women made the decision to stay or leave an abusive relationship during pregnancy. The construct of double-binding proposed by Lutz and colleagues (2006) highlights the barriers women face when deciding whether to leave abusive intimate partner relationships. These barriers include fear of the perpetrator, limited financial options, and lack of community resources. When added to reasons stemming from the developmental tasks of pregnancy, such as the desire to be a good mother, the desire to provide a stable loving home and family for the baby, it is not surprising that women find the decision to leave this relationship so difficult.

The research on double binding and decision making helped me to understand how hard it is for pregnant women to make a decision to leave when

they were faced with the abuse and violence, and how it was hard for some women to articulate how they made their decisions. The double-bind was so strong that women seemed to have a hard time even contemplating leaving. They truly believed that their children needed a father, and were willing to put up with the abuse of themselves to ensure this would occur. Several of the women talked about not realizing or understanding that their relationships were abusive until they were in the shelter and attending the support group.

Early in the Abusive Relationship

The first four themes I identified (trying to make the relationship work, binding-in, loss of self-esteem, and fantasy life) are somewhat consistent with double-binding as described by Lutz and colleagues (2006). During the early part of an abusive relationship, women in my study said they were trying to maintain a relationship with the father of their unborn child. Some women had experienced abuse in their families of origin or witnessed their own mother being abused, and this factor seemed to make it difficult for them to recognize when the relationship was becoming abusive or when they were being abused. Often it was only in reflection about their experiences with the support of counselors in the shelter that women were able to understand what abuse was and how it fit with their own lives. This was also true for the women in Lutz's (2005a, 2005b) study.
This finding may help to explain why women remain in abusive relationships for so long. One woman stated:

> "I didn't even know what to look for; I didn't know what key signs were about abusive relationships" (9)

Other women who have written accounts about the experiences of leaving an abusive partner also echo similar realizations about abuse (Dhillon, 2009; Tamas, 2011).

Some women described how they rationalized their partner's abusive behaviour towards them at this time. The rationalization included the construction of a fantasy or dream of how their lives were going to be changed by the pregnancy and birth of the child. This is consistent with Lutz's study (2005b) in which she found that during pregnancy the women were focused on the partner, the intimate relationship, and constructing a family. "Hopes and dreams associated with pregnancy were emphasized and normalcy sought" (Lutz, p.818). In my study, women said that upon reflection, they realized that the abuse often became progressively worse rather than better and was associated with loss of self-esteem.

These four themes (trying to make the relationship work, control, loss of self-esteem, and fantasy life) were not sequential; they seemed to occur simultaneously and to characterize this phase of the relationship. These themes seem consistent with the first two phases of double-binding—pursing the dream and enduring for the family's sake—described by Lutz and colleagues (2006). In the first phase, pursing the dream, the woman believes that her abusive partner will change, that somehow she can help him change his behavior by changing herself or doing things to support him to change his behavior. It takes time for the women to realize that the man must want to change himself and the change needs to come from him and not from her. For the women in my study this was a painful

process of repeated attempts to change themselves in order to appeal to their partners to change their behavior. Sometimes the change in the male partner's behavior came in small negotiated steps, but for many women the change in the man's behavior never came.

In the second phase of Lutz's (2005a, 2005b) model, enduring for the family's sake, the women talked about the expectations from other family members and society regarding how a pregnant woman should act. Moss, Pitula, Campbell, & Halstead (1997) found that women endured the abuse using several different coping mechanisms including: "…covering for their partner, denying there was a problem, using alcohol or drugs to 'numb out', and considering or attempting suicide or homicide" (p. 439). The women's endurance was influenced by sociocultural values and beliefs regarding violence. The women recognized the social norms that pregnant women should not be in a relationship with an abusive partner that might harm herself or the baby. The women focused on enduring and concealing the abuse while they tried to find ways to make their relationship work. In Lutz's study she found the women had ambivalent feelings that lead to a sense of helplessness. Engnes, Liden, & Lundgren (2012) found that women who are exposed to violence during pregnancy have ambivalent and contradictory feelings. In my study, I did not find the women were ambivalent, but that they talked about having to steer their lives in a different direction than they had expected, and the women voiced concerns about how they felt about leaving their partners and whether they should let him see the baby, but not wanting to live with their partners because of the violence and abuse. I believe

this feeling sounds more like ambiguous loss than ambivalence. Boss (2007) has done research on family relationships and distinguishes between ambiguous loss and ambivalence, and said that; …" ambiguity emanates from a situation outside the person or family, whereas ambivalence is expressed individually" (p. 108). I think that leaving an abusive partner is an example of ambiguous loss because it occurs primarily for reasons outside the women's control. The women in my study spoke about moving in and out of relationship with their abusive partner as they tried to balance the experience of abuse with perceived pressure from family members and others about the importance of the traditional two-parent family, loss of their partner, and hopes their partner's behaviour would change. Research to distinguish between ambiguous loss and ambivalence warrants further research as it could provide direction as to how nurses and other health care professionals could support women during this stressful time.

Several of the women in my study went back to their partners as the birth of their child neared, but when the pattern of abuse and violence returned the women changed to focus on the baby rather than the partner, and left again. The women began to recognize that their partners were not changing and that their babies needed their love and caring attention. Some of the women went to the shelter at this point. The women also talked about how it was hard to let go of their fantasy of a family life with their partner. This was also supported by Lutz (2005b). "Awareness of the dichotomy between the fantasy and dreams for their partner and family and reality grows" (p. 819). While the women were trying to sort out their feelings for their partners, they were also simultaneously beginning

the process of maternal identity formation. It is at this stage that maternal infant attachment occurs (Mercer, 1986, 1995, 2004). Lutz (2005b) noted "The fact that the abuser was the father of her baby or children added complexity to a woman's decision to leave the relationship because there was always some remaining hope that the family could survive and more closely match the fantasized family" (p. 819). Some of the women I interviewed also described how they struggled to decide if they should let their partner see the baby. For some women as their child or children grew older and the violence and abuse continued the women became more resolute in thinking about ending the relationship for good.

The Crisis and Double-Binding

My participants reported that at some point during the pregnancy, a crisis often occurred and they left the home, temporarily or permanently, often with the assistance of police, and went to a shelter. Interestingly, this crisis point is not addressed by Lutz and colleagues (2006). Lutz (2005b) has identified the point in time when women's decision making about the relationship changed as a crystalizing event, but she located this point after the birth of the baby. In my study, there was often more than one crisis during the pregnancy and these events seemed to loosen the double-bind, but didn't necessarily break it completely. Thus some women went back to their abusive partners and tried to make the relationship work once again.

For other women the crisis did break the double-bind, and the women shifted their focus entirely onto the expected baby, with the goal of moving forward without the father. This phase seems to fit with Mercer's (1995, 2004)

work on binding-in and the third phase of the work of Lutz et al. (2006), engaging in a dynamic balance, in which the woman struggles to maintain a balance between growing disillusion and hopelessness and a desire to make it on her own. When I interviewed the women they did talk about having doubts, but they were mostly very positive about their plans to live without their partners. I think the supportive atmosphere and access to resources at the shelter contributed to their positive outlooks. Contrary to the work of Mercer (1995), binding-in to the baby took place in my study without the support of the father. The women in my study obtained support at this point from other sources, including the staff at the shelter. This support increased the women's self-esteem. Nevertheless, some women still returned to their abusive partner, believing that they were now stronger and that they could make the relationship work, while others focused on creating a new life for their baby as a single parent.

Making a Better Life

In the fourth phase identified by Lutz et al. (2006), reconciling dreams with reality, seems to fit with my theme related to creating a new life. Here the woman focused on taking care of herself and her unborn baby. The last phase identified by Lutz et al., revealing and integrating two lives, involves using her energy to protect the child from harm.

A key element of this phase related to becoming a single parent. Ford-Gilboe (2000) interviewed women who had recently become single parents and found that the women self-identified becoming a single parent as a strength factor for their own health and the health of their children, and this is consistent with my

findings. My work and that of Ford-Gilboe are contrary to the common public perception of the weaknesses of one-parent families. Ford-Gilboe notes, "From a feminist perspective, this problem-oriented view of single parent families stems from androcentric bias; because single-parent families do not conform to the traditional nuclear family structure, they have been considered somehow incomplete or deviant" (Ford-Gilboe, 2000, p. 41); She found that there was very little difference between single parent and two-parent families in terms of family cohesion and support for one another, two important markers of family strength (Ford-Gilboe). In my study the women discussed how leaving their abusive partners and moving to a shelter had enabled them to become more confident as parents. Nevertheless, despite increased numbers of single parents and expanded definitions of "family" (i.e., legalizing same sex marriages, opportunities for same sex couples to adopt children), the participants in my study still strongly expressed beliefs and values that reflected more traditional views of family. The recognition that while they had become more confident as in their parenting roles as single parents while also holding traditional views of family is another example of the tension that threaded its way through the experiences of the participants in this study.

Figure 1 illustrates the analysis of my findings.

Figure 1 – Making a Better Life

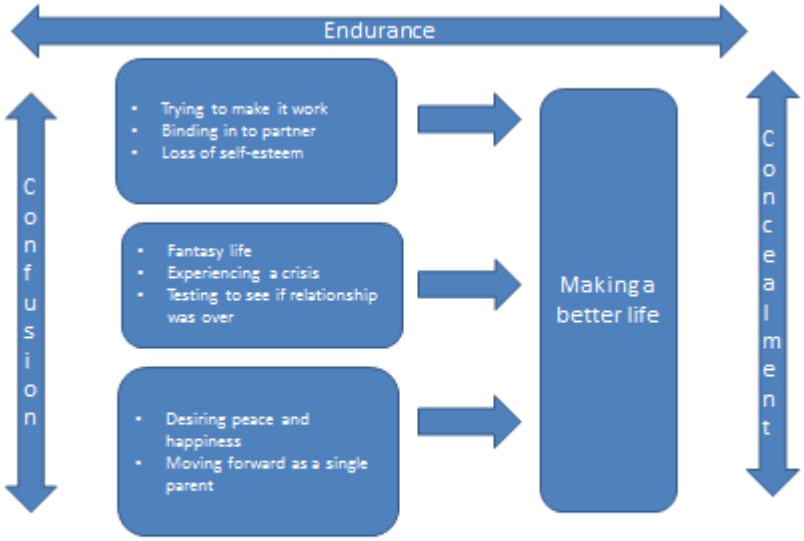

Figure 1 - Making a better life

The women who participated in Lutz's (2005a, 2005b) study were socioeconomically and ethnically diverse and were not were living in shelters. Nevertheless, the women's experiences were similar to the women in my study who were living in shelters. The fact that the women in both studies shared patterns of experience and decision-making highlights the need to look more carefully at abuse during pregnancy to increase our understanding of the women's experiences and their needs for ongoing support as they become new mothers. It may be helpful to view the experience of intimate partner abuse and childbearing as a continuum rather than as a feature of pregnancy being a period of time for increased risk for intimate partner abuse and violence (McCosker, Barnard, & Gerber, 2003). For the participants in my study, the abuse often started before pregnancy and continued following pregnancy. With this change in our focus we could move away from screening for specific symptoms of abuse at one point in time, and move toward helping families understand how their roles and relationships change, particularly during stressful times such as pregnancy. This finding needs to be explored in further research. Work being done by Engnes, Liden, & Lundgren (2012) with women and their abusive male partners may shed further light on men's experiences in relation to seeking help for violence toward their partners during pregnancy.

Research on double binding and decision making illuminates how hard it was for pregnant women to make a decision to leave when they are faced with the abuse and violence, and how it was hard for some women to articulate how they made their decisions. A couple of the women talked about not realizing or

understanding that their relationships were abusive until they were in the shelter and attending the support group.

Limitations of Double-Binding

The construct of "double binding" tries to integrate the process theories of abuse and maternal role theory thus providing a contextually appropriate perspective for understanding women's behavioral response to intimate partner abuse and violence during pregnancy. One short coming of using the double binding construct as a lens to interpret pregnant women's behavioral responses to abuse is the lack of acknowledgement of what a healthy versus an unhealthy relationship is from the woman's own perspective. This in essence means that while a health care professional can talk about healthy versus unhealthy relationships (i.e., abusive relationships), some women such as the women I interviewed are unable recognize the abuse until after they leave the abusive relationship. The women in my study thought the problems in the relationship were their own fault and were focused on trying to change their own behavior to make the relationship work. Using a feminist lens this is consistent with some women's understanding of the feminization of their gender role, which is to be a good wife and mother by doing the women's work of the household. This is consistent with a traditional view of the wife and mother role that the participants in my study were trying to measure up to (Mercer, 1995; Lutz, 2005a). These traditional views likely contributed to the women's concealment of the abuse because they did not fit with their view of society's expectations for pregnant women preparing to become mothers.

A woman's internalization of the "problems" in the relationship as being her own fault serves to cover up her partners' behaviour and thus is part of the concealment that pervades the abuse experience. This self-blaming may cover up the woman's sense of confidence in her parenting and could affect her developing confidence in her mothering role. This finding has important implications for how nurses and other health and social service workers and agencies offer assistance to women. Our challenge is to help women understand that they are "safe" with us, and can tell us about what is happening to them. From this perspective, the task of the health professional is to find out how the woman sees her relationship and use this information to help the woman get the support she needs in order to prepare for the birth and get ready to care for her baby. Lutz (2005a, 2005b) notes, "Becoming a mother assumes a positive, supportive intimate partner relationship, yet pregnancy and being in an abusive relationship often coexist and present competing behavioural demands and social expectations for women" (p. 119). Lutz and her colleagues (2006) suggest that:

> Incorporating the developmental tasks of becoming a mother in future studies of violence during pregnancy would further enhance our understanding of the processes that result in women's behavioural choices regarding their intimate relationships and their health behaviours during this time (p.130).

It is important to remember that the process of becoming a mother is not sudden and distinct like turning a switch or having a birthday, but rather a slow incremental process. As a result, it is hard for women to recognize the process of

becoming a mother when they are in the midst of it; often the process is recognized in reflection after the fact. Similar to Mercer's (1995, 2004) theory of becoming a mother, the women I interviewed had difficulty recognizing the point in time when they became a mother.

Taking a closer look at decision-making reveals that there are stages that women go through that are not accounted for in the work on double-binding by Lutz and her colleagues (2006). While the concept of double-binding is a good start to building an intermediate theory for understanding the decision-making process women use, it fails to address the woman's own confusion about whether she is bringing her baby into an abusive relationship.

Baby as Savior

Some participants in my study talked about hoping that if they became pregnant, their partner would stop being abusive. They discovered, however, that if anything, the abuse became worse. According to maternal role theory, the mother and father work to create a family for the expected baby, but in a pregnant family characterized by abuse, it is as if the unborn baby is expected to create a family free of abuse for the parents. I could not find any literature that directly addressed this point, but Mercer (1995) did discuss those situations in which the father rejects the pregnancy, and wondered whether this rejection caused the mother's progression through the maternal tasks (ensuring safe passage, binding-in to the baby, and committing self to the pregnancy and baby) to stall or stop. Based on the results of my study, I think this assertion is incorrect; While it is true that early in the abusive relationship, the normal tasks of pregnancy seem to be

replaced with double-binding, once women leave their abusive partner they are able to move through the developmental tasks of pregnancy without the father's assistance because they have support from shelter staff and other women.

Behaviour Change Theory and Decision Making

The women in my study talked at length about behaviour change, both their own behaviour and that of their abusive partner. For this reason I searched the literature on abuse to see if any authors had used behaviour change theory to study abuse, and found several studies. Khaw and Hardesty (2007, 2009) used the Stages of Change Model (Prochaska, 2007; Prochaska & DiClemente, 1984) to explore women's process of leaving relationships involving intimate partner violence. The Stages of Change Model was initially developed based on various approaches to psychotherapy and clinical observation of behavioral modification. The model consists of five stages that are based on the individual's readiness to change (Prochaska & DiClemente). In the earlier stages (i.e., pre-contemplation) the individual is less ready to make changes to maladaptive behaviors, than an individual in the later stages (i.e., action), where an individual is more ready to make changes. Ten processes of change were found to influence the individual's movement from one stage of change to the next (Prochaska & DiClemente).

> Specifically, individuals in the earlier stages of change (pre-contemplation, contemplation, and preparation) typically utilize *cognitive* processes of change, such as consciousness raising, self-re-evaluation, and dramatic relief, compared to those in the later stages of change (action and maintenance)

> who tend to use *behavioral* processes of change, such as conter-conditioning, stimulus control, and helping relationships (Prochaska & DiClemente) (Khaw & Hardesty, 2007, p. 414).

Using a strengths-based approach, Khaw and Hardesty found that critical junctures, which they called turning points, marked the mothers' movements from one stage of change to the next. Also important to the process of change are the constructs of decisional balance and self-efficacy (Prochaska & DiClemente). "Decisional balance refers to weighting the pros and cons of change, whereas, self-efficacy refers to an individual's confidence in being able to successfully change" (Khaw & Hardesty, p. 415).

When Burke, Mahoney, Gielen, McDonnell, & O'Campo (2009) used the stages of change model to try and develop a model that could be used to screen women for intimate partner abuse and violence, they found that women did not fit into a single action stage. This is consistent with my study results; the decision-making process is not linear and is made further complex by the women's difficulty recognizing they are in abusive relationships.

Although none of these studies focused on abuse in the context of pregnancy, they all reinforce that behaviour change related to abuse is complex and requires women to weigh many different perspectives. For these reasons, decision making takes time and is may be characterized by extensive trial and error.

Linking Study Findings to Nursing Theory

Thorne (2008) developed Interpretive Description as a design that she intended nurses and other health professionals to use to inform their clinical practice. I discuss the implications for practice in more detail in Chapter 6 but here I would like to discuss some linkages I see between my findings and the work of Watson (1979, 1985, 1988, 2005, 2008, 2012), a nurse theorist whose work I think is particularly relevant to the care of abused pregnant women. I selected Watson because I think the core elements of her theory provide a good foundation for nurses caring for women in the midst of difficult circumstances. The natural response when one observes an abusive relationship is to immediately think about safety issues, with a focus on leaving the relationship. But for the women in my study, at least during the early phases of their relationship, their focus was on staying in the relationship. I think Watson's theory is about providing support for those in our care that will help them meet the goals that they choose for themselves, which in this case may mean helping to support women as they try to find ways to endure abuse. I think Watson's theory is inherently consistent with feminist standpoint theory in terms of allowing women's voices to be heard. If safety is an issue, this support for endurance may include helping the woman move to a shelter temporarily. The resulting nurse-patient relationship is important because it forms a bridge that women can use to leave abusive relationships when they are ready to do so.

In her original work, The Philosophy and Science of Caring, Watson (1979) advocated blending the sciences and humanities to provide an existential,

phenomenological and spiritual theory of transpersonal caring. She drew from stress, developmental, interpersonal, and nursing theories to form an interpersonal and intrapersonal theory of caring. Watson (1988) envisioned care as the promotion of the self-actualization of the care giver and the receiver of care; the interactions between the care giver and the care receiver result in both people moving toward a higher sense of self and harmony with the mind, body, and soul.

Watson (1979) embraced the following basic assumptions for the science of caring in nursing:

1. Caring can be effectively demonstrated and practiced interpersonally.
2. Caring consists of carative factors that result in the satisfaction of certain human needs.
3. Effective caring promotes health and individual or family growth.
4. Caring responses accept a person not only as he or she is now but as what he or she may become.
5. A caring environment is one that offers the development of potential while allowing the person to choose the best action for himself or herself at a given point in time.
6. Caring is more "healthogenic" than is curing. The practice of caring integrates biophysical knowledge with knowledge of human behavior to generate or promote health and to provide ministrations to those who are ill. A science of caring is therefore complementary to the science of curing.
7. The practice of caring is central to nursing.

(Watson, 1979, pp.8-9).

Then Watson further developed 10 practices that provide the structural components for her transpersonal caring theory:

1. Practice loving kindness within the context of an intentional caring consciousness.
2. Being fully present in the moment and acknowledging the deep belief system and subjective life world of self and other.
3. Cultivating one's own spiritual practices with comprehension of inter-connectedness that goes beyond the individual.
4. Developing and sustaining helping-trusting, authentic caring relationships.
5. Being present to and supportive of the expression of positive and negative feelings arising in self and others with the understanding that all of these feelings represent wholeness.
6. Creatively using all ways of being, knowing, and caring as integral parts of the nursing process.
7. Engaging in genuine teaching-learning experiences that arise from an understanding of interconnectedness.
8. Creating and sustaining a healing environment at physical/readily observable levels and also at non-physical, subtle energy, and consciousness levels, whereby wholeness, beauty, comfort, dignity, and peace are enabled.

9. Administering human care essentials with an intentional caring consciousness meant to enable mind-body-spirit wholeness in all aspects of care; tending to spiritual evolution of both other and self.
10. Opening and attending to spiritual-mysterious and existential dimensions of existence pertaining to self and other (Watson, 2012, p. 47).

The caregiver collaborates with the client to assist him or her in gaining control, knowledge, and health. This is especially important for nurses caring for women in abusive relationships because the values (#1 above), spiritual beliefs (#2), and empathy (#3) help to establish the foundation for effective interaction. These three factors then facilitate the establishment of rapport and caring (#4), free expression of feelings (#5), and learning (#7), and exploring the meaning of life (#10). Ideally, the abused woman begins to understand that she no longer needs to conceal her abuse and once this is shared, problem solving becomes possible. The scientific problem solving method (#6), which directly correlates with the nursing process, can be employed to gratify human needs (#9) and to establish a safe and constructive environment (#8). These factors also promote the client taking responsibility for their own health.

Application of Watson's Theory to an Abused Pregnant Woman

Jean Watson's (2012) theory of nursing, *Human Caring Science*, concerns itself with the art of being human. The nurse-patient relationship occurs within a context of intersubjectivity.

The goal of nursing is to help a person gain a higher degree of

> harmony that fosters self-knowledge, self-reverence, self-caring, self-control, and self-healing processes while allowing increasing diversity (p. 61).

Use of the caring practices described by Watson is intended to help the nurse foster self-knowledge in his/her clients (Watson, 2012). I think Watson's (1979, 1985, 2012) theory of transpersonal caring is particularly helpful in providing care for individuals undergoing highly stressful situations. Kilby (1997) used Watson's theory in her case study of woman with increasing blood pressure who experienced a fetal death in utero at term. Drawing on Watson's (1985) description of loss "as an aspect of one's self that is no longer available" (Kilby, p. 47), Kilby developed a plan for intervention and growth for the client. In the transpersonal caring event she acknowledged how her own personal values, beliefs, culture, and spirituality influenced her view of life, parenting, and loss. The relationship was based on the carative factors of trust, sensitivity, honesty, warmth, empathy, congruence, and effective communication (Watson, 1985). She focused on the client's subjective, spontaneous, and intuited perceptions to facilitate the grief process while also maintaining optimal bodily functions (Watson, 1985). The resulting rapport enabled the client to share her feelings such as guilt, loneliness, sadness, failure, and anger about the fetal loss (Kilby). Recognizing, accepting, and validating the client as an individual empowered the grieving woman to begin the movement toward self-actualization (Watson, 1985). "Assisting the grieving client to identify and build positive coping mechanisms is one step that promotes growth" (Kilby, p. 49). Self-actualization is the moral ideal

wherein the client is able to find strength and courage to make plans for their life and death journey (Watson, 1985).

If one were to use Watson's caring theory to guide the use of my study findings in the provision of nursing care for a pregnant woman who was experiencing abuse in her intimate partner relationship, the primary focus early in the abusive relationship would be on providing compassionate care to help endure the abuse, and ease the confusion and concealment. I think this approach could help to loosen the double-bind and may make it possible for a woman to consider leaving an abusive relationship prior to the development of the kind of critical events I termed "crises" above. I would start by asking the woman to tell me more about how she is feeling. My goal would be to help her deal with the tension by striving to reach harmony and balance (mind, body, spirit) in her life. If the woman was feeling depressed I would discuss resources with her to enhance and preserve her dignity and wholeness. I would help her recognize her ability to access these resources, and in so doing, help her endure the abuse she is experiencing while she is deciding whether to stay or leave. I think the promotion of endurance is critical because it helps the woman preserves her integrity as a person.

Watson's Actual Caring Occasion

Watson describes the process by which negative feelings are replaced by positive feelings as actual caring occasions (ACO); this process increases the capacity for transpersonal caring relationships (TCR) (Watson, 1979). The use of an empathetic approach is a key element of this process. The nurse demonstrates

empathy by offering unconditional regard. In the case of abused pregnant women, an important part of an empathetic relationship would be communicating that the nurse is ready to hear both negative and positive thoughts about the abusive relationship. I think that allowing women the opportunity to acknowledge that they experience these conflicting feelings is key to helping them decide whether they want to remain in the relationship or leave it, particularly once the double-bind is weakened. Mullaney (2000) used Watsons' model as the foundation for a study of depressed women. She found that if clients were able to share their negative feelings with the nurse counsellor they felt understood and supported. "Clients stated they felt more able to persist in treatment, despite the negative energy that a clinical depression can emit in the nurse-client relationship" (p. 139). The nurses in Mullaney's study who integrated Watson's theory with their framework for practice found that it helped to move the client's energies toward wholeness and healing. The idea of facilitating the client's energies by being available to hear both positive and negative thoughts about the abusive partner could be particularly useful with women after the crisis when they are binding in with their babies, as I think it could serve to increase the women's self-esteem. For these reasons, I think that the use of the ACO could help women to establish healthier interpersonal relationships, including intimate partner relationships in the future, but this area requires further research.

One of the criticisms of Watson's Caring theory is that it is difficult if not impossible to measure attainment of self-actualization in the client (Morse, Solberg, Neader, Botterff, & Johnson, 1990). While I acknowledge this limitation

of Watson's caring theory, I wonder if the focus of the critic is in the wrong place; rather than trying to measure attainment of self-actualization we, as nurses, should be focused on the client's journey; I think this is Watson's intent. Trying to measure attainment of self-actualization is similar to trying to pinpoint attainment of the maternal role; both are journeys that unfold depending on the individual's life experiences. There will be overlaps with other's experiences, but there will also be differences. Supporting the woman to become the best mother she can be should be our goal as nurses.

In line with Watson's Caring theory is Mercer's (2006) focus on the importance of interactive dialogue, as the way to identify and understand the mother's concerns.

Summary

In this chapter I have discussed the findings of my study in relation to 2 main gaps in the literature. I noted that the abuse literature does not address how pregnancy affects the decision to stay or leave the abusive relationship. My study was designed to address this gap. Feminist standpoint theory was useful for understanding the influence of beliefs and values rooted in society on the experience of women deciding whether to leave an intimate partner who is abusive during pregnancy. I found that early in the relationship the pregnancy seems to be a deterrent to leaving the relationship, but later on as the violence and abuse increased pregnancy was a motivator for leaving the abusive partner. I also found that once a woman leaves an abusive relationship, she is able to undertake the normal tasks of pregnancy, termed binding-in, without the support of the

father of her child. Her ability to complete these tasks successfully is increased if she has support from others, such as staff in a shelter environment. These results help to explain why the decision making process is complex and often occurs over a long period of time. I also explored how the woman's tradition view of her role as wife and mother influenced why she felt confused and concealed the abuse in her relationship, this in turn also influenced her experience of enduring the intimate partner abuse while she was making her decision about whether she should stay or leave her partner during pregnancy.

At the end of the chapter I related my research findings to Watson's theory of caring. Using the transpersonal theory of caring to describe and analyze experiences can help nurses realize the critical sensitivity required for client interactions. Watson's carative factors expose a deep respect for the wonder and mystery of life, a reverence for the spiritual center of the individuals and a focusing on helping people to achieve their potential (Watson, 1985). I think that the development of a nurse-patient relationship based on Watson's theory could help establish a bridge for women to leave abusive relationships when they are ready to do so.

CHAPTER SIX

Introduction

In this chapter, I discuss implications of my study for clinical practice, policy, education, and research.

Clinical Practice

The findings from my research that are important for nursing practice include: helping women to understand what a healthy relationship looks like. This has implications for both pregnancy and for adolescents who are exploring dating relationships. In addition it is vitally important to help nurses understand how they can support women in enduring, this is an important aspect of care deserves further attention to address the woman's own self-identified needs.

Healthy Normal Relationships

There is a need to talk about intimate partner relationships so that young people (both men and women) understand what characterizes a healthy normal relationship, starting early in the teen years or high school and continue on in college or university. This discussion should entail talking with young people about how to have a healthy intimate partner relationship, how to recognize the signs of an abusive relationship, and how to stop abuse or leave an abusive relationship. This suggestion is supported by Lutz (2005b): "Popular literature and health care providers contributed to the confusion by portraying alterations in partnered relationships in pregnancy as common without description of normal relationship changes or distinguishing normal and abusive acts"(p. 820).

Adolescence is a period of significant growth and development that encompasses the physical, cognitive, social, and emotional domains. Banister, Jakubec, and Stern (2003) interviewed females aged 15 to 16 years of age about their dating relationships and found that the girls desire to have a dating relationship out-weighted their desire to avoid health threats such as substance abuse and violence. Burton, Halpern-Felsher, Rankin, Rehm, & Humphreys, (2011) found that the complex interaction of gender, relationships and both physical and psychological development in adolescent females makes dating abuse during this period a significant health risk that is imbued with specific vulnerabilities. Fredland and Burton (2011) suggests that nurses are uniquely situated to generate care options for youth that take into account the complex relationship between the developmental changes of adolescence and the complex social interactions that form the context for the everyday lives of teens. Taking into account how teens and young adults develop and choose options regarding their intimate relationships can help inform nurses about ways to be supportive of young women as their relationships evolve; especially in the event of pregnancy.

Special Prenatal Programs or Services

My findings have implications for nurses who work with pregnant women but it is hard to know what the best way to support abused pregnant women would be. Curry, Durham, Bullock, Bloom, and Davis (2006) conducted a multisite randomized control trial to see if Nurse Case Management for pregnant women experiencing or at risk for abuse could decrease stress for the pregnant women. Their study did not find strong support for Nurse Case Management (NCM), but

this may be because they lacked the sensitive outcome measures to capture these sometimes incremental but important changes that women made in their lives, such as returning to school, obtaining their grade 12 leaving certificate, regaining custody of a child, signing up to receive medical benefits, or qualifying to rent an apartment. The authors acknowledged that "Pregnant women at risk for abuse or in an abusive relationship experience very stressful and complex lives" (p.181). Perhaps their lack of positive findings was due to evaluating their outcomes too soon. Although pregnancy may seem like a long period of time, there are many changes, both physical and psychological, that are occurring at the same time the woman is dealing with her abusive partner. Using the developmental tasks of pregnancy as a lens for this experience I was able to see that many women who I interviewed were focused on becoming a mother and having a father for their baby. Some of the abusive partners refused to help the women get to their prenatal appointments. This was not a reflection of the woman not wanting prenatal care, but more a reflection of the challenges with which she was grappling.

The Stages of Change Model has been proposed as a guide for family practice residents in counselling women who are experiencing intimate partner violence (Frasier, Slatt, Knowlowitz, & Glowa, 2001). While I applaud the move away from "trying to fix the problem" approach, I am concerned about trying to fit women's experiences into the Stages of Change Model without acknowledging the variation in women's experiences. It is important to acknowledge as Frasier and her colleagues do that "Change does not necessarily mean leaving the partner (p.215).

Burke, Mahoney, Gielen, McDonnell, & O'Campo (2009) have focused on the stages of change in trying to understand when women end abusive relationships. But in trying to focus on a single event or time frame as being the end of a relationship as a result of intimate partner violence and abuse they miss out on the relational piece of relationships. We need to understand that relationships are messy and trying to end a relationship is complicated, particular so when intimate partner violence and abuse are part of the picture at the same time the woman is acknowledging her pregnancy. It is also worth noting that different supports, like support groups in a shelter, even if only for a short period before returning to an abusive partner, may be helpful for women at different points in time, particularly when they are in the midst of binding in to their baby and dealing with the abuse partner.

Rose, Bhandari, Soeken, Marcantonio, Bullock, & Sharps (2010) studied the impact of intimate partner violence on the mental health of pregnant women. The researchers found that pregnant abused women were at risk for mental distress at the same time as the women were dealing with their changing perceptions of themselves as women and as mothers. They identified that nurses working with pregnant and postpartum women are in the best position to assess and offer assistance in the form of shelters and support groups to these women.

Supports Groups

Henderson (1998) discusses the role of nurses in helping women in shelters form support groups for abused women, where women can find strength to cope in an atmosphere of mutual understanding and support. The strength of a

support group based on feminist ideology is the recognition that each woman is the expert of her own life, and although she may benefit from the support of others, it is she who examines the options, makes decisions, and deals with all her identified concerns, and in the end she is the only one who knows what is best for her (Henderson). The value of participating in such a support group is the opportunity for women to gain support and offer support to other women who have similar experiences, which helps the woman to feel less alone and enables her to examine options, before making decisions or deciding a course of action (Henderson). These principles could be applied by community health nurses in New Mother groups or Moms and Tots groups. Further training and support is needed for community health nurses to support women who have decided to remain in an abusive relationship during pregnancy. Riddell, Ford-Gilboe, and Leipert (2009) suggest that public health nurses could use a community health assessment approach to raise awareness of intimate partner violence and develop strategies that are specific to the rural communities in which they live and work.

Endurance

As discussed in chapters 4 and 5, the decision to remain in a relationship during pregnancy was "not quite right" was a key feature in the experience of my study participants. Morse and Carter (1996) labelled this phenomenon as endurance, which they defined as the ability to "…gets through extraordinary physical or physiological assault or stressful conditions and remains intact" (p. 47). As nurses, I think that one of the ways we could support to women who decide to remain in a relationship even though it is abusive would be to build a

therapeutic relationship with them and seek ways to support them that acknowledge the each woman's unique experience. This does not mean nurses should not give information on safety planning, for example, but that nurses broadening their approach to include the woman's concerns, which could include her own role as a new mother, her concerns about being a single parent, or her concerns about shared parenting of her child or children.

Another nursing implication of enduring as defined by Morse and Carter (1996) is the importance of identifying ways in which the woman can cope in her current living situation, rather than simply assume that the woman "should" leave the relationship. In my study some of the women related that their ability to endure was related to support to hold on that came from other family members or the police. I think that nurses could also play a role here, but some professional development would likely be required to help nurses learn to work in this way. Research done by Webster, Bouck, Wright, and Dietrich, (2006) acknowledged that the public health nurses (PHNs) were influenced and shaped by their work with abused women. "While the client was struggling to understand her situation, the PHN beginning to work with abused women was often struggling with a number of issues, including coming to terms with the abuse, learning how to ask the question, how to bear witness, and how to support the abused client" (p.145).

Although not specifically related to pregnancy, a comprehensive program that shows promise in helping women to make positive changes, the intervention for health enhancement after leaving (i-HEAL) is a complex, primary health care intervention designed to enhance women's health and quality of life in the early

years after leaving an abusive partner by (a) reducing abuse-related intrusion, and (b) increasing the capacities and external resources needed by women to be successful in moving forward with their lives after leaving abusive male partners (Ford-Gilboe, Wuest, Varcoe, & Merrit-Gray, 2006).

Public Policy

The findings of my study have implications for public policy related to the way abuse is viewed and treated. My work is consistent with two different approaches to program development: restorative justice, and critical consciousness. I have chosen restorative justice because it can bridge the areas of family counselling and feminism when applied in specific circumstances. Almost half of the sample of women I interviewed identified as Aboriginal. Several of the women in this group mentioned to me that they wanted to know more about relationships and would have liked to have the information earlier.

Restorative justice

Restorative Justice has been used for aboriginal sentencing circles. A Restorative Justice approach has been used to incorporate community support and intervention for crime in First Nations communities. While there are many models of restorative justice, a key feature of the Aboriginal restorative justice model is the commitment to furthering Aboriginal independence and self-sufficiency (Cameron, 2006). The strength of this approach has been the interaction between the two parties–the person whose behaviour was harmful and the person who was harmed. Relationship building is a key long term-goal of the restorative process (Bazemore & Earle, 2002). The effectiveness of the restorative process is

reflected in the strengthening of relationships, increased skills in problem solving and constructive conflict resolution, increased capacity of participants to solve their own problems, an increased sense of individual awareness of and commitment to the common good for all, and creation of informal support systems for both victims and offenders (Bazemore & Earle). Restorative justice is both a philosophy and a framework for working with victims and offenders in the aftermath of crime and has been adopted by different programs (Edwards & Haslett, 2003). What makes the programs approach unique is how the key components of the framework are implemented. Edwards and Haslett identify the following as central tenets informing the restorative justice approach they use in cases of domestic violence or intimate partner violence: a focus on harm, participant safety, offender accountability, opportunities for dialogue, and restoration. The strength of their approach is the balance between the focus on harm and ensuring safety of both partners.

> Restorative justice begins with a focus on the harm inflicted and experienced by individuals in the wake of crime….In cases involving domestic violence, we believe exploring any history of abuse experienced in the relationship, and whether there is ongoing abuse, creates a deeper understanding of the nature and extent of violence in the relationship. A fuller understanding of the relationship in this regard provides a context for assisting participants

> in identifying and exploring possible patterns of abuse and their impacts. This knowledge can be important in increasing awareness and safety (p.2).

It is important to recognize that the restorative justice approach is not a quick fix, it is "one small point on a much larger journey" and for some couples they have experienced reconciliation, forgiveness, closure and restoration (Edwards & Haslett). As a consequence of participating in a restorative justice intervention the participants were able to better understand how their choices and actions made prior and subsequent to the restorative intervention impact the dynamics of their ongoing relationship (Edwards & Haslett).

I think that a restorative justice approach has the potential to be helpful for some women and their abusive partners. While I do not believe it is an approach that would work for every couple, I do think it might work for some couples, and that if social policy were framed from this perspective, those couples who really wanted to work on their relationship would have an opportunity to do so. In my study some of the women talked about wanting to find a way to help their partners understand their own behaviour and how they could continue to grow as a couple.

The restorative justice approach has come under harsh criticism from groups who advocate for sexual assault survivors, who felt that women were harmed more than they were helped by the process (Stubb, 2002: Rubin, 2010). Stubbs raises very valid concerns about the relational agency of women with children being re-victimized by interactions with their abuser. But Pennell and Burford (2002) have run programs which were successful in helping families to

relate to each other in non-violent ways. In Pennell and Burford's model, Family Group Conference, each participant has their own counsellor and the conference brings together the 4 participants, and there is a built in consequence if the male partner is threatening or abusive. There is a focus on helping the couple learn new communication and conflict resolution skills. It is true that if restorative justice programs are implemented without enough support and training they have the potential to put women in vulnerable positions where they could be re-victimized.

Research has shown that both male and female partners may choose to stay in relationships that have been abusive, if they can find ways to relate to each other that do not involve abuse. Eckstein (2011) found that men may choose more stereotypically masculine identity reasons for staying with their partners than women do, but overall men and women gave similar reasons for remaining in abusive intimate partner violence relationships Eckstein identified the following two reasons for staying in a relationship as positive emotions toward the abuser and religious or marital loyalty commitments. Eckstein compared men and women's reasons for staying in or leaving violent intimate partner relationships, one area she explored was boundary ambiguity using the stages of change model (Prochaska & DiClemente, 1984; Prochaska, 2008).

In the family therapy literature, Goldner and her colleagues have done research with couples from abusive relationships that wanted to attend counselling as a couple (Goldner, Penn, Sheinberg, & Walker, 1990). These couples recognized they had a problem with violence in their intimate partner relationships and wanted to work out their problems together rather than

separating. “Marriage and family therapists have an important part to play in continuing to develop and test innovative ways of helping couples end violence and improve the quality of their relationships – an endeavor that promises not only to improve the quality of their own lives but also to improve the lives of their children and society as well” (Goldner, et al, p. 424). A similar approach has been used by Stith and McCollum (2011) with positive results. “We spend a considerable amount of time teaching couples a negotiated time-out so that they can de-escalate the conflict in their relationships and we teach them to use a mindfulness meditation to calm themselves down when they feel themselves escalating”(p.316). The benefit of conjoint couple therapy is the couple’s enhanced abilities to resolve conflict non-violently, thus rather than endangering the woman, this strategy actually enhances the safety of the couples and the children in the home (Stith & McCollum; Stith, Rosen, & McCollum, 2003). These findings are also supported by Wuest and Merritt-Gray (2008) who found that interrupting previous patterns of abuse can be an effective way for couples to shift the pattern of their relationship to become non-violent. This positive outcome from couple therapy may be an area that nurses in community and clinic settings could promote.

One area that deserves further attention both for practice and research is the area of patriarchal culture and shame for women and families of South Asian cultural heritage. Although the women I interviewed were abused by an intimate partner the reason for the abuse was not related to bringing shame on their families as a result of their choice of partner, but their family relationships did

influence their attempts to leave their partners. How patriarchal culture honor and shame influences women's decision making deserves further attention as women new to Canada may not know where to turn for help and the abuse may make them feel even more isolated and alone (Papp & Kay, 2012).

Critical consciousness

Critical consciousness is another approach that could be used to frame social policy related to intimate partner violence. This approach has been used by Carolan, Burns-Jager, Bozek, and Chew (2010), who are family counsellors with women in the child welfare system. Critical consciousness involves helping individuals recognize the inner play of trauma and oppression that characterizes abused women's lives and interferes with their ability to mother. The lens of critical consciousness was derived from the ideas of Pablo Friere, who worked on helping people with less economic and social power to find and use their "voice" to advocate for themselves (Carolan, et al.). By enacting critical consciousness through ongoing self-reflexivity the counsellors were able to "…actively examine, discuss, and evaluate how our privilege might impede our ability to empower and support those with less privilege" (Carolan, et al., p. 173). Nurses working with women in prenatal and postpartum clinical and home settings could benefit from understanding how trauma and abuse influences how women make decisions for their own care and the care of their child or children. Carolan and her colleagues remind us that by using critical consciousness we can better understand how to work with women who experience intimate partner violence and abuse. The ways

nurses see a woman's ability as a care-giver in the mother role is influenced by their own experiences of being mothered, and being a mother.

There is a need to take the information about restorative justice and critical consciousness and move to the next level, by engaging with women and their families to address their needs in ways that value their perspectives and values; this has been demonstrated to be successful for women, their children, their abusive male partners (Perilla, Serrta, Weinberg, & Lippy, 2012). Although, this program was done for Latino families these ideas could be explored using action research with women and families in Aboriginal communities. I do acknowledge that any research undertaken with an Aboriginal population would need to follow Chapter 9 of the Tri-Council Policy on Research (2012). The researcher would need to consider how to engage the community in a respective dialogue and consider both how the community and participates would like to participate and use the findings from the research project. The project could offer assistance and hope to decrease intimate partner violence and abuse during pregnancy, and for helping partners to make changes that could lead to healthier partner relationships and parenting relationships, by addressing the gender disparities, that keep women subordinate to men, and address beliefs and values that are deeply rooted in patriarchal social systems.

Research has been done by Vangie Bergum (1997) on the experience of being mothered and becoming a mother. Bergum found that women expect to be different as mothers, but sometimes have difficulty seeing how they will be different or knowing how to adapt to the change in roles. As nurses, we need to

develop a deeper understanding and knowledge of this pivotal experience in women's lives so that we can understand how to support women during this transformation. Bergum wrote a play to help student nurses learn about the complexities of women's experiences of becoming a mother, interactive learning experiences can help nurse educators expose students to different ways of thinking and being.

Education

My study findings had many implications for nursing education. I think that core content on intimate partner violence and abuse could be threaded through several courses such as community health, health promotion, family health, and women's health so that all students would learn how complex the decision making process to leave an abusive relationship during pregnancy is for women and their families. In addition to general knowledge about gender, gender roles and social expectations and how all of these influence health and health care, skill development could include being open to disclosure of experiences of violence and abuse, strong interviewing skills, and learning how to offer support for decision making. I also think however, that there may be benefits to having a workshop type course that focuses specifically on intimate partner violence and abuse similar to the way education is offered about sexuality for beginning health professional students.

There is a need to help both students and experienced nurses understand that leaving an abusive partner is a process. This idea is supported by the work of Webster, Bouck, Wright, and Dietrich, (2006). They interviewed public health

nurses (PHNs) who were working with high-risk postpartum families about their experiences of caring for women who were experiencing intimate partner violence. Four major themes arose from their research including '…coming to term with abuse, asking the question, bearing witness to the stories of abuse, and … 'walking with' the woman who has been abused" (p.142). In this study, experienced PHNs focused on gaining the trust of the clients and being a supportive presence in their lives (Webster et al,). The experienced PHNs "…tend to express the view that their objective is not necessarily to remove a woman from an abusive relationship but to guide her in identifying a healthy relationship, in recognizing patterns of power and control, and in making her own decisions" (147). Because nurses' work is often process focused, we need to provide learning opportunities for students to learn how the process unfolds in families and also support public health nurses in their ongoing learning in this area.

Research

In my research I identified two key findings that stimulate ideals for further research. I am interested in learning more about the factors that distinguish those women who leave and abusive relationship from those who stay. In order to do this, I would need to conduct longitudinal study of women who are abused during pregnancy. This study would provide an opportunity to learn more about how the baby is viewed by the woman. The notion of "baby as saviour", as identified in this study, has not been described by others.

Further research is also needed on ways to loosen or break the double-bind prior to the onset of a crisis. I am particularly interested in seeing whether a nursing intervention based on Watson's conceptual framework would be perceived as supportive and helpful by abused pregnant women.

> Individuals move from enduring to suffering when they are able to acknowledge that which is being endured, and when they are emotionally strong enough to experience the emotional onslaught of suffering….Once they have suffered enough and are able to accept the changed reality, individuals gain new insight and appreciation for life as a reformulated self (Morse & Carter, 1996, p. 43).

This form of enduring is key to women in the decision-making process. Too often, health care professionals try to help women to get out of an abusive relationship before she is ready, or is able to acknowledge the abuse is happening. When health care professionals do this, the woman is unable to move forward in her decision-making process. As health care professionals we need to re-think our approach to helping women who are in abusive intimate partner relationships. One of the ways nurses could help women in abusive relationships is to conduct research about how to help women to endure. Morse and Carter (1996) remind us that our role is to offer support, "…those who are enduring should be encouraged to endure, and the responses of others to the enduring person should help that person to continue to endure by, for instance, encouraging them to 'hold on'"

(p.74). Morse and Penrod (1999) describe suffering as an emotional response to enduring. Although the women in my study did not refer to their experiences as suffering, there was a component of the abuse where the women did suffer emotionally and sometimes physically from the abuse inflicted by their intimate partner.

Morse and Penrod (1999) acknowledge that the role of the nurse in helping people to endure has been relatively ignored in the nursing literature. It is possible that the nurse can be of most assistance to the woman experiencing abuse from her intimate partner when the nurse learns more about the ways she could help the woman stay strong and endure (gather strength to make decisions and change her life) rather than exclusively focusing on safety planning as an early intervention. I did not explore this aspect of enduring in my study, but it is an area that warrants further investigation. Morse and Penrod explain that enduring takes extraordinary reserves of energy" and the nurses role is to support the patient to conserve their energy. "Suffering requires energy, and if one is moved prematurely into suffering, the patient may fear that s/he may be overwhelmed with suffering and disintegrate" (p.57). Furthermore, Morse and Penrod explain how the conceptualization of enduring provides a context for understanding the concept of denial as an adaptive behavior, as opposed to an inappropriate behavior. Upon further reflection, I can understand the implications of shifting the focus from the abuse of the male partner directed at the woman, to understanding how the woman is coping to endure. One of the women I interviewed described as a "fighter" (i.e., drew on her inner strength and determination), and talked about

how seeing herself as a fighter gave her strength to go forward in spite of the many challenges and hardships she was facing. The end goal is to help the woman move toward her goal of a "reformulated self" (in Morse and Penrod's words), in whatever way is meaningful to them–with or without their partner.

Research is needed on what knowledge couples who want to stay together need and on ways support them to develop their relational skills in ways that do not involve violence or abuse.

Feminist Standpoint, Feminist Intersectionality

Lastly, I would like to discuss how new approaches to research may offer new ways of understanding women's decision making to stay or leave during pregnancy. When I first began to write my research proposal I reviewed the literature related to feminism, and feminist standpoint theory was a good fit for what I was proposing to do. In particular the approach with women that valued their own perspectives spoke to me.

When I initially reviewed the literature for my study I was not aware of feminist intersectionality. Since I have been writing up my findings there has been a shift in the research literature to endorse this method, particularly in studies of black and minority ethnic women's experiences (Kelly, 2009, 2011; Rogers & Kelly, 2011). Intersectionality theory provides a framework with which to examine intimate partner violence from the levels of social structural oppression and the individual's identities in their families, communities and society, as such it has the potential to provide feminist researchers with new insights into women's experiences and how they make decisions. Much of this scholarship has been

developed by domestic violence advocates and minority women who have conceptualized violence against women as being much more than a gender issue (Kelly, 2011).

> Feminist intersectionality is built upon the assumptions that every social group has unique qualities; that individuals are positioned within social structures that influence power relationships; and that there are interactions between different social identities, for example race, gender, and class, that have multiplicative negative effects on health and well-being. ...driven by the pursuit of social justice (Kelly, p. E43).

This research model could be used to interview women who experience abuse in a first pregnancy who do not go to a shelter. While I interviewed two women who had one child, this limitation could be expanded on using the feminist intersectionality model.

While the feminist perspective on intimate partner violence is the predominate model, it has come under criticism for relying on the criminal justice system to intervene. "The feminist model is grounded in the principle that intimate partner violence is the result of male oppression of women within a patriarchal system in which men are the primary perpetrators of violence and women are the primary victims" (McPhail, Busch, Kulkarni, & Rice, 2007, p. 817). If I try and step away from the dichotomies of men being bad and hurting

women and women always being the victim, it makes sense to use a gender lens to examine the social process of intimate partner violence.

Using Stark's (2009) theory of coercive control can be helpful for understanding male and female identities as a "…gendered social process with distinct, individual-level, identity-based dimensions and dynamics" (Anderson, 2009, p. 1446). A limitation of using the gender lens of coercive control is the risk of seeing all women as victims and all men as perpetrators if gender is not considered in a broader theoretical context (Anderson), consequently I need to consider more than gender. As well, research into intimate partner violence has drawn on a number of different explanatory models, such as:

> male shame, men feeling powerless rather than powerful, intergenerational transmission of violent behavioral strategies, psychopathology and personality disorders, substance abuse, negative self-concepts, ineffective couple communication skills, poor anger management skills, attachment disorders, childhood abuse and/or neglect, poverty, family conflict rooted in the everyday stresses of family life (McPhail, Busch, Kulkarni, & Rice 2007, p. 819).

The perspectives of frontline workers in agencies that work in the area of domestic violence were taken into account in developing the integrated feminist model, as a piece of a puzzle with interlocking pieces that expand on the

traditional feminist response to domestic violence and maintains its commitment to locating the roots of violence within gender and other forms of oppression (McPhail, et., al). The eight puzzle pieces include: (a) person is political, (b) acknowledgement of male victims and female perpetrators, (c) changing policies and institutional responses, (d) integrating additional explanatory models of violence causation, (e) exploring alternative intervention such as restorative justice solutions, (f) integrative feminist model of care, (g) increasing victim choice and voice by crafting personalized solutions, and (h) feminist analysis of power differentials based on gender, class, race, nation of origin, disability, sexual orientation, and age (McPhail, et., al). An integrated feminist model such as that proposed by McPhail, et., al can help to account for some shortcomings by moving away from a single point of analysis to including multiple points of view in order to addresses our growing awareness of additional explanatory factors and dynamics that influence intimate partner violence and abuse. The explosion of research is this area has resulted in both a deeper understanding of the complexities of the experience of leaving an abusive partner, and recognition of women's strengths. McPhail, et., al suggest that few social problems can be adequately addressed with a single focus and the time has come to recognize that there may be multiple explanations for intimate partner violence for which different solutions are required. Conway, Cresswell, Harmon, Popishil, Smith, Wages, and Weisz (2010) suggest that local programs such as development of parenting models to prevent intimate partner violence by focusing on the family, addressing situational couple violence, and implementing early intervention

programs designed to prevent child abuse and neglect can have a significant impact and empower women, families, and communities. I think that these new approaches could be helpful in designing interventions to support women as they become mothers and hopefully help couples learn ways to communicate that helps them in their intimate partner relationship and their new role as parents.

Lastly, I think the WHO ecological framework (2010) could be used for a longitudinal study to further explore the context of intimate partner violence during pregnancy could enhance our understanding of the factors that influence women's experiences of intimate partner violence and indirectly women's decision-making. One of the strengths of the WHO ecological model approach is the ability to "… view intimate partner violence as a multifaceted phenomenon that is the result of a dynamic interplay among individual, relationship, community, and societal factors that influence an individual's risk to perpetrate or become a victim of violence" (Kelly, Gonzalez-Guarda, & Taylor, 2011). Understanding how men and women relate to each other within the context of intimate relationships is key to understanding how they view themselves individually as a mother or father, and as a couple about to become parents. This important perspective has not been addressed in previous research that has examined women's decision-making in the context of pregnancy.

Concluding Thoughts

When a woman experiences abuse from her intimate partner during pregnancy it can have long lasting implications, not just for her own health but that of her child. As nurses our understanding to date has focused on screening for

abuse and intimate partner violence and safety planning. The current study used an interpretative description research design to explore the tension between making a decision to stay or leave and becoming a mother for women who experience intimate partner violence and abuse during pregnancy. Using feminist standpoint theory helped to reveal the factors that shaped and constrained the woman's experiences of making a decision to stay or leave an abusive partner during pregnancy; this enabled me to explore the social context of becoming a mother that contributed to the women's stories as told from their own perspectives. Drawing all the pieces together allows us as nurses, to see the abused woman's experience from her own perspective. Being able to gain this insight into a woman's experience of decision-making in the context of intimate partner violence and abuse can enable nurses and other health care professionals to appreciate why the woman stays with her abusive partner, and how she struggles to make decisions for herself and her unborn child. This study adds new knowledge to our understanding of the complex relationship between the woman and her child, and her partner - the father of her child, by shedding light on the woman's decision-making process as told from her own lived perspective.

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APPENDIX A – Poster

University of Alberta Letterhead

Have you faced making decisions about staying or leaving an abusive relationship during pregnancy?

I have been a nurse for more than 25 years. I am working on my doctoral degree in the Faculty of Nursing, University of Alberta. I want to understand what factors affected your decisions about staying or leaving an abusive partner relationship during a past pregnancy. Participating in this study involves 1 or 2 private interviews. You may choose when and where we talk.

Intimate partner violence during pregnancy can affect women's health in many ways. It influences how women feel about themselves as new mothers. Decision making at this time can be difficult. Information about this can help nurses and other health care professions offer the support that women would find most helpful.

If you are interested in hearing more about this study, please call:
Kathy Banks, RN, MSN, PhD candidate
Faculty of Nursing
University of Alberta
Phone: 780-492-5229
Email: kibanks@ualberta.ca

APPENDIX B – Postcard

Side A

Side B

University of Alberta Letterhead

Have you faced making decisions about staying or leaving an abusive relationship during pregnancy?

I am a registered nurse with more than 25 years experience. I am a graduate student in the Faculty of Nursing, University of Alberta. I want to talk with women about how they made decisions to stay or leave an abusive partner relationship during pregnancy. Women who have experienced abuse during a past pregnancy are invited to talk with me.

Intimate partner violence affects women's health and how they feel about themselves as new mothers. I want to learn how women make decisions about staying in or leaving an abusive partner relationship. This can help nurses and other health care professions offer the support that women would find most helpful. Interviews will be kept private. You may choose when and where we talk.

If you are interested in hearing more about this study, please call:
Kathy Banks, RN, MSN, PhD candidate
Faculty of Nursing, University of Alberta
Phone: 780-492-5229
Email: kibanks@ualberta.ca

APPENDIX C – Letter to Participants/ Information Letter

PROJECT TITLE: Women's Experiences of Making Decisions about Staying in or Leaving an Abusive Intimate Partner Relationship during Pregnancy

PRINCIPAL INVESTIGATORS: Kathy Hegadoren, RN, PhD, Professor, Faculty of Nursing

(780) 492-4591;
kathy.hegadoren@ualberta.ca

Karin Olson, RN, PhD, Professor, Faculty of Nursing
(780) 492-2551; karin.olson@ualberta.ca

CO-INVESTIGATOR: Kathy Banks, RN, MSN, PhD Candidate (780) 492-5229

The purpose of this study is to learn how women make decisions about staying in or leaving an abusive intimate partner relationship during pregnancy. Intimate partner violence and abuse affects women's health in many ways. The violence and abuse can take many forms: physical, sexual, emotional, or verbal.

I will meet with you two times for about 1 to 2 hours each time. I will record and later type out what we talk about. I expect that the first interview will be the longest. I want to hear how you made decisions about staying in or leaving an abusive intimate partner relationship. Everything you say will be kept private except where professional codes of ethics require reporting, such as child abuse or neglect. I will remove your name and any identifying information from the typed-out interviews. Doctors and nurses involved in your care will not have access to your interview. I will share the interviews with my research committee only. I will keep the recording and typed-out interviews in a locked file drawer separate from the consent forms. I will keep the data for at least seven years. The final report may contain your actual words but nothing will identify you. Your name will not appear in any reports of the study. The results of this study will be described in

oral and written presentations and may be published in professional journals; however the results will be presented as a group and you will never be personally identified.

What you tell me may be used in future studies if you consent to this. Ethics approval for future studies would be received.

I do not expect that you will benefit directly by being in this study. You will have the chance to tell your story. I hope that other women will benefit from what I learn from you. Possible risks to your safety will be addressed by having the interview in a place where you can get help or support if you need this. You can stop the interview or ask me to turn off the tape recorder at any time. If there is anything that you would like erased from the tape, I will be glad to do that. You are also free at any time to withdraw from the study. I would be happy to give you a report of the findings when I am finished the study. At the end of each interview, I will give you $30.00 cash to acknowledge your time and thank you for participating in the study. Even if you end the interview early I will still give you the $30.00.

If you have any questions You can phone my supervisors, Dr. Kathy Hegadoren at (780) 492-4591 or Dr. Karin Olson at (780) 492-2551.

Additional contact If you have concerns about the study, you can phone Dr. Christine Newburn-Cook, Associate Dean Research, Faculty of Nursing, University of Alberta, at (780) 492-6831. The Associate Dean is not part of this study.

Study findings If you want a summary of results of the study, please call me at (780) 492-5229. Please leave your name and mailing address including postal code.

APPENDIX D – Consent Form

PROJECT TITLE: Women's Experiences of Making Decisions about Staying in or Leaving an Abusive Intimate Partner Relationship during Pregnancy

PRINCIPAL INVESTIGATORS: Kathy Hegadoren, RN, PhD, Professor, Faculty of Nursing

(780) 492-4591;
kathy.hegadoren@ualberta.ca

Karin Olson, RN, PhD, Professor, Faculty of Nursing
(780) 492-2551; karin.olson@ualberta.ca

CO-INVESTIGATOR: Kathy Banks, RN, MSN, PhD Candidate (780) 492-5229

Do you understand that you have been asked to be in a research study?
Yes No
Have you read and received a copy of the attached Information Letter?
Yes No
Do you understand the benefits and risks involved in taking part in this research study?
Yes No
Have you had an opportunity to ask questions about this study?
Yes No
Do you understand that you are free to refuse to participate or withdraw from the Study at any time? You do not have to give a reason and it will not affect your care.
Yes No
Have the issues of anonymity and confidentiality been explained to you?
Yes No
Do you understand who will have access to your study data?
Yes No
Do you understand that the interview data you provide for this study may be Analyzed in future studies?
Yes No
Would you like a report of the research findings sent to you when the study is

done?

Yes No

Do you understand that a $30.00 honorarium will be offered to acknowledge your time and thank you for participating in the study at the end of each interview?

Yes No

This study was explained to me by:

_____

I agree to take part in this study and for the data I provide to be used in future

studies.

Signature of Research Participant_____

Date_____

Printed Name _____

I believe that the person signing this form understands what is involved in the study and voluntarily agrees to participate.

Signature of Investigator or Designee_____

Date_____

Printed Name _____

APPENDIX E - Demographic Data

Date: Code#:

1. Age of woman? _____ years

2. Number of pregnancies? _____ Number of live children? _____

3. Age of child(ren)? If more than one from youngest to oldest
   _____

4. Ethno-Cultural Background: _____

5. Educational level of woman?
   a. University or college graduate
   b. Some university or college
   c. High school graduate
   d. Some high school education
   e. Less than high school education

6. Employment status of the woman?
   a. Working full time
   b. Working part time
   c. Full time student
   d. Full time homemaker
   e. Laid off
   f. Unemployed Maternity Leave
   g. Other

7. Yearly Household Income level?
   a. Less than $25, 000
   b. $26, 000 to $35, 000
   c. $36, 000 to $45, 000
   d. $46, 000 to $65, 000
   e. $66, 000 to $85, 000
   f. Greater than $85, 000

8. Woman's description of her current relationship?
   a. Married
   b. Living together
   c. Living apart
   d. Separated
   e. Divorced

9. Did you have other health issues during pregnancy?
   _____

10. On medications? No?___ Yes?___ If yes, for what?
_____

APPENDIX F –Initial Guiding Questions

I will start the interviews by developing rapport with the woman. I will do this by reviewing the information that is contained in the letter to participant (Appendix C) and the consent form (Appendix D). I will outline that in the past I have worked as a Community Health Nurse, Youth Clinic Nurse, and Sexual Assault Nurse Examiner and during these roles I have worked with women who have experienced various forms of intimate partner violence and abuse. I will communicate my empathy by explaining that I am interested in helping nurses to help women who experience intimate partner violence and abuse during pregnancy. If the woman is tearful or emotional, I will state that I am sorry that she has had this experience and that I would like to hear about her experience so that I can help nurses help other women who have experiences similar to her own. If the woman is detached or talks about feeling numb, I will acknowledge her feelings.

Then the following questions will be used to guide the initial interview:

1. Tell me about your experience of being pregnant.
2. Did your relationship with the baby's father change when you were pregnant? In what ways did it change?
3. Please describe the events that lead up to you coming to the shelter.
4. What helps you to manage your day to day life?
5. Who or what has been most helpful to you during this time? How has he/she/it been helpful? (possible prompts re: "what": available resources e.g., financial, personal, program or service, professional)

6. Who or what was not helpful to you during this time? In what ways were they/it not helpful? (possible prompts re: "what": social beliefs about "good mothers" or women's responsibilities in the family; lack of or inadequate access to needed resources; etc).
7. Family can mean different things to different people – what does it mean to you? (prompt re: role of the child in becoming a mother, becoming a father)
8. How has your view of your relationship with the father changed since leaving to come to the shelter?
9. After having this experience, what advice would you give to someone who has had a similar experience?
10. Is there anything else about your story that you would like to add?

These are initial questions, and not an exhaustive list of all questions that I will use in the interviews. I anticipate that as I interview each woman I will develop more specific questions that will enable me to engage in a dialogue with the woman. This engagement in the interview will allow the woman to tell me her story as it has unfolded for her, with her own meaning and understanding of her experience relayed to me in the telling.

APPENDIX G - Projected Budget

TRANSCRIBER
Transcription of tape recorded interviews = 4 hours per interview hour
10-15 participants x 2 interviews =approximately 30 interviews
30 interviews x 1.5 hours/interview=45 interview hours
45 interview hours x 4 hours for transcription =180 transcription hours
180 transcription hours x $20.00 per hour =
$360.00

SUPPLIES

Filing supplies	100 file folder	$6.96
	50 hanging file folders	$14.92
Paper	500sheets/pkg $6.49/pkg x5	$32.45
Printer cartridges	4 @ $39.58	$158.32
Cassette tapes (90 minutes) 20 @$3.50		$70.00
Jump drive portable storage (1GB) 3 @$9.97 each		$29.91
PST 5%		$15.62
		$328.19

SERVICES
Photocopying and Printing $00.10/copy
$700.00

EQUIPMENT
Telerecorder
$24.99
Telephone line splitter –double jack
$5.99

COMMUNICATION
Conference Travel 1 trip/year
$1,000.00
Report & Manuscript Preparation
$400.00

TOTAL **$2818.98**

Resources already secured for the Project
Laptop Computer and printer
Tape recorder

APPENDIX H - Proposed Timeline

June – July 2010	Candidacy oral exam, Liaise with community agency
June-July 2010	Preparation of Ethics application and approval
July-August 2010	Ethics approval Distribute posters and information letters Begin interviews with women participants
July-December 2010	Data collection and comparative analysis
February-March 2011	Dissertation to committee
March 2011	Complete dissertation Final Oral Exam
September 2011	Disseminate findings at meetings and conferences Prepare manuscripts for publication