

Translating Research

Developing an Evidence-Based Health Advocacy Intervention for Women Who Have Left an Abusive Partner

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Improving the health and health care of women who experience intimate partner violence (IPV) is one of the goals of our program of research. Up to this point we have focused on building knowledge about women's experiences of leaving abusive partners (Merritt-Gray & Wuest, 1995; Varcoe & Irwin, 2004; Wuest & Merritt-Gray, 1999, 2001), family health promotion post-leaving the abusive partner (Ford-Gilboe, Wuest, & Merritt-Gray, 2005; Wuest, Ford-Gilboe, Merritt-Gray, & Berman, 2003; Wuest, Merritt-Gray, & Ford-Gilboe, 2004), and how to improve health care (Varcoe, 2001). Currently, our Canadian Institutes of Health Research (CIHR) New Emerging Team is conducting research into the health, social, and economic effects of IPV on women in the early period after they have left an abusive partner. In this paper, we describe how we are transferring knowledge from our previous and current research to develop an intervention to promote the health and quality of life of women who have left an abusive partner.

Background

IPV is a pattern of physical, sexual, and/or emotional violence in the context of coercive control by an intimate partner (Tjaden & Thoennes, 2000). The health effects of IPV are well documented (Campbell, 2002; Walker, Logan, Jordan, & Campbell, 2004). There is some evidence to suggest that the health problems women experience because of violence persist long after the violence has ended (Wuest et al., 2003). Not surprisingly, women who have experienced IPV come into frequent contact with health-care providers, most often in relation to management of chronic health problems (Humphreys, Parker, & Campbell, 2001). However, qualitative accounts of women's experiences suggest that women frequently view these interactions as negative and unsupportive,

leaving them feeling judged and disrespected (Gerbert et al., 1996; McMurray & Moore, 1994). Further, although shelters, crisis lines, women's centres, and elements of the justice system offer essential support to women leaving abusive partners, few health-specific supports are available to women during this transition. Despite growing interest within the health sector in improving the care provided to women who have experienced IPV, the phenomenon of violence has only recently been included in the education of health professionals, leaving the vast majority of health practitioners unprepared to recognize and respond to IPV in ways that are sensitive to the complexity of women's experiences and respectful of women's safety and choices. Access to quality services from a range of systems, including health care, is critical to the success of women's efforts to promote their health and develop new lives in the aftermath of violence (Ford-Gilboe, Wuest, et al., 2005).

There is a growing body of research that describes women's experiences and responses to violence, including their help-seeking efforts (Goodman, Dutton, Weinfurt, & Cook, 2003; Lempert, 1997), the process of leaving an abusive partner (Landenburger, 1989; Wuest & Merritt-Gray, 2001), and the relationships among various types of abuse and mental and physical health problems (Campbell, 2002; Humphreys et al., 2001; Walker et al., 2004). The subject of how this knowledge might be used to inform the development of interventions that address women's health in the aftermath of violence has been largely unexplored (Samuels-Dennis & Ford-Gilboe, 2005; Wathen & MacMillan, 2003). There is a critical need for evidence-based health-care interventions that effectively address the needs of women who have experienced violence.

Philosophical Assumptions

At the broadest level, our program of research is guided by a number of philosophical assumptions that reflect feminist, nursing, health promotion, and primary health-care principles and concepts. These assumptions include the following:

- IPV is not confined to interpersonal relationships but is sanctioned by broader social, cultural, and political structures that systematically oppress women, the poor, and those from non-dominant cultural backgrounds (Varcoe, 1996, 2002).
- Women's health is socially determined (Evans, Barer, & Marmor, 1994; Health Canada, 1999; Moss, 2002; Wuest, Berman, Ford-Gilboe, & Merritt-Gray, 2002) — by income and social status, education, social support, employment and working conditions, social environment, physical environment, personal health practices and coping skills,

health services, childhood development, gender, and culture (Lilley, 2000).

- The experiences of particular women must be at the centre of health care related to IPV. Although women have many commonalities, they are diverse — each woman and her experience of IPV and health are unique.
- Women and their children have the right to live safe, healthy, productive, autonomous lives and to participate fully in community life. A just and equitable society ensures that its citizens have reasonable access to the determinants of health that are modifiable, such as safe, affordable housing, quality education, and opportunities to earn a decent living.
- A primary health-care approach, which seeks to develop an integrated system of accessible, relevant, affordable services that address a range of issues important to health and that are delivered in local communities (World Health Organization, 1978), may be the most appropriate way to address the health of women post-leaving and to reduce fragmentation of services.
- Nursing approaches that are framed within a health determinants perspective, emphasize capacity building through collaborative relationships with clients and across sectors, and view individuals in the context of family and community (e.g., Allen & Warner, 2002; Doane & Varcoe, 2005; Ford-Gilboe, 2002) are particularly well suited to a primary health-care approach.

Considering the Evidence

To provide both a substantive focus and a structure for the intervention, we drew on three sources. First, we built upon our grounded theory, *Strengthening Capacity to Limit Intrusion*, which addresses the processes through which mothers and their children promote their health after leaving an abusive partner/father (Ford-Gilboe, Wuest, et al., 2005; Wuest et al., 2003). Second, we drew upon emerging findings from the first wave of our current work, the Women's Health Effects Study (WHES), a longitudinal investigation of women's health and resources in the early years after leaving an abusive partner (Ford-Gilboe, Varcoe, et al., 2005). These findings contribute to the substantive focus of the intervention. Finally, to most effectively apply these findings in an intervention, we sought relevant intervention studies. Here, we turned to studies examining the efficacy or effectiveness of community-based interventions for women who have experienced IPV, particularly the work of Sullivan and colleagues (Bybee & Sullivan, 2002; Sullivan, 2002; Sullivan & Bybee, 1999), as well as selected studies (e.g., Browne et al., 2001) testing health promotion inter-

ventions, delivered by nurses, to women from marginalized groups. We considered each body of work, moving back and forth among them, identifying and combining the lessons from each.

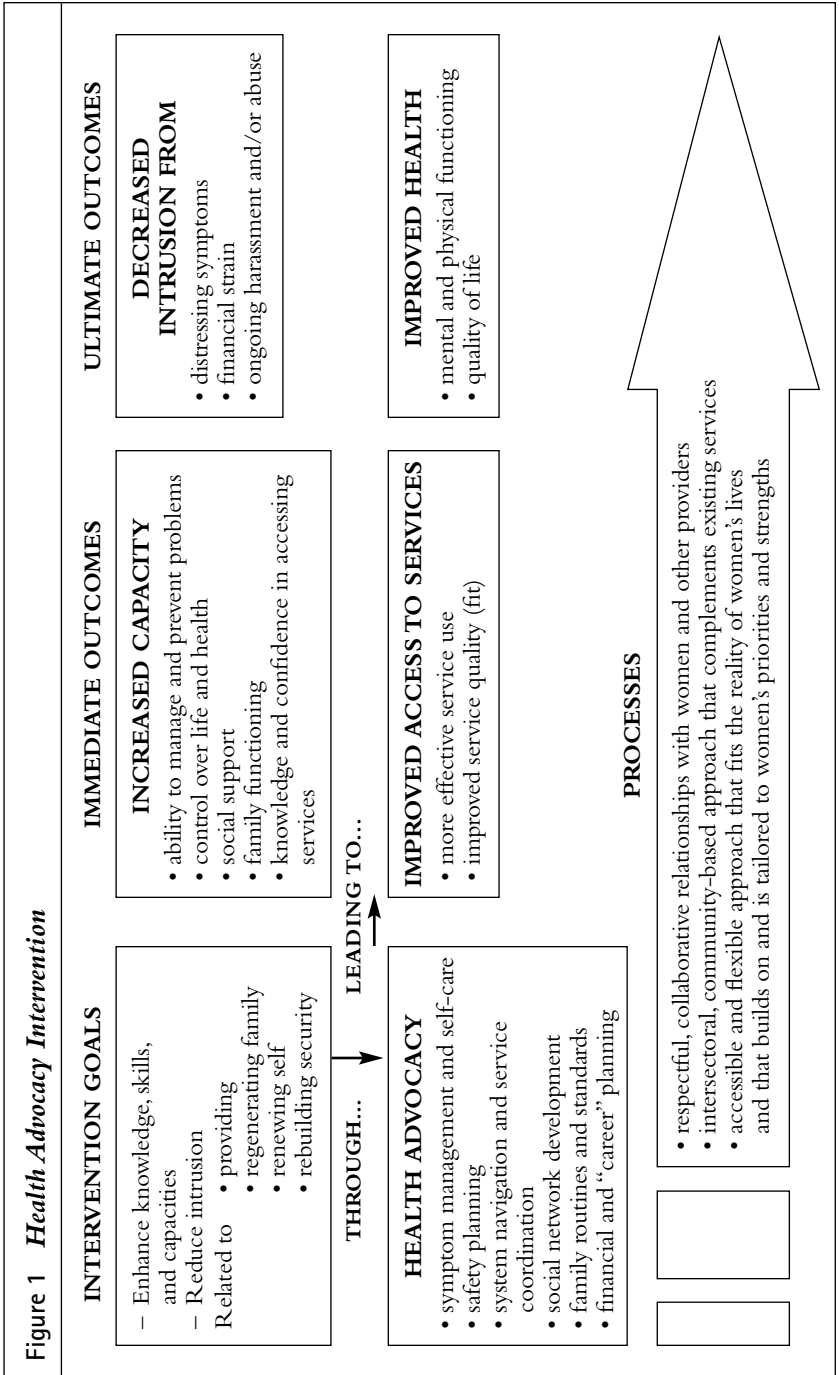
Lessons from the Theory of Strengthening Capacity to Limit Intrusion

Our feminist grounded theory study of family health promotion after leaving an abusive male partner (Ford-Gilboe, Wuest, et al., 2005; Wuest et al., 2003) provided the initial evidence for our approach to intervention. A grounded theory is a framework or substantive theory that captures a social process in social context (Glaser, 1978; Glaser & Strauss, 1967). Such a framework can provide useful direction for practice because it reflects the central problem for those being studied and how they process the problem. We interviewed 40 mother-headed single-parent families post-leaving an abusive partner (1–20 years) and found the central problem to be *intrusion* — external interference in their everyday lives that diverts attention away from family priorities and limits their choices for moving on (Wuest et al., 2003). The pervasive, enduring, unpredictable nature of *intrusion* is what makes it so problematic. *Intrusion* may stem from harassment and abuse from the ex-partner. However, equally intrusive are health outcomes associated with past and ongoing abuse, the costs or “strings attached” to seeking and obtaining help, and undesirable changes to patterns of living consequent to leaving, such as loss of the family home, income, or social relationships. In order to promote the family’s health, families engage in *strengthening capacity to limit intrusion*. The key implication of these findings is that interventions designed to assist women post-leaving need to both reduce bureaucratic intrusion and complement women’s efforts to build their capacity to limit intrusion and manage its consequences.

Our grounded theory offers specific direction for intervention by conceptualizing the processes used by families to strengthen their capacity to limit intrusion: *providing*, *renewing self*, *rebuilding security*, and *regenerating family* (Ford-Gilboe, Wuest, et al., 2005). *Providing* is a process of acquiring the material resources, energy, and skills necessary for survival over time. *Renewing self* refers to women’s struggle to restore themselves and their children as individuals and realize their potential. *Rebuilding security* entails the creation of a life characterized by safety and belonging, as opposed to the risks, fear, and isolation associated with past abuse. *Regenerating family* is a process of replacing the previously destructive family environment with open and safe patterns of interaction. How families engage in each process depends on the level of intrusion (Table 1). When intrusion is high, women focus on meeting current practical needs as part of *surviving* through each of these processes. When intrusion abates and women increase their capacity to limit

Table 1 Processes of Strengthening Capacity to Limit Intrusion		
Process	Surviving	Positioning
<i>Providing</i>	<i>Managing without</i> entails identifying, finding, and making compromises to maintain what is basic for survival.	<i>Managing as if</i> they have adequate resources to get what they deserve includes taking risks to secure their future.
<i>Renewing</i>	<i>Living free</i> entails counteracting past control of the abuser over thoughts and actions by engaging in activities that bring immediate comfort and relief.	<i>Living better</i> entails proactively and purposefully developing personal capacity.
<i>Rebuilding security</i>	<i>Safeguarding</i> is limiting exposure to people or situations that threaten physical or emotional safety.	<i>Cautious connecting</i> is purposefully developing a sense of personal belonging and connection with the community.
<i>Regenerating family</i>	<i>Working as a team</i> entails constructing an explanation of why it was necessary to leave the abuser and changing the ways in which family members contribute to everyday family functioning.	<i>Living differently</i> is articulating and learning to live by new standards for interpersonal relationships.

Source: Ford-Gilboe, Wüest, et al. (2005).



intrusion, they are able to be more proactive and to position themselves for the future. Furthermore, the risk-taking involved in positioning for the future often results in increased intrusion, forcing women to refocus on survival, at least temporarily. Importantly, *strengthening capacity to limit intrusion* does not follow a predetermined trajectory but is an incremental process of change over time that is characterized by ongoing shifts between surviving and positioning and between each of the four sub-processes, in response to intrusion and the most significant family priorities at a particular point in time.

The four processes — *providing, renewing self, rebuilding security, and regenerating family* — define the core components of a holistic health intervention. While the theory was developed using family-level data, we consider the majority of the findings to be useful for guiding an intervention geared to women with and without children after leaving. To illustrate how each process might guide the intervention, we detail the direction for intervention implied by the process of *providing* (see Figure 1).

Based on grounded theory, the intervention should be designed with the aim of working with women to build capacity to limit intrusion, rather than only helping women to access services. Capacity building is the process of increasing the woman's knowledge and skill in making choices that are consistent with her long-term goals, including the knowledge and skills needed to (a) identify the risks and benefits of seeking help, decide when to withdraw from services, and advocate for greater control in decision-making; (b) prevent and manage symptoms associated with chronic health problems, thereby improving everyday functioning and quality of life; (c) use strategies to promote safety and limit exposure to re-abuse; (d) develop a network of mutually satisfying peer relationships; (e) learn new ways of relating to one another and working together as a family; and (f) develop plans for improving her standard of living that fit with her values and aspirations for career and home life. Finally, examination of the grounded theory suggested that, to be successful, the intervention requires a complex, intersectoral approach that includes, but is not limited to, health-related interventions. Processes for creating a more satisfying life post-leaving that are built from women's experiences (i.e., regenerating family, providing, renewing self, rebuilding security) can provide a meaningful structure for identifying women's priorities and developing strategies to address goals in each area.

Lessons from the Women's Health Effects Study

Whereas the grounded theory Strengthening Capacity to Limit Intrusion provides both general structure and substance for the intervention, findings from the WHES underscore the importance of a social determi-

nants perspective on health and provide direction to ensure that the intervention is relevant to women's lives in the *early period* post-leaving. The findings of our grounded theory research related to intrusion from health problems highlight a gap in knowledge regarding the long-term health effects of IPV, particularly post-leaving. Typically, studies of the health effects of violence have relied on samples of women currently experiencing IPV or living in shelters. In no studies has women's health been examined in the early post-leaving period using a community-based sample.

The Women's Health Effects Study is an ongoing longitudinal investigation of a community sample of 309 women from three Canadian provinces (New Brunswick, Ontario, and British Columbia) in which data are being collected annually over 4 years. The study is being undertaken to (a) describe changes in women's health and personal, social, and economic resources in the early years after leaving an abusive partner; (b) examine, by testing a causal model, how changes in women's health may be explained by the interrelationships between the severity of past and ongoing violence and access to resources; and (c) estimate the economic costs associated with women's efforts to manage their lives and their health post-leaving. English-speaking women who had left an abusive partner at least 6 months but no more than 3 years previously and who screened positive on the Abuse Assessment Screen (Parker & McFarlane, 1991) were included in the sample. In wave 1, baseline data were collected through completion of (a) a life history calendar; (b) a structured interview designed to elicit information about women's resources, service use, and demographic characteristics; and (c) an in-depth abuse history and health assessment conducted by a registered nurse. A combination of standardized self-report measures, survey questions, and biophysical measures were used to measure the variables of interest.

Findings from the analysis of wave 1 data provide detailed evidence regarding the intrusion in women's lives post-leaving. The women had experienced multiple forms of abuse over their lifetimes. The majority of women (66%) reported experiences of abuse when they were children and most (59%) reported having more than one abusive intimate partner as an adult and 40% reported being sexually assaulted by someone other than their most recent partner. Although, on average, the women had been separated from the partner for just over one and a half years, 38% reported ongoing abuse and half reported continued harassment from the ex-partner. These findings stress the importance of an intervention that builds on women's efforts to *rebuild security*, takes past and ongoing experiences into account, and highlights the need for continued safety planning. Finally, of the 176 women in the sample who had dependent

children living with them, 87% reported that their children had witnessed the violence directed at them by their ex-partner, highlighting the importance of considering women's issues within the context of family.

Wave 1 findings from the WHES offer specific direction for symptom management, identified in our grounded theory as an essential component of limiting intrusion through *providing*. In the WHES we collected self-report data on diagnoses and medication and used standardized measures to collect data on symptom patterns and severity. These data provide critical information about the primary health problems experienced by women who are in the process of leaving an abusive partner and provide specific direction for nurse interveners. For example, more than half of the women in the sample reported feeling worried or uptight, sad or depressed, difficulty sleeping, headaches, back pain, and difficulty concentrating in the preceding month. Almost one third of the women reported taking anti-depressant medications, a rate three times that reported by women in a similar age group in the 2003 *Canadian Community Health Survey*. These data suggest that nurses must be alert to the possibility of similar patterns and be prepared to support women in building symptom-management skills.

Findings from the WHES also deepen our understanding of interventions related to *providing, renewing, and rebuilding security*, particularly when linked to intrusion from changes in their pattern of living post-leaving. Across the sample, the mean annual family income for the current year was 50% lower than that for the year prior to leaving. Although almost half (45%, $n = 139$) of the women in the study were employed, the vast majority (90%) reported some difficulty living on their current incomes, with 50% of the sample indicating that it was "very difficult" or "impossible" to meet their current obligations. Not surprisingly, 22% of the women reported using a food bank in the preceding month. Of those who were not employed, 26% ($n = 42$) were actively seeking work, while 20% ($n = 34$) were disabled and unable to work. Sixteen percent of the women were currently enrolled in an education or training program. These findings suggest the importance of including women's efforts to improve their financial well-being as part of a comprehensive intervention.

Findings from the WHES on the use of health and advocacy services reflect the sources of help most accessible to women and offer insights regarding possible gaps in service. Health-service use was quite high. For example, 56% of women made at least one visit to their family physician and 14% used emergency room services at least once in the preceding month. Although the reasons for these patterns are not clear, options for service use should be explored with women in order to identify system

gaps and link women with the best services for their needs. Findings related to women's use of other community services raise similar intervention points. Women's shelters provide information and support to help women access a variety of services, such as legal aid, housing, and health care, that they may need after leaving. Yet few women in our sample (16%) stayed in a shelter at any time in the first 6 months after leaving and only one third reported using advocacy services in the preceding month. Although most (82%) of the women were confident that they knew where to access services, 65% reported that it was somewhat or very difficult to access the services they required. Community services, including those in the health sector, are complex and frequently operate in "silos," resulting in poor integration and communication within and across sectors and barriers to accessing and using needed services. An effective intervention takes this fragmentation into account, providing support for women to navigate these systems.

In summary, the WHES offers specific direction for the intervention focused on the process of *strengthening capacity to limit intrusion* due to ongoing harassment, multiple experiences of abuse, health problems, economic problems, and service-access problems experienced by women in the first 3 years after leaving an abusive partner. The convenience sample of women who took part in the WHES may be systematically different from the population of Canadian women who are leaving abusive relationships. However, the early findings emphasize the importance of explicit attention to the health of women and provide insights into the range of issues that should be considered in designing an intervention to build women's capacity to limit intrusion, including intrusion due to continued harassment. Findings related to intrusion from economic problems underscore the importance of a social determinants perspective on health, while findings on patterns of service access and use point to the importance of designing an intervention that will foster continuity of relationships across service sectors and help women navigate complex systems.

Lessons from Intervention Research

While our program of research clearly informs the focus and structure of the intervention, extant intervention research offers additional direction, particularly for the intervention process. Working from our philosophical assumptions, we identified two bodies of work.

Community-based interventions for women who have experienced IPV. Relatively few studies have examined the impact of interventions designed to support women who have experienced IPV, and the quality of those studies varies considerably (Samuels-Dennis & Ford-Gilboe, 2005; Wathen & MacMillan, 2003). As part of a well-designed program

of research in post-shelter advocacy, Sullivan and Bybee (1999) randomly assigned 143 women who were leaving a shelter to intervention and control groups. In the intervention group, trained advocates (undergraduate psychology students) worked with women in their homes and communities 4 to 6 hours per week over a 10-week period, providing individualized service to help women identify their needs, strengths, and goals, sharing information about services, and providing practical assistance to help women access needed services, while the control group were left to navigate the system on their own if they so desired. Outcome measurements for both groups were taken pre-intervention, post-intervention, and 6, 12, 18, and 24 months later.

Immediately post-intervention, the women who had received advocacy services were found to be more effective in obtaining needed resources, experienced less physical violence and psychological abuse, had fewer depressive symptoms, and reported higher levels of social support and quality of life than women in the control group. Importantly, the gains in reduced physical violence, increased social support, and improved quality of life observed in the intervention group were sustained over a 24-month period. Although levels of depressive symptoms and psychological abuse were generally lower in the intervention group compared to the control at each interval, these differences were not statistically significant and were not sustained after the 24-month follow-up (Sullivan & Bybee, 1999). Three years post-intervention, the advocacy intervention continued to exert positive effects on women's social support and quality of life but the impact on risk of re-abuse was no longer evident (Bybee & Sullivan, 2005).

The results of Sullivan and Bybee's research (Bybee & Sullivan, 2005; Sullivan & Bybee, 1999) are salient to the development of an intervention that targets the health of women who have left abusive partners. Their research supports the long-term benefits of advocacy support and validates the knowledge and expertise that lay advocates provide within a larger system of services. The advocacy model helped women navigate the "system" of services that were available, but, as "health" was not the particular focus, the intervention did not, unsurprisingly, affect depressive symptoms. Specifically including health services designed to support women in managing distressing symptoms may be beneficial in extending the benefits of advocacy for women in the post-leaving period.

The success of Sullivan and Bybee's (1999) intervention points to the need to include key features in our proposed intervention, such as an emphasis on process and capacity building, individualized planning, and practical aid in accessing services. Advocacy services are essential but not sufficient. A focus on symptom management and referrals for health care

requires expertise that nurses can provide, both to support women in developing strategies for managing distressing symptoms and to tap into formal and informal networks in the health-care sector in order to expedite referrals and service delivery.

Health promotion interventions with marginalized populations. Other intervention studies have evaluated the contribution of nurses to health promotion interventions. We examined the work of David Olds and of Gina Browne to deepen our understanding of what is known about nursing interventions with populations of at-risk parents. Olds (2002) evaluated a 25-year program of research focused on improving the health, development, and future life trajectories of low-income mothers and children using home visiting during the prenatal and early-infancy periods. Testing of the program in two clinical trials provided evidence of positive effects on parental care; child abuse, injury, and neglect; number of subsequent pregnancies; workforce participation; and social assistance use. In a follow-up study of the children when they reached the age of 15, the children of nurse-visited mothers had fewer arrests and convictions, less emergent substance abuse, and less promiscuous sexual activity than controls.

Components of this intervention that are salient for our planning relate to the theoretical base, the nurse as interventionist, and the rigorous training, support, and guidelines for the interventionists. The program, which was based on theories of human ecology (Bronfenbrenner, 1979), self-efficacy (Bandura, 1977), and human attachment (Bowlby, 1969), focused on enhancing the material and social environment of the family; helping the family to meet small, achievable objectives in order to build the confidence needed to take on larger challenges; and promoting sensitive, responsive, engaged child care (Olds, 2002). Nurses were selected as the home visitors because of their specific training in managing complex clinical situations, competence to address the concerns of the family related to pregnancy and the health of the child, and ability to teach parents to identify emerging health problems and navigate the health-care system (Olds). In a comparative study conducted using both paraprofessionals and nurses, paraprofessional visiting produced small effects that rarely reached statistical significance, while nurse visiting had significant effects on many child and maternal outcomes (Olds et al., 2002). In the expanded Nurse-Family Partnership program that Olds is continuing to develop, the minimum educational requirement for nurse visits is a baccalaureate degree, with master's preparation required for nurses in supervisory positions (Olds).

Browne, Byrne, Roberts, Gafni, and Whittaker (2001) developed a public health nursing case-management intervention, *When the Bough Breaks*, designed to help sole-support parents on social assistance to return to work. This intervention was based on three characteristics for

effective home-visiting programs identified by Olds and Kitzam (1990): an ecological model; nurse visitors who establish a therapeutic relationship and whose frequency and duration of visits is sufficient to address the range of factors that influence maternal/child outcomes; and targeting families at risk due to lack of economic, social, and personal resources (Markle-Reid, Browne, Roberts, Gafni, & Byrne, 2002). The 1-year intervention was comprehensive and included health promotion by public health nurses using a problem-solving approach during home visits, employment retraining, and subsidized after-school recreation or child care. In a randomized controlled trial with 756 sole-support parents receiving social assistance, the comprehensive health promotion intervention was found to be more effective than self-directed care in terms of the number of exits from social assistance and subsequent dollars saved. Furthermore, it was no more expensive in terms of use of health and social services than self-directed care. Intervention and control groups showed similar reductions in parent-mood and child-behaviour disorders as well as equivalent increases in parent social adjustment and child competence. There were substantial problems with dropout in this study, which may have affected the findings. Yet the findings illustrate the benefit of a comprehensive approach that addresses multiple determinants of health (i.e., recreation, coping skills, and access to services) in helping individuals receiving social assistance to develop the ability to enter the workforce. For our intervention, these findings validate the importance of working across systems to support women in building the capacity for economic stability through *providing*.

Women who have left abusive partners are at risk due to their abuse history, shifting resources and life circumstances, and health problems. Lessons from the work of both Olds and Browne confirm the effectiveness — for a range of health and social outcomes — of theory-based health interventions that address the determinants of health and are delivered by nurses. Additionally, Olds's (2002) research reinforces the need to develop solid guidelines for the intervention and to incorporate initial training and ongoing support for the nurses who carry out such interventions.

The Health Advocacy Intervention

Using the evidence from our qualitative and quantitative work and from the intervention studies reviewed, we began to develop a health advocacy intervention, structured by our intrusion theory, targeted to a range of health and social issues as experienced by particular women in the early period post-leaving and delivered by nurses in collaboration with others. We identified two broad goals for the intervention and drafted a model in which the key components and outcomes of the intervention are specified (Table 2). At the same time, we articulated a set of process prin-

Table 2 Exemplar of Direction for Intervention Derived from the Process of Providing in the Theory of Strengthening Capacity to Limit Intrusion

<p><i>Providing</i> is challenging because the women's confidence in their ability to provide has been systematically eroded by abuse. They initiate this work with little energy or material goods and resources due to the abuse and the crisis nature of their leaving. Providing takes place by</p> <ul style="list-style-type: none"> □ managing without (<i>surviving</i>) <ul style="list-style-type: none"> • negotiating and clarifying what they <i>need</i> (food, safe housing, household goods, clothing, medicine, sleep, relief of symptoms and health problems, income, meaningful work, transportation, child care) • scrounging for the basics for survival, which is exhausting due to intrusion related to the "costs" of help (the need to live up to standards, the limitations of help, and shifting eligibility criteria) • crisis management and juggling competing immediate demands 	<p>The goal of the intervention is not to exclusively assess and monitor, but to reduce intrusion and augment women's capacity to limit intrusion.</p> <ul style="list-style-type: none"> • Help the women to name and identify what they need. They feel unworthy; help them to consider their range of needs (sleep, medicine, relief of symptoms, employment, training, credit, safe housing, child care, transportation, food, etc.). • Help the women to formulate strategies for managing intrusive symptoms, preventing health crises, obtaining and managing needed medication, accessing health services, and boosting their energy. • Help the women to access flexible employment and training opportunities. • Advocate by providing information on rights, eligibility, and ways to efficiently access resources and instrumental help.
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<p>□ managing as if (<i>positioning for the future</i>)</p> <ul style="list-style-type: none">• negotiating for what they <i>deserve</i> (stable housing, tuition in order to return to school, money for counselling, recreational activities, treats)• risking — extending themselves beyond what is reasonable in order to secure their future; social norms and system structure force them to manipulate or do what may appear unreasonable, unsafe, or illegal in order to break through the economic ceiling, social class, and so on.	<ul style="list-style-type: none">• Reduce the “costs” of the service being offered.• Initially help the women through crises, but then focus on helping them acquire the competence to self-manage crises.• Discuss (without censoring) what the women wish and hope for themselves and their children.• Avoid limiting or discouraging the women; they had to take extraordinary safety and financial risks to leave the abusive partner and may need to take similar risks to position themselves for the future.• Ongoing support is crucial to help the woman through the transition entailed in risk-taking (quitting her job in order to return to school, doing without in order to purchase a home). When risk-taking is successful, support should be continued until the woman has consolidated her gains. When it is unsuccessful, support should be continued while she regroups and considers her options without having to feel like a failure.
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ciples to guide the practice approach taken by the nurses in working with women and other service providers over time. These process principles provide a foundation for the way in which the intervention is carried out and are critical to achieving specified outcomes. At a process level, the Health Advocacy Intervention is characterized by:

- flexible program delivery based on respectful, collaborative relationships with women and other service providers
- attention to safety, accessibility, and the practical reality of women's lives, tailored to and building on women's priorities and strengths
- an intersectoral, community-based approach that complements rather than duplicates existing services and has the potential to be sustainable.

The Health Advocacy Intervention seeks to improve women's access to the broader determinants of health in the early period post-leaving an abusive partner, in order to (a) enhance the knowledge, skills, and capacities that women need in order to support their health and well-being in the context of their family, community, and culture; and (b) reduce intrusion or the effects of intrusion, understood broadly as ongoing harassment, the cumulative health effects of multiple forms of abuse, undesirable changes to patterns of living, and bureaucratic barriers to adequate support. Importantly, women's priorities and efforts relative to providing, regenerating family, renewing self, and rebuilding security constitute a starting point for the intervention goals of building capacity and reducing intrusion. These four processes demarcate the *boundaries* of the intervention and encourage the nurse to consider: (a) the woman's priorities in each of these areas; (b) the types of intrusion that are most problematic and how these might be reduced or addressed to limit the impact on the woman and her family; (c) the knowledge, skills, and capacities that women need in order to work towards each priority; and (d) the ways in which the woman's efforts may change over time in response to the changing nature of intrusion, her developing ability to limit its effects, and shifts in her goals and aspirations.

The six components of the intervention specify classes of activity that flow from the intervention goals and are undertaken jointly by the nurse and the woman. *Symptom management and self-care* entails the identification and testing of various approaches to reducing the distress associated with symptoms, both those that the woman can direct herself and those that require support from other professionals. *Safety planning* focuses on assessing risks to safety and developing strategies to limit the effects of harassment or ongoing abuse that may draw on formal and informal networks as well as the justice system. *System navigation and service coordination* includes learning about available services, considering the benefits

and costs of using such services, and developing effective ways of advocating for access to services that fit with preferences and priorities. *Social network development* entails the seeking out and developing of relationships with peers or extended family members that meet human needs for emotional support, social interaction, belonging, and/or practical aid. *Developing family routines and standards* focuses on taking stock of family patterns of interaction and developing strategies to reinforce standards for relating to one another that are important to the family. *Financial and career planning* entails reflection on the multiple ways in which women engage in meaningful work, at home and outside the home, and developing strategies to strive towards the woman's personal goals for financial security and meaningful work that fit with her preferences, resources, and other demands.

Finally, the immediate and ultimate outcomes specified in the model reflect reasonable changes that may occur for the women and/or their families as a result of engaging in collaborative health advocacy activities. Specifying these outcomes permits assessment of whether the intervention is producing results that are tied to theoretical concepts and are practical and desirable for women and their families. The model constitutes a starting point for engaging in consultation with stakeholders about the relevance and completeness of the intervention as well as the feasibility of testing it and eventually, if effectiveness is demonstrated, promoting its integration into the "system." The model also suggests that key stakeholders will include providers of existing services in the social service and anti-violence sectors, policy-makers, and women themselves. Such consultation will be critical to the success of the intervention, by (a) building on the considerable expertise of direct-service practitioners who know the reality of working within complex systems, (b) establishing collaborative alliances to reduce service fragmentation when testing the intervention, and (c) engaging in dialogue with policy-makers about the results of testing the intervention in order to enhance knowledge uptake.

Conclusion

The earlier phases of our program of research and intervention studies with women who have experienced IPV and women who are marginalized in other ways point in similar directions with respect to the development of a comprehensive intervention to improve the health and quality of life of women who have left abusive partners. Drawing on these different sources of evidence, we have proposed a health advocacy intervention for women post-leaving that is intended to reduce intrusion from multiple sources and to build women's knowledge, skills, and capac-

ities; is tailored to women's priorities and the realities of their lives; and is carried out collaboratively with a range of stakeholders. The specific goals, activities, outcomes, and process principles described in the model provide a starting point for engaging in meaningful dialogue with stakeholders as we move towards testing the intervention.

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