Supporting Mother-Infant Relationships Affected by Intimate Partner Violence in Prince Edward Island: A Pilot Project

A Thesis

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Dedication

This thesis is dedicated to my parents, Gordon and Barb.

Their guidance, encouragement and continuous support during these past three years has been wonderful. My mother has always been my academic and life mentor. Thank you for this.

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UNIVERSITY OF PRINCE EDWARD ISLAND

ABSTRACT

SUPPORTING MOTHER-INFANT RELATIONSHIPS AFFECTED BY INTIMATE PARTNER VIOLENCE IN PRINCE EDWARD ISLAND: A PILOT PROJECT

By Julia E. Campbell

Purpose: The purpose of this research was to explore the relationships between mothers and infants exposed to intimate partner violence and to investigate its impact on such relationships; to address gaps in literature as there also appears to be a lack of research that explores the association between mother-infant relationships and infant development in families affected by intimate partner violence; and to identify the support needs, resources, barriers to support, and preferences for support intervention that promote mother-infant relationships, from the perspectives of mothers affected by intimate partner violence.

Setting/Participants: Three Prince Edward Island mothers with children less than 36 months at time of interview, who have been affected by intimate partner violence.

Methodology: Qualitative research methods were employed in this pilot project. Face-to-face, semi-structured interviews were conducted with participants.

Results/Conclusions: All three participants reported changes in their infants as a result of being exposed to intimate partner violence. Some of these changes were more significant than others. Two of the three participants believed that the mother-infant relationship was greatly affected by intimate partner violence, while one participant claimed that it had no effect on her relationship with her infant. The participants expressed a lack of support services for mothers affected by intimate partner violence in Prince Edward Island and identified their abusers as their main barrier in accessing the available support, along with transportation, finances, and lack of knowledge of support resources.

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Chapter One

Introduction

Introduction

The Canadian Public Health Association, in collaboration with other professional organizations and associations, has recognized intimate partner violence (IPV) as "a priority health issue to which the health professions must respond" (Clark & Du Mont, 2003, p. 52). This study is a pilot project which is part of a greater Atlantic Canadian study. This pilot project consists of both qualitative and quantitative research methods, however for the purpose of this thesis, only qualitative findings will be reported. Intimate Partner Violence is broadly defined with definitions of what constitutes IPV varying across the research literature and in the general public (Johnson & Bunge, 2001). For the purpose of this thesis, IPV is defined using the definition from the Centers for Disease Control (Saltzman, Fanslow, McMahon, & Shelley, 1999), which outlines IPV by the types of intimate partners and the categories of violence. Types of intimate partners include: current or former spouses (including common-law spouses), dating partners, current or former boyfriends, divorced or separated spouses (Saltzman et al., 1999). Categories of violence used within this definition of IPV include physical violence, sexual violence, threat of physical or sexual violence, psychological/emotional abuse (including coercive tactics) where there has also been prior physical or sexual violence or prior threat of physical or sexual violence (Saltzman et al., 1999). For the purpose of this thesis, the terms 'family violence' and 'domestic violence' will be used interchangeably with IPV.

Statement of the Problem

Prince Edward Island is currently lacking research surrounding family and intimate partner violence (R. Brown, personal communication, May 27, 2005). In fact, little to no research has been conducted on the prevalence, types of, and prevention of IPV in the province (R. Brown, personal communication, May 27, 2005). Therefore, a comparison to other Canadian provinces remains a difficult task. Although current research identifies the serious nature of exposure by infants and young children to violence and abuse, Health Canada (1999) recognizes that the many effects of abuse on prenatal and infant development requires further investigation. Additionally, Clark and Du Mont (2003) state that existing research may not adequately or accurately reflect the scope of or potential costs of the issue of IPV.

The relationships between mothers and infants, 36 months of age or less, affected by IPV have not been empirically described. Moreover, the degree to which mother-infant relationships may mediate the impact of IPV on infant development is unknown. Sumner and Spietz (1994) claim that children's developmental achievements are very much dependent on their relationship or interaction with the mother. Past IPV research however, has focused on the relationship between parents and older children (Mullender, Hague, et al., 2002). As Hughes and Luke (2000) state

> there is solid evidence for the negative impact on children of witnessing spouse abuse...it is now time to do more than document detrimental effects, to investigate in closer detail many of the factors that are related to adjustment. These factors are important as they likely mediate or moderate the impact of exposure to parental violence on children's psychological functioning (p. 185).

Also, others have confirmed this statement and claim that no current publications that have studied IPV have examined mediating variables to "understand the variance in

children's behavioral and emotional adjustment" in families affected by domestic violence (Levendosky, Huth-Bocks, Shapiro & Semel, 2003, p. 275). Social support to promote favorable mother-infant relationships in families affected by IPV has also been neglected in the literature. Finally, international, national, and provincial policy documents underscore the necessity and timeliness of this research.

In addition to fulfilling a significant gap in research and practical knowledge, this research seeks to address national and provincial policy recommendations. In Canada, The *National Children's Agenda* and the *Federal/Provincial/Territorial Early Childhood Development Agreement* recommend improving parenting and family supports to enhance early child development. Additionally, the *Family Violence Initiative* supports research and evaluation efforts to identify effective interventions for family violence. Prince Edward Island's *For Our Children: A Strategy for Healthy Child Development* (Healthy Child Development Advisory Committee, 2000) recommends programs to encourage safe and secure parenting relationships, minimize risks to children's development, nurture sensitive periods for learning and support early childhood intervention.

Purpose of Study

This qualitative study examined the experiences of three Prince Edward Island mothers with IPV. The purpose of this research was threefold:

- to explore the relationships between mothers and infants exposed to IPV and to investigate its impact on such relationships;

- to address gaps in literature as there appeared to be a lack of research that explores the association between mother-infant relationships and infant development in families affected by IPV; and
- to identify the support needs, resources, barriers to support, and preferences for support intervention that promote mother-infant relationships, from the perspectives of mothers affected by IPV.

Past research has shown that children exposed to IPV experience severe psychological and behavioral consequences and also that family violence may produce alterations in mother-infant relationships that predispose children to poor outcomes (Health Canada, 1999). Mothers of preschool children in violent relationships have been observed to be more sensitive and responsive to their children than mothers who had not parented through IPV. This heightened sensitivity and responsiveness in relationships may be significant to the successful development of some children exposed to IPV. This theory however, remains unexplored (Levendosky et al., 2003). Furthermore, no research has been identified that explores: (1) mother-infant relationships affected by IPV, (2) the link between mother-infant relationships and infant development in families affected by IPV, and (3) the support needs, barriers to support and preferences for support intervention that promote mother-infant relationships from the perspective of mothers. This study sought to address these significant gaps in literature. It was anticipated that findings from this study might influence the understanding about the extent to which the quality of mother-child interactions are affected by IPV, the understanding of the role that mother-child interactions play in protecting children exposed to IPV and planning the delivery of community based support to those affected by IPV.

Demographics of Prince Edward Island

Prince Edward Island (PEI), Canada's smallest province, is located on the eastern end of the country. Although it is the smallest in size and population, PEI has the highest population density of all provinces at 24.47 persons per square kilometer (Wikipedia, 2006). The current population of the island is 137,800 people, with 33,000 of those people living in the province's largest city and capital, Charlottetown. The second and only other city in PEI is Summerside, with a population of 15,000 (Wikipedia, 2006).

According to the Statistics Canada (2001), the census data reports that of the total PEI population, 48% are males and 52% are females. In terms of marital status, 31% of the population never married, 53% are legally married (and not separated), 3.2% are separated but still legally married, and lastly 5.5% are divorced (Statistics Canada, 2001). Furthermore, in terms of family structure, 89% of families are comprised of married couples, while the remaining 11% are common-law couples. The majority of lone- parent families (83%) are lone female parents, with 17% of lone-parent families consisting of a single male parent (Statistics Canada, 2001). A great deal of the PEI population (38%) have less than a high school graduation certificate, while 22% do have a high school graduation certificate and/or some postsecondary education. Moreover, 12% have a trades certificate or diploma, 14% have a college certificate or diploma, and only 13% of Islanders have a university degree or diploma (Statistics Canada, 2001).

The following section presents a review of the literature (Chapter Two), which includes the background of IPV, followed by the methodology (Chapter Three), which presents qualitative research methods. Findings from the data collection phase of the

research process are displayed (Chapter Four) and a discussion (Chapter Five) of the findings is presented.

Chapter Two

Literature Review

The research included in this literature review spans from the years 1993 to 2006. Peer- reviewed journals, books, websites, and personal communication are used as sources of information. While Bogat, Levendosky, Theran, Von Eye, and Davidson (2003) define IPV as "physical and psychological violence perpetrated by men against their female partner", these authors claim that there is no agreement among researchers about how to accurately and exclusively define and measure this concept (p. 1271). IPV causes women to experience chronic physical and psychological stress which can produce poor mental and physical health (Bogat et al., 2003). In addition, IPV is widely recognized to have profound effects on child psychological and behavioural development, as Levendosky et al. (2003) identify, "young children may be particularly vulnerable to the impact of domestic violence" (p.275). This literature review will contain a general discussion of intimate partner violence, and focus especially on IPV against women and more specifically Prince Edward Island women and the effects of abuse on children.

Intimate Partner Violence: Definition and Types

Cox (2003) offers a comprehensive definition of IPV stating that it is:

> A pattern of assaultive and coercive behaviours that may include inflicted physical injury, psychological abuse, sexual assault, progressive isolation, stalking, deprivation, intimidation, and threats. These behaviours are perpetrated by someone who is, was, or wishes to be involved in an intimate or dating relationship with an adult or adolescent, and are aimed at establishing control by one partner over the other (p.323).

According to Browne (1993), violence in couple relationships may include criticisms and emotional put-downs, verbal harassment, sexual intimidation and assault, physical abuse and coercion, restraint of normal activities and freedoms and denial of access to resources. More specifically, Coker et al. (2000) identify four types of IPV, which include: battering, physical assault, sexual assault, and emotional abuse. Battering may be distinguished from physical assault in that battering is chronic and continuous in nature, and is regarded as a process by which one partner experiences a loss of power and control, entrapment, and vulnerability due to the other partner's exercise of power and force (Coker et al., 2000; Health Canada, 1999). Domestic violence "knows no boundaries" as it occurs across all socioeconomic classes, educational levels, religions, cultures, ethnicities, geographic groups, and genders (Brown, 2005; Cox, 2003).

Statistics Canada (2002a) reports that both men and women are exposed to IPV, with 8% of women and 7% of men reporting to have experienced at least one incident of violence by a spousal partner. Approximately 48% of women and 17% of men abused by an intimate partner seek social services following an incident of violence (Statistics Canada, 2002a). The likelihood that women report IPV is twice that of men, with approximately 37% of women and 15% of men reporting IPV to the police in 1999 (Statistics Canada, 2002a). In fact, females accounted for 85% of all victims of reported domestic violence in PEI in 2002 (Brown, 2005). In addition, Walker (1995) revealed that women are also more accurate reporters of the context of violence than men, and found that men are more likely to report only violent acts they commit when the intent to harm is present. While these numbers are disturbing, many statistics surrounding IPV are not accurate due to underreporting (Cox, 2003).

The Violence Against Women Survey (VAW) revealed that 29% of ever married women had been victims of IPV (Metropolitan Action Committee on Violence against Women and Children [METRAC], 2000), creating the notion that "men are the primary perpetrators of violence in intimate relationships" (Browne, 1993, p. 1078). While men also report being the victims of intimate partner violence, the forms and consequences tend to be more severe for women, which is also a reflection of lower reporting rates by men (Statistics Canada, 2002a; Power, 2004). Both men and women may suffer from physical, behavioural and psychological consequences as a result of IPV, however women report being more fearful than men as a result of the violence (Statistics Canada, 2002a; Power, 2004). Although statistics are not available, IPV within same-sex relationships also exists (Sullivan & Gillum, 2001).

A variety of correlates of IPV exist and as revealed by Coker et al. (2000), substance abuse and violence in the woman's family of origin were identified as the strongest precursors (Levendosky & Graham-Bermann, 2001). This proved to be true with all forms of IPV (Coker et al., 2000). In fact, METRAC (2000) found that women in violent relationships were more than twice as likely to have witnessed their own father assaulting their mother and were three times as likely as women in non-violent relationships to know that their partner had also witnessed violence as a child. Additionally, Brown (2005) states that there are many factors indicating a greater risk of experiencing domestic violence and include: women between the ages of 15 and 24, individuals living in common-law relationships, alcohol abuse, persons of Aboriginal descent, and persons undergoing a separation.

Intimate Partner Violence: Against Women

Although North America is viewed as a place where women have equal rights and status, violence against women is still prevalent and is a priority health issue (Browne, 1993; Clarke & Du Mont, 2003; Coker et al., 2000; Goodman, Koss, Fitzgerald, Russo, & Keita, 1993; Robinson, 2003). Historically, society's concept of violent victimization has been centered on assaults between acquaintances and strangers; however women's greatest risk of abuse and assault is from their intimates (Browne, 1993). Cox (2003) states that women are considerably more likely to experience both lethal and non-lethal violence from a non-stranger or partner. Acts of IPV against women are facilitated by the fact that intimate partners are "readily available, the amount of time at risk is high, and assaults can be carried out in private when the target is completely offguard" (Browne, 1993, p. 1077). Male violence against women is a major source of fear, stress, injury and even death and crosses lines of ethnicity, culture, socioeconomic status, sexual orientation, and age (Browne, 1993; Goodman et al., 1993; Power, 2004).

In incidents of woman abuse reported to police in 1996, 72% of the women were assaulted by their current intimate partner and 28% were assaulted by a former or estranged partner (METRAC, 2000). Furthermore, four out of five people murdered by their spouses are women murdered by men (Robinson, 2003).

Intimate partner violence has medical, psychological and behavioural consequences (Browne, 1993; Eby, 2004; Power, 2004; Robinson, 2003). Cox (2003) discloses that women who have experienced IPV report poorer overall health than women who have not experienced IPV. Medical consequences may include physical injuries such as cuts, bruises, fractures, muscle pain, joint pain, sexually transmitted diseases,

pregnancy, miscarriages, infertility, brain damage, blindness, deafness, and gastrointestinal problems (Jaffee, Epling, Grant, Ghandour, & Callendar, 2005; Lutenbacher, Cohen, & Mitzel, 2003; Power, 2004; Robinson, 2003), while it may also result in behavioural concerns such as self-mutilation, eating disorders, substance abuse, and suicidal ideation and attempts (Robinson, 2003). The majority of women exposed to violence experience a range of psychological symptoms (Browne, 1993; Levendosky & Graham-Bermann, 2001; Levendosky et al., 2003). Various authors found that women who experience IPV are more susceptible to low self-esteem, self-blame, increased levels of depression, feelings of guilt, shame, embarrassment, fear, confusion, helplessness, hopelessness and anxiety (Browne, 1993; Coker et al., 2000; Levendosky & Graham-Bermann, 2001; Lutenbacher et al., 2003; Power, 2004). Moreover, abused women are at an increased risk for dissociative disorder, borderline personality disorder and post-traumatic stress disorder compared to unabused women (Levendosky & Graham-Bermann, 2001; Robinson, 2003; Browne, 1993). The prevalence of post-traumatic stress disorder in abused women is extremely high, ranging from 45% to 84% (Levendosky & Graham-Bermann, 2001; Levendosky et al., 2003;). Also, Levendosky and Graham-Bermann (2001) reveal that women suffering from IPV experience characterological changes in personality, which ultimately leaves them vulnerable to repeated harm. Over and above the abovementioned effects of abuse, Jaffee et al. (2005) found that women victims of IPV have less access to important social supports, such as family or friends.

Intimate Partner Violence: Women in Prince Edward Island

Prince Edward Island has a safe housing association that was developed in 1980 to provide a safe place for women and children who were victims of abuse to work

towards the elimination of violence (Transition House Association (THA), 2006.). This association consists of safe homes and independent accommodations to aid women and children living in violent surroundings to escape such environments (THA, 2006.). In one year alone, over 11,000 calls of family and IPV were received by this association (THA, 2006). In addition, 299 new cases of wife assault and 89 cases of family abuse were opened by PEI Victims Services in one year (R. Brown, personal communication, May 27, 2005). Of the 604 cases of domestic violence reported to PEI police in 2002, children were known to be involved in 50% of the cases, while in almost all of these cases involving children, the children were physically present throughout the reported violence (R. Brown, personal communication, May 27, 2005).

A survey conducted by the federal government of Canada on women and children victims of violence uncovered that there were 232 women and dependent children admitted to Prince Edward Island shelters between April, 2001 and March, 2002 (Statistics Canada, 2002b). Of those women admitted for abuse, "58% were fleeing physical abuse, 100% psychological abuse, 83% threats, 42% harassment, 8% sexual abuse, and 17% financial abuse" (Statistics Canada, 2002b, ¶ 4). In addition, the majority of these women claimed they were not only protecting themselves from the abuse, but protecting their children from witnessing abuse of their mother (Statistics Canada, 2002b). Ninety-two percent of the children admitted to Prince Edward Island shelters were less than ten years of age (Statistics Canada, 2002b).

Intimate Partner Violence: Infants and Children

Children exposed to IPV against women see, hear, and are aware of violence against their mother by their father or their mother's partner (Health Canada, 1999).

Health Canada (1999) identifies the environment in which these children live as "toxic" and state that children's well-being, growth and development are at risk and severely compromised in such situations. Thirty-nine percent of Canadian women who experience IPV state that their children have witnessed the violence, implying that 11% to 23% of all Canadian children witness some form of violence against their mother in the home (Heath Canada, 1999). Additionally, it is estimated that between two and six children per classroom have witnessed some form of violence against women in the home within the recent year (Health Canada, 1999).

These acts of violence provide models of behaviour for future adults. Great danger exists in that children will learn aggression in a violent home and that it will become part of their behavioral pattern, indicating that violent patterns of behavior are transmitted from generation to generation (Health Canada, 1999; Levendosky & Graham-Bermann, 2001). Findings show that abused children often become abusive parents and abusive spouses (Levendosky & Graham-Bermann). Generally, the male child who experiences family violence will initially identify with his mother and become her confidant and supporter. This however, changes as the male child reaches adolescence, when he begins to identify with his father and may become abusive to those with whom he has a relationship (Levendosky & Graham-Bermann). The female child who experiences family violence may adopt the role of the abuser or of the victim, depending on the circumstances. For instance, girls whose mothers exhibit only a victim role will generally take on this role themselves, thus increasing the probability that they will become victims of violence if no intervention takes place (Levendosky & Graham-Bermann). Additionally, young girls who experience family violence tend to marry at an

early age in hopes that their marriage will be better than her parents. The cycle of violence is then repeated, as these women are faced with the stresses of a marital relationship and motherhood at a young age (Health Canada, 1999).

Symptoms of exposure to woman abuse commonly begin or continue during pregnancy (Health Canada, 1999). The VAW survey conducted in 1993 reported that 21% of abused women were assaulted at a time while they were pregnant and of these, 40% of the women indicated that the abuse began during the pregnancy (Health Canada, 1999). Health Canada (1999) states that although much remains to be studied in terms of prenatal development and the intrauterine environment and violence, those who experience abuse during pregnancy are at an increased risk of injury to the fetus.

Young infants experience consequences of being exposed to violence in the home (Health Canada, 1999). Health Canada (1999) identifies that such stress may be measured in infants through heart rate, galvanic skin response, and overt crying and distress. In addition to the effects directly expressed by the infant, the risk for difficulties with attachment and bonding between mother and infant is increased (Health Canada, 1999; Levendosky et al., 2001; McGuigan, Vuchinich & Pratt, 2000). This may be due in part, to the mother's inability to focus on and care sensitively for her infant because of the negative effects on her from violence (Health Canada, 1999). This can also lead to the infants' failure to thrive. Furthermore, Perry (1995) has found that there are permanent negative effects on infants' central nervous systems, thus predisposing them to more impulsive, reactive, and violent behavior. Long-terms effects of infant exposure to IPV between mother and spouse may include failure to thrive, listlessness, disruption in eating and sleeping routines, and developmental delays, while effects of preschool exposure

include aggressive acts, clinging, anxiety, cruelty to animals, destruction of property, and symptoms of post-traumatic stress disorder (Health Canada, 1999). Perry highlights the need for further research in the area IPV and exposure by infants and young children, specifically.

Children and adolescents who witness violence in the home are at an increased risk of suffering from emotional and behavioral problems, specifically post traumatic stress disorder (Health Canada, 1999; Levendosky & Graham-Bermann, 2001). Children exposed to woman abuse may experience feelings of anxiety, fear, irritability, difficulty concentrating, anger outbursts, intrusive memories of the abuse, and hyperarousal (Health Canada, 1999). Further emotional problems may lead to school refusal, withdrawal from social interactions, and difficulty separating from the mother (Health Canada, 1999).

Additionally, these children may exhibit problems in their social adjustment, may suffer from attention deficit disorder, and are at an elevated risk of depression (Health Canada, 1999, Levendosky & Graham-Bermann, 2001). Furthermore, Cox (2003) states that children who have witnessed violence in the home, without sufficient support and intervention, may display aggressive behavior, dysfunction and/or learning disabilities in school and disobedience. This aggression is most commonly displayed by boys against peers, teachers, and their mothers (Health Canada, 1999). Thus, children and youth who witness violence in the home require carefully developed and specialized intervention (Health Canada, 1999). Ultimately, as cited by The NSW Health Department Health Domestic Violence Policy Discussion Paper (1999), "Children are profoundly affected when living in an environment of violence, fear or intimidation. They are affected whether or not they actually witness physical violence. Domestic violence, which is a

spectrum of abusive, intimidating, and controlling behaviours, constitutes a form of child abuse (p.26)" (Davis, Taylor & Furniss, 2001, p. 341).

Health Canada (1999) states the following

> The child who is hyperactive and non-compliant in school and headed for a strong dose of Ritalin may be acting out the scenes from the family battleground and dealing with symptoms of post-traumatic stress disorder. The bully in the day-care centre who is the focus of concern by staff and complaints by other parents may be modeling the abuse of power and control he sees everyday in his household (p.5).

Intimate Partner Violence: Support Needs and Resources

The relationship between social support and psychological well-being of abused women is no secret. Social and community support can be a major factor in freeing women from abuse and can also reduce the isolation that many abusers enforce (Bosch & Bergen, 2006; Hollenshead, Dai, Ragsdale, Massey, & Scott, 2006). Many factors influence abused womens' help-seeking behaviors and include: severity and frequency of the abuse, availability of resources, and perceived sense of self-efficacy (Yoshioka, Gilbert, El-Bassel, & Baig-Amin, 2003).

Various authors claim that most abused women share their experiences with a family member (Bosch & Bergen, 2006; Hollenshead et al., 2006; Yoshioka et al., 2003;). In one study, 54% of women sought support from a family member, while 47% went to social services agencies, and 36% went to a member of the clergy (Yoshioka et al.). Also, abused women don't only seek the help from their family, but from their abuser's family as well (Yoshioka et al.). Further, Hollenshead et al. found that despite the various avenues of assistance available to abused women, 35-45% of these women never seek assistance from someone outside of their family. Another study reported that a

large majority (86.9%) of women surveyed would rather speak to a friend about the violence than a formal support network (Fraser, McNutt, Clark, Williams-Muhammed, & Lee, 2002).

Women who turn to their families are not always treated in the manner they would like (Bosch & Bergen, 2006). Many women who seek assistance from a family member are often "questioned, blamed, or misunderstood", as the family does not want to be troubled with partner issues that can be "awkward, embarrassing and a personal safety risk" (Bosch & Bergen, 2006, p. 312). Of the 54% of women who sought support from family in the abovementioned study by Yoshioka et al. (2003), 12% of their families chose to not become involved when informed of the abuse.

In terms of accessing formal support services, abused women most commonly seek the assistance of the police, social services, crisis counselors, physicians, psychologists, women's groups, lawyers, and the clergy (Hollenshead et al., 2006). In one study reported by Hollenshead et al., 39% of women surveyed found the police to be helpful, while 19% reported an increase in violent activity due to police intervention. It has only been in recent years that the legal system has changed its handling of IPV from the traditional viewpoint that IPV is a problem that should remain in the home, rather than be addressed in the judicial system (Hollenshead et al.). This author also reported that women victims of violence are continuously seeking more information on judicial processes that surround IPV and that more education is needed in this area.

Hollenshead et al. (2006) noted that while battered women's shelters and support groups are the most specialized services offered to abused women, they are often the least contacted. The reasons for this have been speculated and may be attributed to a lack of

availability of these services in certain areas, or the stigma associated with women sharing their experiences of violence (Hollenshead et al.). Despite this fact, it has been found that these types of services are the most effective in helping abused women cope with the abuse (Hollenshead et al.).

Furthermore, regardless of the type of support, women expressed their desire for it to be non-judgmental (Bosch & Bergen, 2006). In one study, support was most often welcomed by abused women when it was non-judgmental (Bosch & Bergen, 2006). Bosch and Bergen also found that helping abused women in a non-judgmental manner enabled them to identify the abuse and empowered the women to make their own decisions. Treating women in non-supportive ways is a significant predictor in keeping women in the abusive relationship (Bosch & Bergen). One study found that women who experienced emotional abuse, in the absence of physical or sexual abuse, consistently reported a lower level of comfort in seeking any type of support (Fraser et al., 2002).

Intimate Partner Violence: Barriers and Secrecy

Due to the sensitivity and secretive nature of IPV, many barriers exist for women seeking support (Anderson, Gillig, Sitaker, McCloskey, Malloy, & Grigsby, 2003; Davis et al., 2001; Wolf, Ly, Hobart, & Kernic, 2003). Violent relationships with intimate partners are not characterized by isolated incidents of violence followed by periods of harmony, but rather occur on a continuum whereby women invest a great deal of energy in preventing violent episodes in hopes of maintaining peace within the relationship and family (Coker et al., 2000; Power, 2004). Commonly, women do not share these experiences with others and although many do not want the relationship to end, they do however want the violence to stop (Power, 2004). A variety of barriers exist to disclosing

IPV and may include fear for a women's own safety and the safety of children and other family members; denial or disbelief; emotional attachment to, or love for partner; commitment to the relationship; shame and embarrassment; depression and stress (Davis et al., 2001; Lutenbacher et al., 2002; Power, 2004). Wolf et al. (2003) identify other barriers to seeking police help, with a large barrier being the abuser himself. In this study women revealed that they attempted to seek help and support, but were physically and/or emotionally prevented from doing so by their intimate partner (Wolf et al.). Economic dependence was also reported as being a large barrier for women seeking support, as leaving a relationship and beginning a new independent life, coupled with poor emotional status made it seem impossible to obtain help (Anderson et al., 2003; Wolf et al.). Also, many women feared repercussions from their abuser which would lead to further consequences. This too, hindered women in seeking help and support during times of crisis (Anderson et al.; Wolf et al.).

Despite these recognized barriers to support for women experiencing IPV, Davis et al. (2003) claims that "Little is known about the stages and what factors motivate women to seek assistance from informal supports such as family and friends" (p. 335). In addition, there is little known in regards to the informal support needs that may help women in abusive relationships to move on (Davis et al., 2003). A great deal of secrecy exists surrounding this sensitive topic (Cox, Cash, Hanna, D'Arcy-Tehan, & Adams, 2001). In many cases, violence occurs between intimate partners who are known to appear happy and successful on the surface, however there is a dark side that is not always obvious (Cox et al., 2001). Commonly, "family members will go to great lengths to hide family violence" (Cox et al., 2001, p. 283), as it is often considered a private

family matter (Lutenbacher et al., 2002). This too, makes it difficult for victims to access support. Community attitudes, norms, and outlooks prevent women from even acknowledging the violence in their lives. Family members and friends can often be blaming and judgmental and even make threats to women with abusive partners (Bosch & Bergen, 2006). This in turn, inhibits them from sharing their stories with family and friends and from seeking help from exterior resources (Krishnan, Hilbert, & VanLeeuwen, 2001).

In one study reported by Davis et al. (2003), 65% of women surveyed stated that there was no value in seeking help or support from family for a variety of reasons. These reasons include feelings of fear and shame, history of abuse within the family, and not wanting to disappoint and let down the family (Davis et el., 2003). Furthermore, it is suggested that family and friends may be intolerant of women who return to violent relationships, due to their lack of understanding of the cycle of violence. Family and friends may also fear the abuser and any potential repercussions of providing support. Having said this, Davis et al. (2003) suggest that in terms of providing the most help and support for women in abusive relationships, sisters, friends, and neighbours are identified as the top three resources. Moreover, Bosch and Bergen (2006) claim that friends, neighbors, mothers, sisters, and sister-in-laws are the most commonly sought types of informal support. Women surveyed reported that emotional or psychological abuse was the most difficult to discuss with family and friends, because "...without the bruises and scars women have little evidence of their abusive reality" (Davis et al., 2003, p. 339).

According to Davis et al. (2003), isolation is a common problem with women experiencing violence. Evidence suggests that isolation may be either imposed by the

abuser in an effort to maintain control over the victim, or imposed by the victim herself as a result of the many feelings of helplessness, hopelessness, and shame (Davis et al., 2003). Cox (2003) explains that because of the many feelings experienced by victims of violence, it may lead to further isolation and thus make the woman more dependent on the perpetrator. Isolation is a difficulty experienced by women living in both urban and rural settings; however those in rural areas may experience even greater chance of isolation. In one study that looked at the experiences of rural women seeking support for abuse, these women lacked transportation, access to money, job opportunities, and telephone service (Bosch & Bergen, 2006). Furthermore, "Many rural women with abusive partners have sought help from formal support networks but have been negated, discounted, or treated in a non-supportive manner" (Bosch & Bergen, 2006, p. 312). Moreover, Krishnan et al. (2001) states, "Extreme physical isolation, limited availability and access to appropriate social and health services, patriarchal family structures and views, and strongly held religious beliefs often complicate help-seeking in rural communities" (p. 29).

International, National and Provincial Contexts

International Perspective

IPV is increasingly understood globally, as "a human rights violation and a major public health issue" and is one of the most widespread forms of violence against women around the world (DuMont, Forte, Cohen, Hyman, & Romans, 2005). The Canadian Public Health Association, in collaboration with other professional organizations and associations, has recognized IPV as "a priority health issue to which the health professions must respond" (Clark & Du Mont, 2003, p. 52). According to DuMont et al.

(2005), it is estimated that worldwide, one in every three women has experienced IPV in her lifetime.

The issues surrounding IPV are on the international agenda which is confirmed by various international congresses, alliances, and conferences around the world. More specifically, the *World Congress on Family Violence* (WCFV) convenes delegates from every continent and multiple countries around the world to share, promote, foster and utilize information, ideas, practices, research and strategies directed toward the prevention of family violence (WCFV, 2003). According to WCFV (2003), "The World Congress on Family Violence is called together to advance best practices in protection, prevention and treatment of the physical, mental, emotional, sexual, social, legal and economic effects caused by family violence on children and on women and men at every stage of life" (p.3). The sponsors, co-sponsors and cooperating organizations for the WCFV include *International Network on Family Violence, National Council on Child Abuse and Family Violence, World Health Organization* (WHO), *International Forum for Child Welfare, International Network for Prevention of Elder Abuse,* and the *International Society for Prevention of Child Abuse and Neglect* (WCFV, 2003).

In addition, there is a *Global Campaign for Violence Prevention*, which includes the *Violence Prevention Alliance* (VPA). VPA, newly established in 2004, is a global network for groups from various sectors and levels to come together to share a vision that addresses violence prevention around the world (WHO, 2006). This international alliance provides participants with the necessary means to "increase capacity for information-gathering on the epidemiology of violence; improve knowledge about what

works in violence prevention policy and programming; and encourages widespread implementation of policies and programs known to be effective" (WHO, 2006, p.4).

Canadian Perspective

Canada has been in the forefront with initiatives surrounding the prevention of family violence and a great deal of work has been completed to address this issue nationally (DuMont et al., 2005). For example, a variety of federal, territorial, provincial, and municipal government initiatives against family violence have ranged from "public awareness and education campaigns, service enhancement and implementation programs, the establishment of domestic violence courts, pro-charging police policies, law enforcement training initiatives, and the expansion of hospital-based sexual assault centers to serve women assaulted by the intimate male partners" (DuMont et al., 2005, p.5). This work has resulted in "the adoption of the *Declaration on the Elimination of Violence Against Women* in 1993 by the UN General Assembly and the appointment of a Special Rapporteur on Violence Against Women in 1994 by the United Nations Commission on Human Rights" (DuMont et al., 2005. p. 5).

Canada has recently played host to an international conference entitled the "World Conference on Family Violence Prevention 2005", which took place in Banff, Alberta, Canada in October of 2005. This conference brought together a diverse collection of various international policy leaders, researchers, and experts in the area of family violence who collaborated to heighten global awareness of this growing issue (R. Brown, personal communication, December, 2005). The Department of Justice Canada has also played a significant role in Canada's efforts in placing the issue of IPV against women and children on the international agenda (G. Campbell, personal communication,

April 11, 2005). In particular, this department has been specifically active in the development of international protocols, and a participant at multiple international conferences on domestic violence and violence against women (G. Campbell, personal communication, April 11, 2005).

There has been evidence that many of these efforts have had a positive effect on the prevention of family and domestic violence. For instance, DuMont et al. (2005) claims that Canadian efforts between 1994 and 1998 have had some positive effect in that the rates of male-to-female IPV was lower in 1999 than in 1993. This improvement has been attributed to a rise in community-based supports and shelters across the country (DuMont et al., 2005). Furthermore, a series of amendments have been made to the *Criminal Code of Canada* to strengthen the laws related to IPV (G. Campbell, personal communication, April 11, 2005).

Much of the work of the Federal Government of Canada has been linked to the *Family Violence Initiative* (FVI), which focuses on its long term goal of reducing the incidence of family and domestic violence (Public Health Agency of Canada, 2006a). The FVI marks a new level in national efforts to decrease family violence in the country. This initiative has seven million dollars of permanent annual funding which supports and complements activities across seven major departments and agencies including the Public Health Agency of Canada, Canada Mortgage and Housing Corporation, Justice Canada, Royal Canadian Mounted Police, Canadian Heritage, Status of Women Canada, and Statistics Canada (Public Health Agency of Canada, 2006a). Together, these parties work to increase awareness of the issues that surround family violence, emphasize the need for community involvement in the fight against family violence, strengthen the justice,

housing and health care systems to better respond and support the need for research to identify effective interventions (Public Health Agency of Canada, 2006a).

The Public Health Agency of Canada also manages the National Clearinghouse on Family Violence (NCFV), which is a national resource center for information on family violence that provides comprehensive services that address family violence prevention, protection, and treatment (Public Health Agency of Canada, 2006b). The NCFV offers services that include publications on various aspects of family violence, such as handbooks and reports, a directory and referral system, a library reference collection, and a bi-annual newsletter (Public Health Agency of Canada, 2006b).

Prince Edward Island Perspective

Historical Overview of Violence Prevention Activities in Prince Edward Island

According to the Government of Prince Edward Island (2001), the PEI Family Violence Prevention Strategy has been built on a number of significant events that have occurred over the past 20 years. The early 1980's were a noteworthy time in PEI in terms of family violence prevention in the province. It was in 1981 that the issue of family violence was addressed for the first time in the Legislative Assembly in Charlottetown by a private member's motion (Government of PEI, 2001). Since that time, a multitude of services and prevention activities have been established. Anderson House, a shelter for battered women in Charlottetown opened its doors in 1981, followed by the establishment of 24-hour child abuse and 24-hour rape and sexual assault telephone lines that offered support to callers. The police mandatory charging policy was established in 1983. The late 1980's were also a very important time in family violence prevention in PEI, as the Provincial Victims Services Program was launched as well as the

proclamation of the Adult Protection Act in 1988. Two committees were instituted in 1989; the Inter-ministerial Committee on Family Violence Prevention and the Child Sexual Abuse Inter-agency Committee (Government of PEI, 2001).

The Coalition for Woman Abuse Policy and Protocol (CWAP) in PEI was also formed in 1989 to address the need for a comprehensive policy regarding abuse against women (CWAP, 2002). This is a collaborative effort of various community, local, and provincial associations and organizations. Following the murder of a PEI woman by her estranged husband, a PEI judge inquired further into the policies and procedures surrounding family violence. The result of this revealed the need for further development surrounding this issue (CWAP, 2002). The main goal of this project therefore, was to reduce the incidence of violence towards women by bringing together front line service providers and policy makers on the areas of education, justice, health and social services, as well as survivors of family violence (CWAP, 2002). This process has been implemented in three phases: the assessment phase, the development phase, and the implementation phase.

The assessment phase of the project brought about specific objectives, as the gaps in policy and protocol were identified. More specifically, the actions that took place during this phase recognized that:

- "Survivors of family violence and community organizations must be significantly involved in policy development and evaluation.
- The 'powers-that-be' need to take action and put woman abuse high on the list of priorities.
- Policies can't change attitudes.
- We need a holistic, coordinated response to woman abuse" (CWAP, Phase 1, ¶3).

The development phase consisted of the formulation of working groups to develop and evaluate protocols for responding to abuse against woman and to develop strategies for implementation, evaluation and sustainability (CWAP, 2002). A comprehensive policy and protocol development tool was also designed in this phase of the project. The third phase of the project, the implementation phase, consisted of a collaboration workshop, resource development, multi-sector information sessions, and the development of an evaluation framework (CWAP, 2002).

The 1990's brought about many more family violence prevention activities, because now the topic was no longer as taboo as it had previously been in the 1980's. For example, a Provincial Family Violence Coordinator position was created within the Provincial Government in 1991 (Government of PEI, 2001). A committee working towards family violence prevention in Eastern PEI was formed in 1992, and three years later in 1995, the position of a Community Outreach Worker for Eastern PEI was created (Government of PEI, 2001). A Provincial Sex Offender Program was established in 1994 and in 1995 the Provincial Cabinet approved a five-year strategy on Family Violence Prevention (Government of PEI, 2001). Notably in 1995, the Premier appointed 23 members to the Premier's Action Committee on Family Violence Prevention. This committee is still working hard against family violence today. One of the members of this committee is the Family Violence Consultant for PEI, whose permanent position was also created in 1995 (Government of PEI, 2001). In 1996, The PEI Victims of Family Violence Act was proclaimed and the position for Community Outreach Worker was created for the Queen's Region of PEI (Government of PEI, 2001).

PEI was the second province in Canada to enact legislation around family violence, and has what is referred to as the *Victims of Family Violence Act*, which came into effect in 1996 (Community Legal Information Association of Prince Edward Island [CLIA], 2005). This act addresses the need for victims of family violence to remain in their own homes, while enabling the justice system to provide effective responses to family violence in a timely manner. Additionally, this act provides a civil way to supplement the Criminal Code of Canada (CLIA, 2005). This act helps victims of family violence by ensuring their safety through what are known as an emergency protection order and victim assistance order. These orders may allow victims to remain in their own homes, and may also contain provisions such as no contact between the victim and the abuser, temporary custody of children, and no further acts of violence (CLIA, 2005). The emergency protection order allows a justice of the peace to take immediate action to protect victims of violence if he or she feels the need to act is serious and urgent. It is effective as soon as the abuser is made aware of the order and may be in effect for up to ninety days, as decided by the justice of the peace (CLIA, 2005; G. Campbell, personal communication, April 11, 2005). The victim assistance order however, is meant for long-term protection of victims. In other words, this order can be made effective when an emergency protection order expires or when the situation is no longer an emergency (G. Campbell, personal communication, April 11, 2005).

In the early 2000s, a large number of consultations and needs assessments were conducted, while in 2001 the Premier announced the renewal of the 5-year mandate of the Premier's Action Committee against Family Violence (Government of PEI, 2001).

Furthermore, in January of 2005 the Federal Government allocated over $600,000 in support of 23 community based crime prevention activities in PEI (Public Safety and Emergency Preparedness Canada, 2005). A portion of these funds were targeted specifically towards the prevention of family violence in the province.

In the most recent years, many working groups and committees have been developed and are continuing to strive towards the prevention of family violence in PEI. One particular example is the *Voices for Children Coalition*, which is a community based, volunteer-directed organization whose mandate is to work together to contribute to the well-being of Island children (A. Nicholson, personal communication, January, 2006). This coalition has recently developed a working group entitled "Circle of Caring for Children (Living in Situations of Family Abuse): A Project of Voices for Children Coalition". This working group has recently met for the second time in April of 2006 and has begun to address some of the many needed issues that relate to children affected by violence (A. Nicholson, personal communication, April, 2006).

Current Family Violence Services and Resources in Prince Edward Island

A variety of resources exist across PEI to address the issues that surround intimate partner violence. These resources range from emergency and acute to long term services and are widespread in all areas of the island. Each resource will be described in detail below.

Transition House Association of Prince Edward Island

The Transition House Association of PEI, which believes that "...it is a basic human right to be free of abuse and fear of abuse in relationships" (THA, 2006, p.1), was established in 1980 in an effort to work towards the elimination of family violence in

PEI. This association works to provide a safe place for women and children who are victims of abuse and offers multiple services to accommodate the wide-ranging needs of victims of violence. These services are funded by a combination of the PEI provincial government, Canada Mortgage and Housing Corporation, and by contributions from individuals, community groups, and local businesses (THA, 2006).

Anderson House is an extremely important component of the THA, as it is a provincial emergency shelter for women and children victims of violence. This shelter is staffed twenty-four hours per day, seven days per week by trained women who honor confidentiality (THA, 2006). It is a safe and supportive place for women and their children who have experienced violence or abuse or who live in constant fear of abuse. This service is accessible to women and their children with disabilities. Women are not admitted to Anderson House if they are under the influence of alcohol or drugs, nor if they display symptoms of psychiatric problems or are solely seeking housing (THA, 2006). A specialized service that is offered to the residents of Anderson House is the Child Care Program, which is run by a full-time Child Care Specialist. This program offers high quality play experiences for the children in an effort to alleviate the effects of having witnessed and/or experienced abuse. It is also beneficial in that it provides the mothers with time to rest, relax, and reflect on experiences (THA, 2006).

In addition to the emergency shelter, THA offers women and children leaving Anderson House the option to live in second stage housing. This too, is a safe and secure environment for women and their children who hope to make changes in their lives when they leave Anderson House and Second Stage Apartments are a source of independent, supportive and comfortable housing for these victims and are located in Charlottetown,

Summerside and O'Leary at confidential addresses. The residency at these apartments is up to one year and rent is based on one's income or rent ceiling set by the Department of Health and Social Services and Canada Mortgage and Housing Corporation (THA, 2006). Lastly, the THA has a 24-hour toll-free crisis/support line. Trained individuals at the Anderson House offer support, information, and referral to callers.

Community Outreach Services

There are outreach services offered in four main regions in PEI to address the issues that women and children victims of violence face in the community or once they have been residents of Anderson House and the Second Stage Apartments and have returned to their independent living. The four regions include Queens County (Charlottetown), East Prince Region (Summerside), West Prince Region (O'Leary), and Eastern PEI (Monatgue) (THA, 2006). They are entitled Queens Region Outreach Services, East Prince Family Violence Prevention Inc., West Prince Family Violence Prevention Cooperation, and Family Violence Prevention Eastern PEI, respectively (N. McColeman, personal communication, March 2, 2006). These independent bodies are closely affiliated with Transition House Association of Prince Edward Island (V. Smallman, personal communication, March 2, 2006).

These outreach programs are "a free and confidential service providing emotional support for women victimized by family violence" (Government of PEI, p.2, 2005). Additionally, these programs offer one-to-one support and encouragement, support groups, wellness and lifestyle programs, public education, library resource materials, referrals and advocacy to other community services and agencies, and private and confidential appointments (East Prince Family Violence Prevention, n.d.). One specific

group that the Queens Region Outreach Service coordinates is the "Liberty Group", which is a 10-week support group intended for women who have been or who are currently in an abusive relationship (THA, 2006).

Public Health Nursing in Prince Edward Island

Public health nurses provide health related programs that are equally accessible to all Islanders. These specially trained nurses work with individuals, families, groups, and communities to prevent the outbreak of and consequences of communicable and social diseases, to detect and prevent illness, and to promote health and healthy lifestyles across PEI (Government of PEI, 2004). Public health nurses also work in collaboration with regional health teams and authorities that have common areas of interest. There are eight regions of PEI that have a public health nursing office, including O'Leary, Summerside, Wellington, Kensington, Montague, Charlottetown, Souris, and Alberton.

Public health nurses in PEI are available and willing to meet with victims of violence to provide information, advocacy, and emotional support.

Prince Edward Island Family Resource Centers

PEI has nine family resource centers, seven of which are funded by Health Canada. They are located in various locations across PEI and offer over 65 programs and services to parents, children and families (Social Development Canada, 2005). In particular, these centers offer a range of services including prenatal programs, parenting programs, parent support groups, teen parenting programs, family management and support programs (Social Development Canada, 2005). Important to note is that there is a Francophone Family Resource Center located in Wellington, PEI west of Summerside

and a Mi'Kmaq Family Resource Center located in Charlottetown (R. Brown, personal communication, May 27, 2005).

Additional Resources

In addition to the abovementioned resources available to victims of intimate partner violence in PEI, there are several other services that are accessible to Islanders. Firstly, there are a range of telephone numbers that one can call to access information, support, and counseling (Government of PEI, 2004). These include the child abuse line, which is a toll-free, after-hours phone number that receives calls which are screened and if needed, referred to on call workers across PEI. The PEI Rape and Sexual Assault Crisis Centre also has a toll-free, 24-hour telephone line for victims of rape and sexual assault. This service is provided by volunteers who are trained to answer calls and provide information, support, and advocacy to callers (Government of PEI, 2004). Also, PEI has what is referred to as the Island Help Line, which is similar to the previous telephone lines mentioned; it is a toll-free, 24-hour line for Islanders requiring information, support, or counseling on numerous issues (Government of PEI, 2004).

Secondly, there are Child and Family Services offered in five regions across PEI. These services are located in Charlottetown, Souris, Montague, Summerside, and O'Leary and offer social resources to families in need, ranging from financial assistance to child protection services (Government of PEI, 2004). Child and Family Services of PEI also offers similar services and have an office located in Charlottetown. This service specializes in anger management for victims and abusers (Government of PEI, 2004). Community Mental Health Services are also available in five regions across the Island, as well as Victims Services, which have offices located in Charlottetown and Summerside.

The latter assists victims of crime through the provision of information, referral, counseling, and compensation (Government of PEI, 2004). Lastly, an important resource available to women victims of violence in PEI is the East Prince Women's Information Centre, which aid women with a variety of issues ranging from employment and addictions to domestic violence and assault (Government of PEI, 2004).

Overview of Qualitative Research and Intimate Partner Violence

To best answer the research questions of this study, qualitative research methods were used. This exploratory study claims no particular disciplinary or methodologic roots and therefore is known as a generic interpretive descriptive qualitative study (Thorne, Reimer- Kirkham, & MacDonald-Emes, 1997). This is a method of choice for researchers who want to obtain a straight description of an event or phenomenon (Thorne et el., 1997).

This study was conducted across Prince Edward Island as a pilot project for a larger study to be conducted in Atlantic Canada. As mentioned, this study examines three research questions. The research questions are as follows:

1) What is the impact of IPV on mother-infant relationships?

2) What is the association between mother-infant relationships and infant development in families affected by IPV?

3) What are the: (a) support needs, (b) barriers to support, and (c) preferences for support intervention to promote mother-infant relationships affected by IPV?

More specifically, to determine the perspectives of parents affected by IPV, the data was collected using face-to-face, semi-structured interviews. Gillis and Jackson (2002) explain the need for the interview format to be flexible, specifically when

discussing a sensitive topic. Interviews may be one of the few opportunities participants have to discuss the sensitive issue at hand (Speziale & Carpenter, 2003), and therefore confirm that qualitative research is an appropriate choice when conducting research on IPV.

This design specifically sought to capitalize on the strengths of the experiential knowledge of parents affected by IPV. The rationale for choosing face-to-face interviews over other methods of data collection is that the topic of IPV is extremely personal and sensitive in nature. Face-to-face interviews are appropriate for researching this topic as participants may feel more comfortable and willing to share their thoughts, feelings, and perceptions in an individual setting as opposed to a group setting (Gillis & Jackson, 2002). Additionally, more original thoughts tend to surface in individual interviews than in focus groups (Gillis & Jackson, 2002).

The next chapter describes interpretive description as the methodology chosen to seek information on women's experiences with IPV.

Chapter Three

Methodology

The purpose of this research was to explore the relationships between mothers and infants exposed to IPV and to investigate its impact on such relationships; to address gaps in literature as there also appears to be a lack of research that explores the association between mother-infant relationships and infant development in families affected by IPV; and to identify the support needs, resources, barriers to support, and preferences for support intervention that promote mother-infant relationships, from the perspectives of mothers affected by IPV.

For the purpose of the pilot project, quantitative research methods were used in conjunction with qualitative research methods. However, the quantitative portion is beyond the scope of this thesis and therefore only qualitative research methods were utilized for this thesis. Within this chapter, the chosen research method will be discussed and the activities that were undertaken in relation to site selection, participant recruitment, data collection, data management and data analysis will be described. Additionally, ethical details and trustworthiness features of the project will be explained.

Research Questions

For this pilot project, three research questions were examined. The research questions are as follows:

1) What is the impact of IPV on mother-infant relationships?

2) What is the association between mother-infant relationships and infant development in families affected by IPV?

3) What are the: (a) support needs, (b) barriers to support, and (c) preferences for support intervention to promote mother-infant relationships affected by IPV?

This research study took place over nine months, from January, 2006, to September, 2006. All three interviews took place in the month of March, 2006.

Research Methods

Thorne et al. (1997) found that many nurses were conducting legitimate qualitative research for which there was no name. This research often involved "description of and interpretation about a shared health or illness phenomenon from the perspectives of those who live it" (Thorne et al., 1997, p. 171). As mentioned, this study claimed no particular disciplinary or methodologic roots and therefore is known as a generic descriptive qualitative study. These types of studies present comprehensive summaries of a phenomenon or event from the perspective of those who live it (Thorne et al., 1997). Thorne, Reimer-Kirkham, and O'Flynn- Magee (2004) states "The foundation of interpretive description is the smaller scale qualitative investigation of a phenomenon of interest" for the purpose of capturing themes and patterns within "subjective perceptions and generating an interpretive description capable of informing clinical understanding" (p.5). Interpretive descriptive studies are built upon relatively small samples and use data collection methods such as interviews, participant observation, and documentary analysis (Thorne et al., 1997). Accordingly, to determine the perspectives of mothers affected by IPV, the primary source of data collection was face-to-face, semi-structured interviews. It was expected that face-to-face discussions with mothers affected by IPV would provide an in-depth representation of their experiences, thought, feelings, and preferences.

The interview is one of the most widely used methods of collecting self-report data in qualitative research, as its purpose is to allow researchers to construct reality in ways that are consistent with the meanings of the individuals being researched (Fontana & Frey, 2000; Nunkoosing, 2005; Patton, 2002; Polit & Beck, 2004). Mothers were asked a series of 30 open-ended questions. An interview guide (see Appendix A) served as a framework to the semi-structured interviews. All of the interviews contained more than 30 questions. This was due to the semi-structured nature of the interview, as I would use the interview technique known as "probing" (Polit & Beck, 2004, p. 342) to assist the participants in elaborating on their thoughts and feelings.

Patton (2002) explains that probing is a skill that is gained through experience of knowing what to look for in an interview. Additionally, it is a skill that comes from listening to what is and what is not said (Patton, 2002). Probes provide guidance to the interviewee and allow the interviewer to maintain a sense of control over the interview (Patton, 2002). In addition to Patton's (2002) description of probing, Rubin and Rubin (1995) identify three main functions of probing: to identify the level of depth that is intended for the interview, to signal to the interviewee to finish up the question being answered, and to demonstrate to the interviewee that the interviewer is listening attentively.

In total, three interviews were conducted with mothers of infants who had experienced IPV. All mothers had met the inclusion criteria prior to initiating the interview. For mothers to be eligible to participate, they had to meet five criteria. The index child exposed to IPV had to be 36 months of age or less at the time of the interview; mothers reported exposure to IPV in keeping with the abovementioned

definition of Saltzman et al. (1999); mothers reported exposure to IPV since the birth of the child; mothers reported that the mother and infant were no longer in the violent relationship; and mothers represented a range of educational levels, marital statuses, incomes, ethnicities, and geographic locales. The researcher conducted all interviews, which were completed at a locale of mutual choosing between researcher and participant. Each participant was interviewed only once, with interviews lasting from 45 minutes to 2 and one half hours. The letter of information (see Appendix B) that was provided to participants stated that their entire participation would require no more than two hours of their time.

Interpretive description requires that the researcher become intimately involved with the data, specifically individual cases (Thorne et al., 1997). Then, "abstract relevant themes from within these individual cases, and produce a species of knowledge that will itself be applied back to individual cases (Thorne et al., 1997, p. 175).

Site Selection

The province of Prince Edward Island was chosen as the site for this pilot study, which is part of a larger study to be conducted in the provinces of Prince Edward Island, New Brunswick and Nova Scotia in the near future. The decision for the pilot project to be conducted in Prince Edward Island was based on feedback from a National Granting Agency and at the request of the co-investigators of the larger project. The purpose of a pilot project is to conduct a small-scale version of a major study, which helps to determine the strengths and weaknesses of the study design (Polit & Beck, 2004), and to determine any changes that would be need to be made to the instruments.

Participant Recruitment

After consulting with the co-investigators on the project, it was decided that 5-8 women would provide an adequate sample for the purposes of the pilot project and would also address the requirements for a Master's thesis. As per the requirements of the Masters in Applied Health Services Research Degree Program, I completed a 16 week residency where I worked with individuals, associations, professional organizations and other experts in the area of family and intimate partner violence. During this time, I traveled across PEI assessing, exploring and evaluating the current situation and issues surrounding IPV across the province. One of my main goals for this residency was to establish rapport with and gain entrée (Polit & Beck, 2004) to this network of people working on the many issues that surround IPV. This experience was extremely beneficial when the time came to actively begin recruiting participants for the project.

I utilized a variety of active recruitment strategies between the months of January, 2006 and May, 2006. I intended to reach as many individuals and groups as possible who work with, or know of women who would potentially meet inclusion criteria. These activities included the following:

- I contacted all four Community Outreach Coordinators who work with the Transition House Association of Prince Edward Island. The four coordinators are responsible for family violence prevention in the areas of Charlottetown, Summerside, O'Leary, and Montague. Contact was made by email, telephone, and face-to-face meetings were set up with three of the four coordinators. I provided the coordinators with copies of the letter of information to participants (see Appendix B), the advertisements (see Appendices D and E), the interview

guide (see Appendix A), consent forms (see Appendix C), and any other pertinent information that was requested in regards to the project. If the coordinators knew of any of their clients who could potentially meet the inclusion criteria for the project, they would provide such individuals with the letter at which point the participant could make the decision whether or not she was interested in participating.

- I contacted multiple individuals across PEI by email, phone, or both. These included various public health nurses, staff of the local women's shelter, Victims Services, Child and Family Services, the Provincial Family Violence Consultant, various Family Resource Centers, other staff members of the Transition House Association of Prince Edward Island, and the Provincial Correctional Center Manager.
- I met face-to-face with the Child Care Specialist at Anderson House in Charlottetown. I provided her with posters, letters of information, and my contact information. She passed on this information to the House Manager who was out of the province during this meeting. Both individuals were keen and very interested in the project. They too, continuously assessed their clients for eligibility in the project and if appropriate, provided the women with the letter of information at which time the women could decide if they were interested in participating and contact me directly.
- In January of 2006, I designed a poster advertisement to aid in the general recruitment of participants (see Appendix D). The advertisement was printed on white, glossy paper and included brightly colored text. It included some general

information regarding the project, as well as my name, telephone number and email address. I posted the advertisements in areas across PEI and included places such as various medical centers, pharmacies, family resource centers, offices of public health nursing, offices of child and family services, the two major health centers on PEI – the Queen Elizabeth Hospital in Charlottetown and the Prince County Hospital in Summerside, community centers, the University of Prince Edward Island, and Provincial Correctional facilities. Due to participant recruitment being unsuccessful after one month, I personally distributed another poster advertisement (see Appendix E) to various community members including the abovementioned parties, staff of the local women's shelter in Charlottetown and Family Violence Community Outreach Coordinators.

- I purchased classified advertisements to run on two separate occasions in the two largest circulating newspapers on PEI; *The Guardian* and *The Journal Pioneer*. After consulting with the staff of *The Guardian* in Charlottetown, it was stated that Saturday was the day of the week that had the highest volume of readers. I therefore, decided to run the advertisement on two Saturdays (February 25, 2006 and April 1, 2006). In addition to including advertisements in *The Guardian* and *The Journal Pioneer*, I placed a one-time ad in *The Eastern Graphic*, which is a local newspaper that circulates only on Wednesdays and mainly in the Eastern half of PEI.
- I placed an advertisement on two local websites; one on the *News and Events* section of the University of Prince Edward Island website and the other on the *Edwards Magazine* website. *Edwards Magazine* is a Canadian feminist online

magazine that is published monthly. I consulted with the editor of *Edwards Magazine* in March 2006 and she explained that more people read the articles online than the side bar links. She invited me to write a 1000 word article explaining my research study and indicating my need for more participants.

- In April of 2006, I attended a Provincial working group entitled "Circle of Caring for Children Living in Situations of Family Abuse: A Project of Voices for Children Coalition". While at this meeting, I was given the opportunity to discuss this research project with many community members. I openly expressed my need for participants and provided some of the attendees with my contact information. Attendees included members of the Royal Canadian Mounted Police, Charlottetown City Police, Victims Services, members of the Eastern and Western School Districts, foster parents, and the Child Care Specialist from Anderson House in Charlottetown.
- I activated a new email account (ipvresearch@hotmail.com), to which only I had access. This email address appeared on all advertisements and letters that contained contact information.

Data Collection

A total of three interviews took place with willing participants. Two of the interviews took place in the participants' homes, and the third took place at the local women's shelter. The interviews were semi- structured and asked approximately thirty questions (see Appendix A). These questions captured information on seven broad categories. The seven categories included: *Background and Demographics, Experience in Violent Relationship, Relationship with Child Parented Through Violence, Perceived*

Impact of Violence on Child Development, Support Needs and Resources for Mother-Infant Relationships, Barriers to Support for Mother-Infant Relationships, and Preferences for Parent-Infant Relationship Support. Participants were probed for detail because as McCracken (1988) and Polit and Beck (2004) explain, by prompting the participants, structure is given to the interview and more detailed information may be elicited. More specifically, Polit and Beck claim that, "the goal is to ask questions that give respondents an opportunity to provide rich, detailed information about the phenomenon under study" (p. 342).

The interviews were tape recorded using a hand- held tape recorder. Prior to beginning the interviews, I ensured that the batteries, audiotapes, and the recording device were functioning and also made certain that I had spare audiotapes and batteries in case I required them. According to Burns and Grove (2005), in the interviewer's attempt to establish a comfortable atmosphere, recording equipment should be placed unobtrusively and when possible, should use battery powered recording devices as opposed to plug-in, so as to increase the possibility of unobtrusive placement. Important to note, is that although the recording device was discrete, all participants were aware of and gave consent to having the interviews audio-taped. It was essential that all interviews were tape-recorded to ensure that I obtained accurate information and was not solely relying on notes.

I did not take extensive notes throughout the interviews, as I felt that it was extremely important for me to maintain eye contact. Also, I did not want the participant or myself to feel distracted by copious note-taking. I did however, occasionally jot down points that I felt were important or ones that I wanted to re-visit within the interview.

There was one occasion where I did take multiple notes, because the participant began to verbalize many important details upon the completion of the interview and once the tape-recorder was shut off. I asked for her permission to take notes while she continued to talk. Upon completion of all interviews, I wrote field notes which included information on the location, environment, mood and atmosphere of the interview. I also included my personal thoughts, feelings, and reflections about the interviews. According to Price (2001), researchers often have difficulties thinking while under pressure and struggle with gathering information, responding and making mental notes about where to ask further questions. Patton (2002) claims that the fact that the interviews are being tape recorded does not deny the need for the interviewer to take notes. Patton (2002) further discusses the advantages of note-taking during an interview, as it can assist the interviewer to formulate new questions as the interview progresses and can be particularly useful in focusing on something that was said in earlier portions of the interview (Patton, 2002; Rubin & Rubin, 1995). This supports my reasoning for taking some notes during the interview. Additionally, note taking assists the researcher in pacing the interview "...by providing non-verbal cues about what's important, providing feedback to the interviewee about what kinds of things are especially 'noteworthy'-literally" (Patton, 2002, p. 383).

A research assistant, who has many years experience working with children as a Child and Youth Worker in the province of Ontario, accompanied the researcher to the interview locations to provide childcare. This childcare was extremely valuable in that it minimized distraction during the interview process and allowed the mother to express her experiences, feelings and thoughts without feeling that her child or children would hear.

The research assistant was a university student and signed a pledge of confidentiality prior to the commencement of the interviews.

Data Management

Consistent with the ethical requirements of conducting this research, all audio-tapes and written materials associated with the study were, and will continue to be kept in a locked filing cabinet at the Principal Investigator's office at the University of New Brunswick. Each individual participant's information and recording tapes were kept in a sealed envelope until it came time to transcribe the interviews and analyze the data. All information pertaining to the study will remain confidential and in the locked filing cabinet for a period of five years, at which time they will be destroyed.

Data Analysis

Thematic analysis, informed by Auerbach and Silverstein (2003), was the chosen method of analysis in this pilot project. This method of analysis was used to bring depth and understanding to the identified themes.

Coding is an analytical procedure used in qualitative research that allows the researcher to organize the text and identify themes and patterns amongst large amounts of data (Auerbach & Silverstein, 2003). According to Auerbach and Silverstein (2003), the term 'coding' can be misleading, as it suggests a "routine mechanical process", whereas developing themes and patterns is anything but mechanical. (p.31). Ultimately, the challenge in qualitative analysis lies in making sense of large amounts of data (Patton, 2002).

Following are the steps that I took in coding and analyzing the interview data. Each step will be discussed in detail below.

- Step 1: Read over all interview transcripts.
- Step 2: Developed coding scheme.
- Step 3: Began coding interviews using specific codes.
- Step 4: Re-read all transcripts, concentrating on collapsing codes into broader terms to determine categories.
- Step 5: Cross-coded with other members of research team.
- Step 6: Noted the frequency with which the categories appeared to identify themes.

Step One: Initial Reading of Transcripts

I personally transcribed all interviews verbatim. Patton (2002) discusses the importance and benefits of transcribing one's own interviews. This author declares that transcription provides an additional opportunity to become immersed in the data and is a point of transition between data collection and analysis (Patton, 2002). Furthermore, this task typically generates "emergent insights" (Patton, 2002, p. 441).

I began this process by reading over all of the interview transcripts. This is done to familiarize the researcher with the data and to get a better sense of what one is working with. This is encouraged by various authors (Auerbach & Silverstein, 2003; Marshall & Rossman, 1999; Patton, 2002). Reading over the data with the research questions in mind forces the researcher to become familiar with the data in intimate ways as it is constantly sifting through his or her mind (Marshall & Rossman, 1999; Auerbach & Silverstein, 2003).

I took handwritten notes during this read-through, which enabled me to gather my thoughts and ideas on paper to help me start the initial stages of coding. Patton (2002)

labels this task as memoing, which is defined as the recording and filing of insights as they occur. I also did what Auerbach and Silverstein (2003) refer to as identifying the "relevant text" (p. 37). In other words, I concentrated only on the text that was relevant to the research questions and mentally discarded the remainder. If there was text that I was unsure about, I always identified it as relevant text, so as to ensure that nothing important was omitted. The decision whether or not to retain or omit this text came at a later stage in the analysis when I had a better idea of what the emerging themes were. Additionally, Patton (2002) suggests that this note-taking is helpful as it can provide the researcher with insight into what can be done with the different parts of the data. Marshall and Rossman (1999) claim that the task of reading over the data is extremely beneficial in the long run as it allows the researcher to perform minor editing to "clean up" what seems to be unmanageable and overwhelming (p. 153).

Step Two: Development of Coding Scheme

After reading through all transcripts, I developed a coding scheme. According to Patton (2002), the development of a coding scheme is the first step of qualitative analysis. I chose to begin with very specific codes, which ranged from one word to small sentences, as I anticipated that I could collapse an abundance of specific codes into ones that were more abstract and broad. Auerbach and Silverstein (2003) state that one should think of coding as a staircase, moving from a lower level, which is the raw text of understanding to a higher, more abstract level which are one's research concerns. These authors define research concerns as "what you want to learn about and why" (Auerbach & Silverstein, 2003, p.44). I chose to use color codes, which is a technique suggested by Patton (2002). Color coding is a technique that uses colored markers to identify codes.

For example, a code labeled "barriers to support" was assigned the color red, meaning that when reading the interview transcripts, statements that fell under this code were highlighted with a red marker. I was cautious not to restrict myself by trying to fit certain texts into previously identified codes.

Steps Three and Four: Coding Interview Transcripts

As previously mentioned, I initially began with very specific codes. My justification for beginning with such is that I wanted to ensure that I was all-inclusive in my analysis and that nothing was left to memory or omitted altogether. Also, as stated by Auerbach and Silverstein (2003) the goal of coding or naming the text is to "choose a short quote or name that captures the essence of the idea "in a dramatic and emotionally vivid way" (p.60). My personal fashion of doing such was to write down whatever first came to mind. If I felt that what initially came to mind was not suitable for the text that I was working with, then I would put more thought into it and change the code to be more appropriate for that text. I was cautious not to be too specific or narrow in my ideas. I recognized that there were clear similarities between some of the codes and that some could in fact be grouped together. Auerbach and Silverstein (2003) state that this is a common occurrence in this phase of coding. According to Patton (2002), this is a challenge known as "convergence", which states that the researcher must figure out what fits together, by looking for "recurring regularities" (p. 465). In the case where I found a code to be too narrow, I consciously merged two or more groups into larger ones, which is consistent with what Auerbach and Silverstein (2003) suggest doing.

Step Five: Cross-coding

Upon completion of my independent coding of the transcripts, the coded transcripts were sent to two other members of the research team at the University of New Brunswick. These two team members independently coded the transcripts. Once this was complete, I and the two research team members had a teleconference to further discuss the similarities, discrepancies and any changes that needed to be made to the coding scheme. A final coding scheme was established and I was able to continue on with the identification of categories and themes.

Step Six: Identifying Categories and Themes

According to Marshall and Rossman (1999) this stage of data analysis, of generating categories, themes, and patterns "...is the most difficult, complex, ambiguous, creative, and fun" (p. 154). Consistent with how Patton (2002) defines inductive analysis, I discovered categories, themes and patterns through my interaction with the data. I began the process of generating salient categories by reading through all of the codes, discarding those that were irrelevant to the research questions and making notes of what I found to be repeated throughout the transcripts. These recurring ideas "reveal patterns that can be sorted into categories" (Patton, 2002, p. 465). Once I had a list of these recurring ideas, I noted the frequency with which each one appeared and identified broad categories. Auerbach and Silverstein (2003) suggest that the researcher should "organize themes by grouping repeating ideas into coherent categories" (p. 61), whereas a theme is defined as "an implicit idea or topic that a group of repeating ideas have in common" (p. 62).

To identify themes, I read my list of categories multiple times once again, to get a good sense of what I was working with at this point in the analysis. I initially struggled quite a lot with how to name the themes because I wanted to ensure that the name captured what I was felt had emerged from the data. I then had to read and revise the repeating ideas and in fact changed some of the categories. Auerbach and Silverstein (2003) states that as one struggles with naming themes, it is common to revise the categories to "conform to your new understanding of the data" and that this is a positive step in analysis because one is learning about the participant's experiences "in a more nuanced way" (p.65).

Ethics

Ethical approval for this research project was required from the University of Prince Edward Island Research Ethics Board, which was granted on January 27, 2006. (See Appendix G). Upon recruiting willing research participants, information regarding the study and its objectives were provided. The research settings were always mutually agreed upon between myself and the participants to ensure that it was a safe and comfortable location for all involved. The issue of safety is critical when discussing IPV. After participants were screened for eligibility, they were provided with a letter of information and consent form. All written information was presented in plain language at not higher than a grade eight level. During the initial meeting of participants, I began by introducing myself and thanking the individuals for their willingness to participate. The letter of information and consent form were then described in detail to participants, and opportunities for questions regarding the same were provided throughout the entire

process. The participants were made fully aware of their right to withdraw from the research at any point during or after the study without penalty or prejudice.

Confidentiality of written and verbal information was guaranteed throughout the entire course of, and following the completion of the research study. Participants' names were protected in the study with the use of the terms "Participant A", "Participant B", and "Participant C" and with the use of pseudonyms in the final stages of thesis writing. Study participants were made aware of the actions required of the researcher in the event that confidentiality must be breached due to mandatory reporting laws. The participants were made aware of who would have access to the information during the informed consent process. Due to the small size of the population in Prince Edward Island, total anonymity of participants cannot be assured.

Participants were informed of appropriate assistance if they felt they had sustained any psychological, physical, or social harm from their participation in the study. The researcher's contact information was provided to all participants in the event that there were any questions or concerns. No questions or concerns were raised by the participants.

Participants were offered a small financial incentive to thank them for their time and efforts. They received this compensation upon the completion of the interview process.

The "Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans" outlines the various guidelines that must be adhered to by researchers (Medical Research Council of Canada, 2003). This policy statement provides unique guidelines for those conducting research with vulnerable populations. Vulnerable mothers may have compromised physical and/or mental health and may be at emotional risk from ongoing

abuse (Levendosky & Graham-Bermann, 2001). Some feel that conducting research with vulnerable and powerless populations only adds to their oppression, however as discussed by Swain, Heyman, and Gillman (1998), research can actually provide oppressed groups with an opportunity, which they would otherwise not have, to make their voices heard. With the information gained from this research, it is hopeful that the participating parents will have this opportunity and will provide the basis for intervention and support programs in Prince Edward Island.

Trustworthiness

According to Lincoln and Guba (1985) "The basic issue in relation to trustworthiness is simple: How can an inquirer persuade his or her audiences (including self) that the findings of an inquiry are worth paying attention to, worth taking account of?" (p. 290). These authors further concur that researchers may find it useful to reflect on four questions to assess trustworthiness. In response to these four questions have come criteria which are termed "internal validity", "external validity", "reliability", and "objectivity" (Lincoln & Guba, 1985, p. 290). Lincoln and Guba (1985) however, believed that these criteria were not suitable to the naturalistic paradigm, and therefore proposed four new terms which they felt are more appropriate: credibility, transferability, dependability, and confirmability. These terms are used more commonly today (Polit & Beck, 2004).

There are also a variety of operational techniques that can be used to establish credibility, transferability, dependability, and confirmability (Lincoln & Guba, 1985). First, credibility is defined as the confidence in the truth of the data (Polit & Beck, 2004). For example, to improve and document the credibility of qualitative research, Lincoln

and Guba suggest the following techniques: prolonged engagement, persistent observation, triangulation, peer debriefing, member-checking, searching for disconfirming evidence and research credibility. Second, transferability refers essentially to the generalizability of the data which requires the researcher to provide sufficient descriptive information in the research report so that others can evaluate its applicability of data to other contexts (Polit & Beck, 2004). Third, dependability of qualitative research "refers to the stability of data over time and over conditions" (Polit & Beck, p. 434). Two techniques used to assess the dependability of data are step-wise replication and an inquiry audit (Polit & Beck). Lastly, confirmability refers to the neutrality of the data (Patton, 2002; Polit & Beck), which is "the potential for congruence between two or more independent people about the data's accuracy, relevance, or meaning" (Polit & Beck, p. 435). Approaches to enhance confirmability include bracketing, maintaining reflexive journals, or audit trails (Polit & Beck). Furthermore, as noted by Patton (2002), it is crucial to recognize that certain philosophical underpinnings and theoretical orientations for qualitative research will create varying criteria against which the quality and credibility of such research is judged.

There are multiple ways in which credibility, trustworthiness and rigor can be enhanced which include triangulation, peer debriefing, and reflexivity. I will discuss how I used each of these as modes to enhance the trustworthiness of the research.

Triangulation

Multiple researchers collaborated to analyze the data. More specifically, I and two other researchers from the University of New Brunswick collaborated to code the interview transcripts. This university will be one of the four sites at which the larger

research study will begin in the fall of 2006. Black and Champion (1976) highly recommend the use of cross-coding, as it not only enhances the reliability and validity of the study findings, but also diminishes the possibility of researcher bias. The researchers with whom I collaborated to analyze the data will also be participating in the upcoming study. Patton (2002) supports triangulation in research and claims that it is ideal, as it strengthens the research by increasing its validity. Lincoln and Guba (1985) state that triangulation "...makes data believable" (p. 307).

Peer Debriefing

Peer debriefing, a technique used to establish and/or enhance credibility of research, involves the researcher meeting with his or her peers and colleagues to explore various aspects of the research (Lincoln & Guba, 1985; Polit & Beck, 2004). There is no set prescription for peer debriefing, but it can be extremely useful in many ways. As I had the fortunate opportunity to be a member of the Atlantic Canadian IPV research team, I was able to utilize this technique on many occasions throughout the entire research process. I met regularly with my thesis supervisor, who is a co-investigator on the larger CIHR-funded project and who is experienced specifically with the research methodology. I also had the opportunity to meet via telephone, email, and in person with the principal investigator of the larger study, who is experienced with both the research methodology and the phenomenon being studied. This was beneficial in discussing any developing bias. As well, I engaged in consultations with other graduate students, various researchers and many community members who are experts in the area of study. These consultations focused on a variety of issues, ranging from evidence of researcher bias to the development and explanation of themes.

Reflexivity

Reflexivity, which is one of the major techniques in establishing confirmability (Lincoln & Guba, 1985), is defined as "critical self-reflection about one's own biases, preferences, and preconceptions" (Polit & Beck, 2004, p. 730). One technique that can be applied to all four areas of trustworthiness is the reflexive journal, described by Lincoln and Guba (1985) as a type of daily personal diary that records information about self and method. Information in a reflexive journal may include the daily schedule and logistics of the project, the researcher's personal reflections, and/or a methodological log, where methodological decisions and rationale are recorded and reflected upon (Lincoln & Guba, 1985).

This was a technique that I used from the initial stages of the research project. I updated the journal on a daily basis and listed the research activities that took place each day. I would record the logistics of the project, express and reflect on my personal feelings at various points in time throughout the research process, and would make note of methodological decisions made. More specifically, during a summer residency program, I spent a lot of time contacting and meeting with various community members who work with IPV in the province. I began a personal journal at this time that recorded information on the nature of the contact with each community member, which became extremely useful during the participant recruitment phase of the project. I then was able to look back at the journal and immediately identify who to contact and who would be most helpful in terms of assisting with the recruitment of participants. Ultimately, this journal aided the researcher's memory and thus enhanced the reliability of the study.

Chapter Four

Findings

In this chapter, the themes and findings that emerged from the face to face interviews with mothers affected by IPV in PEI are presented. Direct quotes from the participants are used to best display their comments, reflections, and experiences. As mentioned, pseudonyms will be used to protect the participants and other associated individuals. A short description of each participant precedes a thorough description of the themes that have emerged based on each participant's individual experiences and story.

There were two particular aspects of generating themes with which I struggled. Firstly, I had difficulties in differentiating between a theme and a pattern and secondly, I wasn't sure of how many themes I should expect to have in the final stages of this analysis. After a review of the literature and speaking with other qualitative researchers, I learned that "there is no hard-and-fast distinction" between a pattern and theme, but it should be clearly stated as to which term you are using and why (Patton, 2002, p. 453; G.Storr, personal communication, December, 2005). In terms of how many themes I was to have after this preliminary analysis, Auerbach and Silverstein (2003) reveal that although there is no rigid rule, they suggest reducing the number of repeating ideas by a factor of three or four.

Once again, the research questions that guided this study were:

1. What is the impact of IPV on mother-infant relationships?

2. What is the association between mother-infant relationships and infant development in families affected by IPV?

3. What are the: (a) support needs, (b) barriers to support, and (c) preferences for support intervention to promote mother-infant relationships affected by IPV?

Two major themes and multiple sub-themes have emerged from the analysis of the interview transcripts. The first theme explores the impact of the violent relationship, which addresses research questions one and two. Sub-themes include the impact of IPV on the infant and impact of IPV on the relationship between mother and infant. The second major theme centers on the support for mothers who have experienced IPV and are further discussed under sub-themes which include support resources, barriers to support, and mother's preferences for support. This theme answers research question three.

Introduction to Participants

The following describes each of the three female participants. These descriptions are brief and some information has been omitted for the protection of the participants' identity.

"Susan"

Susan is approximately 30 years old and lives in an urban area in PEI. She lives with her three children; two sons and one daughter. Her sons are approximately ages 2 and 6 and her daughter is around the age of 4. Susan is a full-time student and does not work outside of the home. She recently bought a new home after her separation from her husband. It is a split-entry home with hardwood floors and a large living area. The kitchen and dining area were combined and were attached to a large outdoor patio off the back of the home. When I arrived at Susan's home, it was quiet as her two sons were at daycare/school. Her daughter was home and playing in her toy room. The atmosphere

was welcoming and the home was clean and colorful. The atmosphere changed slightly and became more chaotic as the two boys arrived home from school. For the majority of the interview, the children played with the research assistant in their playroom in the basement.

"Vanessa"

Vanessa is approximately 30 years old and lives with her two daughters in an urban area in PEI. Her daughters are aged approximately 6 months and 3 years. She rents one half of a duplex in an older neighborhood. There appeared to be many children living in the neighborhood, which was evidenced by all of the toys and bikes on each homes' yard. Also, many kids were playing in the street as I approached the home. Vanessa is a homemaker with a high school education. She receives social assistance. The home was cluttered with toys and baby supplies however, the atmosphere was relaxed. The older daughter was well behaved and developed a relationship with the research assistant immediately. In fact, upon conclusion of the interview, the child would not let go of the research assistant's hand and did not want her to leave. The baby was present during the interview and slept in her rocker, only fussing once to have her diaper changed. Vanessa was very easy to talk to and appeared keen to answer the interview questions to the best of her ability. She appeared relaxed and sat next to me on the couch with her legs crossed, at times tending to the baby sleeping in the rocker. Part way through the interview, the doorbell rang. It was a neighbor dropping off a large box of food and diapers for this mother. He stated that a family member of his works for a food distributor and he wanted to contribute to this family. Vanessa did not know this neighbor at all, but was evidently grateful and touched by his actions.

"Jane"

Jane is approximately 20 years of age and lives with her two daughters in a rented apartment in an urban area in PEI. Her daughters are aged approximately 1 and 2 years. Jane has not completed high school, but has been in the process of trying to work towards returning to school. She receives social assistance. Jane chose to have this interview conducted at the local shelter for women and children in Charlottetown. After discussing this request with the shelter staff, a private room with closed doors was made available to myself and Jane. This particular room is typically used for police interviews and other personal matters. The shelter is a heritage home located in downtown Charlottetown. The interior is beautiful with high ceilings and old hard wood. The atmosphere was very welcoming and the staff in the shelter was very friendly and accommodating. Jane and I both sat in big, comfortable arm chairs next to one another with a small end table in between the two chairs. We were facing each other directly. There were no other residents at the shelter during the time of the interview. Jane's daughters played in the third floor playroom with the research assistant. This playroom was very colorful, full of toys, and appeared to be a safe environment.

While Jane appeared comfortable in talking about her experiences, she was reluctant to elaborate on specific questions asked.

Impact of Intimate Partner Violence

When a woman and her infant are involved in a violent relationship, it can have a devastating and lasting impact on various aspects of the woman's life (Health Canada, 1999; Jaffee et al., 2005; Lutenbacher et al., 2003; Power, 2004; Robinson, 2003). The following sections will present the impact of violent relationships on infants, and on the

mother-infant relationship. Susan, Vanessa, and Jane have all experienced violence in their relationships. Accounts of the impact that violence had on their lives follows.

Impact of Intimate Partner Violence on Infants

According to the participants, they consistently stated their infant's lives were affected by IPV in one way or another. As noted in Chapter Two, infant's growth, development and overall well-being are all at risk and can be compromised in violent environments (Health Canada, 1999; Levendosky et al., 2001). This was supported by all three participants who noted changes in their infant's behavior and suspected that it was a result of the violence they experienced.

Susan

Susan did not notice any changes in her infant immediately however, with time became concerned with various aspects of her child's behavior and emotional status. When asked if she thought the IPV affected her infant, she had the following to say:

> Ah, it came out slowly at first. Um, the baby, who is two and a half now, he was a very good natured baby when he was born. He was a nursed baby. He was so content. He was very happy to be alive kinda little tyke. Very happy to be here and eventually as he got older; nine, ten months, eleven, going on a year, babies – they pick up more. They understand more than what we give them credit for. Because um, that's when the aggressiveness started. Whether it be towards other children, whether it be towards myself. And it never really seemed to be with him and his dad. I always felt the aggressiveness was coming towards me. Not as if he was saying 'this is your fault', but I just felt like he thought I was the bad guy. Where as I knew this was just a little person trying to express what he's seeing. Just when he started really walking, talking, ah being able to express what he wanted or, or, what he was trying to communicate with me. And he would communicate this through anger, through pushing other kids, biting, shoving, ah, throwing things, getting into stuff that he knew he wasn't supposed to (Susan, Interview).

She was often bothered by how she thought her children perceived her while living in a violent environment. She believed that her children, no matter what age, were very perceptive and understood that something was not right between their mother and father. She claimed that even her infant was aware of the stressful nature of the household, which was evidenced in the abovementioned ways. Moreover, she speaks to how she felt her infant displayed stress.

> If we go on a play-date or in a play group in another social situation where there are other children his age, even older children, he'll try to bully them. This is a 2 and a half year old. He, he can make his six year old brother cry. Um, just by being a little bully. Not all the time. He can be charming at the best of times, but other times he will show aggression, and ah, ah just, very um, the discipline would be a problem. There are times where you seen him when he came in here, he was all shy and he wanted his mom. He will cuddle and he certainly will do that, but other times he'll just get in the mood. Where he will just be a bully or he'll walk along and he'll pick up a boot and just throw it for no reason. And I never could understand where this- how they said little people could have stress, but sure they can, sure he has stress. And is just really, I – I can recognize the signs um, where somebody else might just be him growing, but of course he is stressed. Little people do have stress. And that's just his way of acting out what has been going on between me and his dad (Susan, Interview)

Susan noted that these behavioral and emotional issues were evident in her infant after he began witnessing of the violence between his mother and father.

Vanessa

Vanessa also spoke of behavioral changes in her infant and claims that these changes occurred as a result of the violence. Vanessa describes these changes the following way.

> Um, she started becoming um, afraid of things. Like, when we'd go home, she'd start to freak out when- the closer we got to the house. And say she 'didn't want to go home', ah, there were 'bears in the house' and she didn't ah, she was scared of him (meaning her

> father). She became scared of him and didn't want to play with him. She was crying all the time. She was having, she started having nightmares. That type of thing. Now, it was hard to sometimes know if she was really being affected or if it was just regular two year old behavior. So, but when she started, she when she started showing signs of being afraid to be with him, that when (Vanessa, Interview).

In addition to the behavioral changes noted at home by Vanessa, the staff of the daycare which her daughter attended also noticed that things were askew. Vanessa stated:

> And they noticed her going through some really emotional times. Like, crying sometimes for no reason, so they thought that it was maybe having an effect on her. That she knew something was changing at home (Vanessa, Interview).

When asked if the violence has affected the personality of her daughter, she claimed

> I think it did at the time. Yeah, she was withdrawing at the time, but. From him especially, but even from me a bit like, she just, like, her behavior was so unpredictable. Like, she'd go from really clingy to really emotional to ya know. I never, and I never, like I said I – she was my first daughter so I didn't know if it was typical behavior for her age, or if it was – you know (Vanessa, Interview).

Jane

In addition to behavioral and emotional issues as a result of the violence, Jane discussed infant developmental issues concerning her child. She described her daughter's developmental struggles as follows:

> Well, she's kind of a loner. Like, she loves people and she likes being around kids, but…she went to daycare for awhile and she was kind of on her own and she likes to do everything on her own (Jane, Interview).

When asked if she thought her daughter was withdrawn, Jane stated that she thought she was somewhat withdrawn. Additionally, she states

> And she doesn't talk. She did when she was a baby, but then she stopped. She used to but she said basic words and that before, but she just stopped (Jane, Interview).

When probed about the lack of speaking, Jane said that her daughter does not talk at all and does not use any words. Not even to her mother. When asked if she perceived her daughter to be on the same developmental stage as other children her age, she stated the following:

> No, she's not. I don't think she's on the same developmental stage. It's just because she doesn't really talk and you know-. If you teach her something, she won't really copy you. Sometimes she will, but she kind of just wants to do everything on her own (Jane, Interview).

Jane alluded to this on more than one occasion in the interview, once again saying

> She's kind of not undeveloped, but you know, you know her development is kind of slow, but I have an appointment to get her to a speech-therapist and that (Jane, Interview).

As evidence above, these mothers clearly state that their infants have been affected by the presence of IPV between their mothers and mother's partner in one or more ways. The violence has influenced these children behaviorally, emotionally, cognitively and developmentally. In addition, their relationship with others has been altered. The specific effects of IPV on the infants' relationships with their mothers will be discussed in detail below.

Impact of Intimate Partner Violence on Mother-Infant Relationship

Two of the three mothers interviewed, had similar feelings related to how their relationship with their infant has been affected by IPV. These two cases will be presented first.

Both Susan and Vanessa felt that their relationships with their infants were affected due to the violent experiences. Both claimed that they were not able to mother their children as they would have liked because of their altered emotional status.

Susan

Susan did not hesitate when asked if she thought the violence affected her as a parent and claimed that it did. She explains in more detail:

> To me, my relationship with the baby um, it affected it in a way that when I would get yelled at or in an argument, or um, a yelling match with my ex-husband about something, it would in turn put me in a bad mood. Ah, put me in a bad mood because ah, I shouldn't have to be dealing with it and why do I constantly feel like I have to defend myself and I shouldn't have to. I'm a grown woman, I'm married – Three children. I shouldn't have to defend myself to nobody and justify any actions unless they were um, you know justified. However, in turn I would get in a bad mood or I would just get saddened and then that sadness or that anger would get reflected onto my children. Whether it be, I might be impatient with them, I might be short with them, I might um, say you know "we're not going to McDonalds" and then I change my mind. Just in that way. Never, ever, ever, ever would I ever discipline them with my hand or any other object or anything. But I, I struggled with, I could be a little bit more tolerant of whining or their screaming, it' just that I got so agitated. Agitated… It's a little tricky, but I noticed that since I wasn't well physically and emotionally, it really reflected in her. And when I started feeling better, um, I was very agitated because he didn't – he wouldn't – I was doing the necessary things with him or her however, my husband would constantly say you know "you can't even bathe her because you don't love her obviously because you're depressed". But I was really agitated and when I would spend time with her I was agitated because he was giving me all these insults (Susan, Interview).

While Susan described her relationship with her infant as 'good', she is always trying to improve the relationship with her children. She stated that she has always been very close with her children, due to the fact that her partner worked seventy hours per week, leaving her with the children. When asked if her relationship with her infant was a priority throughout the IPV, she instantly said that yes, it was. She did not want her relationship with her infant to be affected in any way, because of what was going on between her and her partner. She admits however, this was not an easy task. She recalls:

> I wanted – as much as I was going through, there's no way that any of my anger or bitterness or anything could reflect on him. Oh, you know, there was just no way I was going to have an angry baby because I was in a bad relationship (Susan, Interview).

She explained that while the overall relationship with her infant was a priority at the time, she was very careful to hide any violence from the children. She did not want them witnessing or hearing any of the abuse that took place. This was not always the case, and as the violence escalated, the children did witness and hear most of the abuse that took place in the home.

Susan spoke of the feelings related to mothering through violence, which included feelings of guilt, shame, and embarrassment. Susan says when referring to her son:

> He shouldn't have to worry about grown up problems. It's a little person, and I would just be so ashamed (Susan, Interview).

Vanessa

Vanessa had more to say about her emotional status while experiencing IPV and how it influenced her mothering abilities. When questioned if she thought it affected her as a mother, she had the following to say:

> Um, not like. It hasn't made me aggressive towards my kids, but it definitely- it's hard to parent when you're dealing with a lot of (pause)...stuff. Yeah, you're emotional and you're trying to act like everything is fine and (Vanessa, Interview).

She believed that as a mother, she became more lenient in her parenting simply because she was under so much stress from the violent relationship, claiming that

> It was easier to just like, yeah, let things go instead of dealing with it. And you're so- you're dealing with so much stress that you tend to um, well in my case like I usually as a parent try to look um, more at the long term. But when you're going through something like that, you're basically parenting just to get done whatever needs to be done at that moment (Vanessa, Interview).

She felt very distracted and distant from her children because of various stressors associated with being a victim of violence, which was obvious to her daughter as evidenced by the following:

> Like [Molly] will say to me like "Mom, you're just going uh huh". Like, she'll be talking to me and I'm just going "uh huh", "uh huh" because my mind is on all of the other stress. And, so I think like now, when I compare with how I was with [Molly] and how I am with [Maria], I find the more stress I'm under, um, yeah, I don't parent the same. Like, it's not like I don't, don't take it out on them, but I just become very (sigh), I feel like I'm not really in the room like I'm- Like, I'm going through the motions. Like, they're fed and they're changed and they're bathed and you're going through all that but I don't find, I find I'm thinking about everything else (Vanessa, Interview).

Vanessa expressed feelings of guilt when talking about her mothering abilities. Vanessa states:

> Um, well I think when you're going through a lot you tend to maybe parent out of guilt or you – you're so kind of, your head is so clouded (Vanessa, Interview).

Vanessa talked about her feelings related to her relationship with her infant being a priority during the times of IPV, suggesting that her daughter was the reason she ended up leaving her abuser:

> Yes, yes. It was. I think, I probably would have stayed with him longer if it wasn't for [daughter]. That was the – probably the number one reason. Cause I just – It was one thing for him to take something out on me, but when he started – it affected her – and when he started taking things out on her, then it was just like, no. Yeah, because, it's just, like, there's no need for that. Like, like it's you know, I'm an adult I can, I can somewhat defend myself but she can't (Vanessa, Interview).

All three participants stated that their relationships with their children were priorities, even during the IPV. Despite this commonality, Jane had some different feelings related to her relationship with her infant than did Susan and Vanessa.

Jane

When Jane was asked the same question as Susan and Vanessa in regards to whether she thought the violence affected her as a parent, her response was that it had not influenced her as a parent in a negative way. In fact, Jane reported that the violence made her closer with her children and that she has become more loving towards them since leaving the violent relationship. Similarly, when asked if she thought the IPV affected her relationship with her infant, she felt that nothing had changed due to the violence. She describes her relationship briefly by stating:

> Well, we're really close. I'm always with them 24/7. We play a lot and, I always hug them and tell them I love them all the time. Hopefully it'll stay that way (Jane, Interview).

Jane also noted that even though her daughter does not speak, they have their own method of communication. She remarks:

> You know she- Like, whatever she does, even things she does to me, she can't really talk but I understand her and that (Jane, Interview).

Additionally, Jane believes that the family environment was not disturbed because of the IPV.

As noted above, Jane did not feel that her relationship with her infant had changed as a result of the IPV. When asked, considering all of the burdens she had to bear, if her relationship with her infant was a priority, she stated this:

> Because it wouldn't really matter to me if I was in love or with their father or not, they would be my main priority anyway. They come before anything in my life (Jane, Interview).

Supporting Mothers in Violent Relationships

All mothers were questioned regarding the support that surrounds women victims of violence across PEI. As noted in Chapter Two, there are existing support services in place for these mothers, however there are also various barriers that hinder or prevent mothers from seeking or accessing this support. The participants speak to the support resources, barriers to support, and share their preferences for support in the following section.

Support Resources for Mothers Affected by Intimate Partner Violence

All three participants sought at least one form of community support following their experiences with an abusive partner. Despite trying to conceal the violence for varying amounts of time, Susan, Vanessa, and Jane reported that they were aware of some, but not all local support resources. Susan had this to say when discussing her attempts to hide her personal experiences with IPV.

> I put this mask on, if we went to a wedding or I don't know, some party, or birthday party, um, everything is great. Couldn't be better and um, he did it too. And I was so good. I could have won an Academy Award for my performance (Susan, Interview).

Susan

Susan had a personal experience with a support service that was related directly to helping women victims of violence. Specifically, she sought the services of one of the Community Outreach Programs, coordinated by the Transition House Association of PEI. She became aware of this service through a family member and credited the connections in the small province of PEI for this. Although she was not exactly sure of what services were offered at this local resource centre, she contacted them by email. However, it was

not immediately that she contacted this resource as she was troubled with thoughts that maybe her case would not warrant this type of service. For example, she did not reply to the returned email for a couple of days thinking that she didn't require this type of intervention. She recalls her thoughts at this time.

> And, I didn't answer her for a couple of days and she just kept on sending emails and I thought (sigh) – I told her a little bit of it and she- she suggested me coming in for a visit and then you know I said I don't have any broken bones, like you know, you don't need to send me to Anderson House, this is not – I'm not real bad. And she made me feel as comfortable as anything (Susan, Interview).

Susan also expressed her preference of communicating through email. This was convenient for her. She was pleased with the service she received as her emails were always answered in a timely manner. This was also a positive experience for Susan as the program was offered free of charge. She found one aspect of the program to be particularly valuable in terms of mothering.

> [Barb] was very good to focus on- I guess to let go of the past as much as it made me bitter and angry and so much negative feelings, and focus on me being happy, because when I'm happy my children are happy. And, it's- if I'm faking happy, then they can tell. And I know they can. So, when I'm happy, they're happy. They're genuinely happy. And she offers programs and such, um, um, like how to deal with the feelings of child at different stages and how to be a good mother (Susan, Interview).

Furthermore, Susan spoke highly of this support resource because the staff never "sugar-coated" the situation and always made time for her when it was needed. The following quotation captures her appreciation for this.

> I saw her multiple times and every time I went in there it was never like "How are ya today you poor thing?" (in a quiet voice), it was "How's it going? What kind of cookies? I got all – I got sugarcookies... I'd go in there with a tear-stained face, my mascara, teeth not brushed, looking just, like awful – like the cat dragged me

> home, and ah, not a word. Not a word, just a big hug and say "it's gonna get worse before it gets better" (Susan, Interview).

In addition to Susan utilizing the Community Outreach Program as a support resource, she also met with a marriage counselor and a member of Victims Services of PEI. Although she did not speak in great detail about these services, she did report that they were effective in terms of helping her manage her feelings related to being a victim of violence. Her main resource, of which she spoke very highly, was the Community Outreach Program. Susan noted that she is still in regular contact with the staff of this program.

When asked if she was aware of any support services available for her children, she had just recently been made aware of a course entitled "Positive Parenting from Two Homes". She signed up for this program and at the time of the interview had taken part of the course. One of the benefits, according to Susan, of this program was that it is offered in both major cities in PEI. Susan also wanted to have her children see a child psychologist however at the time of the interview; she was on a four month waiting list and had no further comment regarding this support resource.

Finally, Susan expressed her gratefulness of her social support network of family and friends in her times of need. She was overwhelmed with the support she received, as evidenced by the following:

> And I think – a really, what helps really is to be able to confide in a best friend. Like I have, I'm fortunate enough to have such friends in my life, but I'm blessed to have a really good close bunch of friends. I have two best friends, one actually lives on the other side here. And a person is really blessed to have good friends in their life. Really, because they're just your confidants. They always make time for you (Susan, Interview).

Vanessa

While Vanessa was aware of some community support resources, she expressed that she was not aware of any that targeted women victims of violence specifically. She did seek a social worker and was disappointed when they did not refer her to a resource specific to IPV. She had been seeking counseling through Child and Family Services and also Social Services, both departments within the PEI provincial government. It was not until she really took the time to research other community support resources that she became aware of services for family violence prevention. Eventually, one of the counselors with Child and Family Services notified her of the Community Outreach Program in her area. Vanessa too, sought the services of the Transition House Association of PEI's Community Outreach Program in her area, although she did not go into great detail about her experiences with such.

Vanessa felt most strongly about seeing a social worker and indicated her belief that this was most beneficial for her. She states:

> That was kind of my outlet. Like, where I could go and talk about everything. What was helpful, was just – um, like at the time when I first started going it was two months before I even left him and it had already happened probably three times at that point. And, I didn't even really see it as abuse. Like, I didn't um, like, it was affecting me that way like, the weird thing was I had felt like as if I had been raped. But, I couldn't even use that word, because it was my husband. I couldn't really put into words what was going on. I just knew that my self-esteem, like everything emotionally, like I was totally withdrawing, and I was internalizing everything and it, it just helped draw out for me what was really going on (Vanessa, Interview).

Vanessa felt as though the face-to-face contact with the abovementioned service providers was very beneficial for her. She occasionally would use the telephone as a means of communicating, and mentioned that she had never used the computer.

Although Vanessa had some support from family and friends, she found it very difficult because her immediate family lived in another province. She also felt as though she lost support because her ex-husband's family was all from PEI. She believed that they did not want to take sides and chose to not get involved with her situation. As a result, Vanessa chose to remain quiet about the subject.

> I really didn't want to tell people what's going on, I just kind of said "we're separating and maybe we'll be able to work it out" and I didn't want to give a whole lot of details because it was embarrassing (Vanessa, Interview).

Jane

Jane expressed immediately that she had a good sense of what support resources were available to her. She knew of the Transition House Association shelter, known as Anderson House because of her experiences as a child. She had lived there as a young girl with her own mother and then returned with her two daughters when she too, became a victim of IPV. While Jane stated that this shelter was her main support resource, she was also aware of various resources in the community such as Social Services and the Family Resource Centers across PEI. She did not however, use any of these services herself.

Jane did not have the informal support network of many family or friends. She recalls that her mother in-law and her sister would occasionally help her if it was needed, but other than that, she was on her own. No community members outside of Anderson House acted as support resources for her. Jane says the following when referring to her feelings of isolation during the entire experience with IPV:

> Oh yeah. [Lucy] told me here that when it came to isolation, my case was the worst she's seen by far. One time I stayed in the house

> for sixty-two days straight. Like, I didn't go to the store. In the middle of nowhere. No phone, no car (Jane, Interview).

Barriers to Support for Mothers Affected by Intimate Partner Violence

A variety of barriers exist and ultimately prevent women from obtaining support for their experiences with IPV. As noted in Chapter Two, a great deal of secrecy exists around this sensitive topic. In addition to a multitude of barriers, the literature demonstrates that the abuser himself is often the largest barrier a woman faces in seeking help regarding IPV (Davis et al., 2003). Susan, Vanessa, and Jane all stated that their abuser was a barrier in some way and hindered them in seeking support.

Susan

Susan spoke of a few barriers that she encountered when trying to access support resources, however, each time she referred to a barrier it always involved her abuser. Initially she spoke of the size and population of the city in which she lives. She felt that because of the small size of the city, she hesitated to seek support out of fear that someone in the community would find out. This would result in feelings of embarrassment and shame. For example, she would fear that she would be seen entering the building that is known as the "Family Violence Prevention" office. Susan says the following regarding this as a barrier in accessing support:

> The next that might compare to that was just if anybody ever found out. One time, somebody had seen our vehicle parked downtown, on [West] St., cause- where [Barb's] office is downstairs in the mall and ah, they asked me and so I had to come up with a lie – I was at ah, [a] Development Centre doing my resume. Ah…such a lie, but it came out of my tongue really quick (Susan, Interview).

The second barrier to support that Susan spoke of, was the nature of the issue for which she was seeking support. She expressed this below:

> Bruises are easy to cover up, but your heart isn't, and your heart is open. Um, and bruises are a lot easier to explain than emotional abuse. If someone sees a wound on you, like maybe here (pointing to her upper arm, bicep area), they automatically assume somebody has grabbed you. They know that something is going on, but if act happy all the time and hide it, what do you mean emotional abuse? So, my first reaction was, what do I do, where can I go, none of my friends have experienced this? (Susan, Interview).

Thirdly, Susan mentioned transportation as a barrier to support. She explains that they had one family vehicle. While the support she was seeking was relatively close to her home, she still had to drive by car. This was difficult at times, and once again her abuser would prevent her from accessing community support. She stated on many occasions how he acted as the barrier, some of which is captured in the following:

> I was still living at home and not thinking that this would ever happen, my husband started going through my private emails and found them. Even though I made the extra effort to put them in a folder called "Susan's" – he's not very computer literate. Some how he managed to find it. And, he woulda had to do some digging. I was really surprised, that he could go that far and he read them all. And he was my barrier, um. Even though I still snuck around and went to the meetings because it was – when he read them it said [Barb Jones], he instantly knew who she was and he would say "Oh dear, you poor battered woman having to go see [Barb]". Um, "I didn't break your arm, maybe I should have". Just always dripping with sarcasm. "You poor battered woman, who do you think is going to believe ya? Nobody? You know my family has money and I can buy my way outta any situation". And I was just like, deep down I knew it was wrong that like, money doesn't buy everything. And I would tell it to him. "Oh, you poor little battered woman, Oh, you don't have a cast, maybe you should start walking with a limp, should ya?". And, so I started lying. Um, and I'm not a good liar, so I'd say I'm- I'm going in town shopping, ah, I dunno somewheres, whereas I was going to a meeting. He'd hide my keys. So I'd get in the car with my keys, click- wind it over, the car wouldn't start. And I knew the battery wasn't dead, it was in a heated garage for God's sake (Susan, Interview).

Vanessa

Vanessa identified different barriers than did Susan. One of the reasons she felt it was difficult to seek resources was due to her upbringing. She recalls:

> Well, first of all, like um, I don't know. I guess the way I was raised to a degree I felt that kind of what happens in your marriage, you should work it out within your marriage. And, um. I had already been married before, so I was even more driven to not want to let this one fail. And, um. Then, the fact that I don't have family here, so it was – then a lot of our friends were mutual friends (Vanessa, Interview).

She believes that her feelings of isolation hindered her in seeking support, she often wondered where and to whom to turn. She was overcome with feelings of exhaustion and did not have the energy or the time to spend on looking for community support. Vanessa expresses her experiences with comments such as the following:

> Um (pause), yeah. I think sometimes it's sort of focusing on "how do I get out of this?" or "how do I – where do I go?". I became extremely, ah, well I guess now looking back on it, it was probably depression. But, I was tired all the time and sleeping a lot and, and, just not really have the energy (Vanessa, Interview).

In addition to the lack of energy and time, Vanessa also cited her financial situation as a barrier. She did not elaborate on this point, stating simply that she was not in a stable financial situation and required aid from her parents and from the provincial government. Her daughter's daycare was partially subsidized, however not for reasons related to the abuse, but rather for the circumstances surrounding her pregnancy.

One of Vanessa's additional concerns with support resources was with the police system. Initially, she did not have a positive relationship with the local police department, and felt as though her concerns were dismissed. While the end result was

positive, it took time before the police and judicial system recognized her need for protection and safety. She explains her situation:

> ...the police now are really helpful, but they only became really helpful when they read my statement and read all the details of what I went through when I was married. But up until then when I kept saying, you know "he's following me around"," he's showing up at my door", all of that they kept saying "well that's not enough" "that's not-" ya know. And it wasn't until I had to basically explain everything for them to take me seriously for why I was afraid of him. Because one of the first questions they asked well "Did he really punch you in the face?" or "Did he-" and "If he's only showing up at your door or driving by slow, or trying to intimidate you, then it's not really a crime to do that". So, they can't do a whole lot and I think they should take it a little more seriously when a woman is that persistent saying you know (Vanessa, Interview).

It became evident in the interview that Vanessa felt very strongly about changing how the abusers are dealt with judicially. She labeled the police and judicial systems as not necessarily a barrier to support, but definitely something that she found frustrating as she attempted to recognize the appropriate support she needed during this time. She presented her feelings on this:

> One thing though. One thing I find is that it seems like the Island is really good for supporting women who've been in this situation. However, it still seems that people serve more time, like jail time for stealing a car or robbery or something like that than for abusing their wife. And I think that needs to change. I mean, if you go through. Like right now I'm going through – there are criminal charges against him. I'm going through all of that. Or, but if you go through all of that and then they get off with probation or anger management or something like that, it kind of I dunno, it minimizes what you've gone through. Because it's all – it's a very emotional to be – you know, you're talking about this you want to help and you want to help other women and you want the person to get help too, I do think they should be put in counseling for when they're convicted. But, you know. I don't think jail time is just an answer, but I think they should – shouldn't look at it as "well you know if they robbed somebody that's more of crime than if they abuse their wife". Yeah, so even if you- if they attack someone in a bar then

> they would get in more trouble than if they do it several times in their own home (Vanessa, Interview).

Although Vanessa's abuser was somewhat of a barrier to support, she did not speak a great deal about this.

> Yeah, like maybe if I had known more of counseling for children or if I had talked to someone to see how it's affecting her, maybe that – maybe I would have even left even sooner. I didn't stay that long. I mean, I know there's women that stay a lot longer. But um, sometimes – yeah, maybe that would have helped (Vanessa, Interview).

Jane

Of all three participants, Jane spoke most frequently about her abuser and how he was her largest barrier in accessing support. Because her partner dictated where she would go and when she would go there, she was not able to access the support resources she needed.

> And we were living out in the country and like we didn't have a phone or a car because we just didn't. We both weren't working and he was drinking a lot and but I couldn't ever really leave, like, I would stay in the house for weeks and sometimes a couple months at a time without going anywhere. I could never make an appointment to go anywhere or anything cause I'd have to ask him for permission to ever go anywhere so (Jane, Interview).

In addition to Jane's abuser acting as a barrier to support, she explained how she lived in the country with him with no car or telephone. The only service she knew of at the time was in the more urban areas of PEI. It was impossible for her to access resources without any communication links. When probed for further discussion on the barriers to support, she briefly mentioned that her financial situation was not ideal and again could have been a hindrance in obtaining help. As well, she felt as though she could not have sought support with the children in her care. For example, she remarked,

> Yeah, it would be kind of hard to do something like that with kids there too. You'd have to take care of them (Jane, Interview).

Jane also verbalized that she would not want her children to be around when she was speaking of her experiences with IPV. This was a common concern across all three mothers.

Mother's Preferences for Support

Susan, Vanessa, and Jane expressed various preferences for support related to each of their experiences with IPV. These preferences are presented below.

Susan

Susan had multiple suggestions for support surrounding IPV in PEI. She felt that there are inadequate services for children less than six years of age. Specifically, she would like to see a program developed that addressed the needs related to children's feelings and aids in improving the relationship between mother and infant in times of stress.

Susan expressed that she would prefer to receive support from only one person, as opposed to receiving assistance in a group support setting. While she did not dismiss the idea of group support, she felt that for her, one-on-one support would be best.

> I find that being in a group sometimes, especially if you're a little hesitant like me, to give information out. Some people have no problems with um, sharing, you know you meet and they tell you their whole life story. Whereas you have to get to know me a little bit. And sometimes, I find one-on-one might be better because people would be more hesitant to say like when others are listening (Susan, Interview).

When asked who she would like to have provide this one-on-one support, she articulated that she would prefer it would be provided by a woman who has gone through a similar experience. While she also expressed an interest in having professionally trained

individuals provide support to women victims of violence, she was clear in stating that a woman with similar experiences would be most beneficial.

> First choice definitely is a woman who's gone though it. Just because she knows. She knows what it's like, especially with children. She knows what you go through. She knows the feelings that you're feeling. She knows what you're gonna be feeling. And she knows the hate and the bitterness that you feel. All those feelings that you have bottled up and you just think that you're half crazy because it's a rollercoaster ride. I would like, professionals, like Norma ah, but also I would like women that had been- they might not have a PhD or a degree of any kind but you know what they have life experience. And that's what counts. It speaks volumes (Susan, Interview).

When asked what method of communication she would prefer in terms of support, she mentioned that face-to-face would be her choice. She noted that she used email on occasion, but thought that face-to-face support would be of most benefit to her. In terms of location for her, Susan preferred support within her city. Although Susan did talk about how she traveled to PEI's other city for one session related to support for mothers experiencing IPV, it would be most convenient for her if sessions were offered closer to her home. In terms of duration, Susan preferred support for short periods of time. As a mother of three, she discussed how many things can come up unexpectedly and she would like to be able to attend any support for IPV consistently. She had previously enrolled was enrolled in a program that was two nights per week for three hours per night. She found that this was too much time to commit with her busy schedule. She stated that ideally she would commit to a type of support program lasting no longer than one month. Alternatively, she would like to attend something that is one day per month.

> Um, maybe it be one Saturday a month or some consistency where I won't be like "Ah, do I have to go to that again". And maybe take a little break and start it again (Susan, Interview).

Lastly, she expressed her positive feelings towards advertising related to women and IPV. She has seen an increase in publicity surrounding the topic and was pleased with what she saw. She would prefer that advertising be user-friendly, and supports this with the following:

> That there are publications that don't scream at you like "Are you a battered woman? Do you need help? Call Anderson House". They're really worded in a friendly way. They're uplifting. Not to make you feel so ashamed to make a phone call (Susan, Interview).

Vanessa

Vanessa also had some concerns with the services that were offered for her children. She expressed that these services are lacking in PEI and would like to see some more support services for children and for mothers, to help them recognize and deal with the implications of the child's experience with IPV. Vanessa explains:

> To know how to – like if the child is reacting to the abuse, to maybe help the mother how to deal with it because if you're dealing with a lot of it yourself, it's hard to help someone else too (Vanessa, Interview).

In comparison to Susan, Vanessa also expressed her preference for one-on-one support compared to group support, saying that she was not willing to share her story with many people. She would however, attend group meetings if she thought they would be beneficial and if it were appropriate to her situation. When asked by whom she would like the support to be provided, she stated that she would prefer to consult with a woman who has been through similar experiences. In Vanessa's past experience with support resources, she felt the information gained from others who had been victims of IPV themselves to be most valuable. As well, Vanessa expressed the value in having women of all classes and backgrounds involved in the support process. She noted that while the

women she was in contact with for support were of different stature and backgrounds, they all had one thing in common and could relate to one another in one way, which was their experience with IPV. Ultimately, she would like to seek support from someone who is non judgmental and unbiased.

When asked about her preference for how the support is delivered, she favored face-to face communication. However, this would be her first choice only if she had left her abuser and was no longer in the violent environment. She did say that communication through telephone or online would work while still living with the abuser.

Vanessa believed that she would benefit most from receiving support weekly. From her past experience, she believed that with all of the stress she was under, she needed some type of support on a weekly basis. She also added that she would like to see childcare provided at the resource locations, since she did not wish to discuss her situation while her children were present. She remarked on her experiences with this.

> Cause you can't have your kids sitting there in the therapy with you. You don't want them hearing all that. And, at the same time, like when we were – when I was going to counseling um at first when I was still with him. He was watching my daughter, but that was a source of stress as well. You know, because he's wondering what I'm saying in those counseling sessions and, and all that. And I'm wondering how, if he's taking out his frustration on her when I'm gone and…all of that so (Vanessa, Interview).

As noted above, finances were of some concern for Vanessa. She was required to pay a fee for services she has sought previously, but would really prefer that these services were offered free of charge.

Jane

Jane spoke of a few preferences for support, notably discussing her wish for services to be offered in rural areas of PEI. While she has no transportation, she would like to see some rural areas get some support services for women victims of violence. Similar to Vanessa, Jane mentioned the idea of having childcare available for mother who were seeking support in the community. As well, she too would prefer to have one-on-one support and ideally speak to a woman who had similar experiences with IPV. If she were to attend a group support session, she would like to see someone who has gone through IPV as the facilitator of this group.

When asked if she would prefer the support in person, online, or via the telephone, she stated that either face-to-face or telephone contact would suit her needs. She did not have a preference as to which one would be most beneficial. In terms of frequency of support, she felt that a couple of hours per week would suffice. She did express that she did not prefer to seek help immediately after the violence had ended because she would like some time to herself. She stated:

> ...just because you know you have to get settled in and your life is going to be changing, so you need to, I dunno know – Not like, right away. Maybe like a month (Jane, Interview).

When Jane discussed her need and preferences for support resources related to mothers parenting throughout experiences with IPV, she said:

> I would like it, but I don't really think I need it. I'm- There is a lot going on between us, but I don't know, I really understand that kind of stuff, I don't think I need counseling, like it doesn't depress me or make me sad (Jane, Interview).

It is important to note that Jane did not believe she required follow-up support after withdrawing from her current support resource.

Summary of Results

The three research questions that guided this pilot project were answered through the identification of the abovementioned themes and sub-themes. As evidenced in the preceding pages, mothers who had experienced IPV while raising an infant, bear a great deal of stress and suffer from various tribulations. Many aspects of a mother's life were affected as a result of IPV. Infants' lives are also greatly affected in many ways, including behavioral, emotional, cognitive and developmental effects. Their mothers, trying to raise them while under the various stressors that are associated with being a victim of IPV, were also greatly disturbed. They too suffer from emotional and physical effects. The mother-infant relationship does not go unharmed when IPV is a reality between mother and her partner. Two of the three mothers interviewed clearly describe how their relationship with their infants were negatively altered by the violent environment and surrounding circumstances.

In addition to the various troubles that surround the infant, the mother, and the mother-infant relationship during and following an experience with IPV, the participants spoke in detail about their awareness of support resources, barriers to support and their preferences for support. While the mothers were aware of some community support resources, they were not aware of all the supports available. Many of the resources were not apparent to them until they did some individual research into the topic. Moreover, they all described the challenges they encountered when trying to access support for IPV in PEI. They were faced with barriers that included transportation and access, financial

difficulties, childcare, and the abuser himself. While acknowledging the current resources within the community, they explained their preferences for support, which included one-on-one, face-to-face contact, preferably with a woman who had similar experiences with IPV. Moreover, they did not want to devote many hours to this, because they were also trying to move on with their lives and with their families.

As the previous chapters have presented a review of the literature on IPV and the findings of the study, the subsequent chapter connects the findings to the literature and addresses the research questions.

Chapter Five

Discussion

Introduction

The purpose of this pilot project was to explore the relationships between mothers and infants exposed to IPV and to investigate its impact on such relationships and on infant development. In addition, I wanted to examine the support needs, resources, barriers to support, and preferences for support intervention that promote mother-infant relationships, from the perspectives of mothers affected by IPV. The questions that guided this study were:

1. What is the impact of IPV on mother-infant relationships?
2. What is the association between mother-infant relationships and infant development in families affected by IPV?
3. What are the: (a) support needs, (b) barriers to support, and (c) preferences for support intervention to promote mother-infant relationships affected by IPV?

Face to face, semi-structured interviews were conducted as a means of collecting the qualitative data. Three mothers were recruited and participated in this pilot project.

This chapter includes a discussion and interpretation of the themes that emerged from the interviews, as well as a description of the limitations of the study. Recommendations for future research are made. The abovementioned themes are identified and are discussed in relation to the overview of literature presented in Chapter Two.

Several themes emerged from the data. To address the objectives, the findings will be compared to the literature.

Theme One: Impact of Intimate Partner Violence

Impact of Intimate Partner Violence on Infants

When infants are exposed to IPV, many aspects of their growth and development is at risk of being compromised, specifically their behavioral patterns (Cox, 2003; Health Canada, 1999; Levendosky & Graham-Bermann, 2001). It has been noted that children often learn aggression from an upbringing involving IPV, which in turn has drastic effects on their behavior, suggesting that these violent patterns of behavior are transmitted from generation to generation (Levendosky & Graham-Bermann, 2001; Health Canada, 1999). Susan has experienced this first hand. Her son has displayed aggression on numerous occasions, involving Susan herself, his siblings and other children at school. She has even referred to him as a 'bully'. While the literature claims that male children who experience IPV typically identify with their mothers in their younger years and become her confidant and supporter (Levendosky & Graham-Bermann, 2001), this is not the case with Susan. Now that Susan's children live with her full-time, her son sees her as the disciplinarian and often requests to go see his father. Susan is hurt by this. While he can be affectionate towards his mother at times, she has noticed a drastic change in his behavior in the recent months. He can often be found yelling at others including his mother, siblings and other children, throwing objects, and getting "into things" that he knows are not acceptable. Discipline is often a problem with this child. For example, when Susan does not allow her son to have candy before breakfast, he screams, cries, throws objects and claims that he wants to go to his father's home. Susan believes that this is because he knows he can get away with more when visiting his father.

The two remaining participants have infants who demonstrate unpredictable behavior. Their behavioral challenges were not typically related to aggressive behavior however, they displayed alterations in their behavior in relation to the emotional difficulties experienced by these infants. According to Health Canada (1999) and Levendosky and Graham-Bermann (2001), children's emotional troubles can be manifested through post-traumatic stress disorder, difficulty with social adjustment, depression, and attention deficit disorder. While these mothers did not report any specific diagnoses for their children, emotional troubles were evident in all three cases. Vanessa's infant was affected by her mother's experience with IPV, evidenced by excessive crying, feelings of extreme fear, difficulties sleeping, nightmares, and symptoms of withdrawal. These findings are similar to that of Health Canada (1999) stating that stress of experience with violence may be exhibited in infants through heart rate, galvanic skin response, and overt crying and distress. Vanessa's infant cries and screams uncontrollably when they drive by their old neighborhood, where they lived when Vanessa's abuser (and her daughter's father) was living with them.

Jane's infant also displays a change in her behavior and has experienced some major developmental troubles. Her daughter used to speak basic words; typical for a child her age, but since witnessing the violence endured by her mother has regressed and no longer speaks. She does not communicate verbally with anyone, including her mother and sister. She too, has demonstrated signs of withdrawal and was described by her mother as an independent child. She has had various difficulties with social adjustment. For example, as opposed to playing with other children, she chooses to play by herself

and does not interact with others. This was evident when observing this child and her sister playing in the toy room at the shelter where the interview took place.

It is important to note that the mothers in this study stated that their children themselves were not actually victims of the abuse. These symptoms are a result of their witnessing and being present in an environment infused with IPV. Davis et al. (2001) believes that this in itself is a form of child abuse.

Impact of Intimate Partner Violence on Mother-Infant Relationships

It is documented that attachment and bonding between mother and infant can be greatly affected in violent environments (Cox, 2003; Health Canada, 1999; Levendosky & Graham-Bermann, 2001). Most women who are victims of violence from their intimate partner experience a wide range of physical, physiological, and psychological symptoms, which can affect their mothering abilities (Browne, 1993; Jaffee et al., 2005; Levendosky & Graham-Bermann, 2001; Lutenbacher et al., 2003; Power, 2004; Robinson, 2003). According to Levendosky et al. (2003) and Levendosky and Graham-Bermann (2001), the prevalence of post-traumatic stress disorder in women who have been abused ranges from 45%-85%. Susan suffers from post-traumatic stress disorder, which has ultimately affected her relationship with her infant as she struggles with feelings of sadness and agitation. She feels as though her feelings of sadness and agitation are reflected on her children and thus she does not mother in the way she would like, in a happy and relaxed manner. Both Susan and Vanessa believe that their relationships with their infants have been negatively affected by their experiences with IPV. The remaining participant believes that it has strengthened her relationship with her

infant and claims that the violence she experienced actually improved the mother-infant relationship.

Susan and Vanessa's experiences with violence have changed the way they mother their infants. Due to the serious emotional effects that the violence had on each of them, they were not able to parent their infants in the way they would have liked. Susan was emotionally upset as a result of the violent episodes and believed her feelings affected her children. She was very short-tempered with her children when she was agitated, a result of the stress she experienced. She wishes she could have been more tolerant of her children during these stressful times. Vanessa, on the other hand was so mentally and physically exhausted from the stress of the abuse, that she became lenient with her daughter and let her get away with more than she should have. She could only focus on the basic needs of each moment and struggled with disciplining her child, when discipline was warranted. She did not have the energy to discipline her, because she felt it was easier to let it pass. Vanessa knows that this was recognized by her daughter and felt that although she was there physically, she was not present mentally. She lived to get through each day and only concentrated on what had to be done in the short-term. Both Susan and Vanessa discussed their feelings of guilt and shame with their mothering abilities. These feelings are consistent with the findings of various authors who note that women who experience IPV are more susceptible to low self-esteem, self-blame, depression, feelings of guilt, shame, embarrassment, fear, confusion, helplessness, hopelessness, and anxiety (Browne, 1993; Coker et al., 2000; Levendosky & Graham-Bermann, 2001; Lutenbacher et al., 2003; Power, 2004). Vanessa feels as though she

mothers out of guilt. As evidenced above, all of these emotional effects of abuse greatly affect the bond between mother and infant.

Jane expressed another perspective in terms of her relationship with her infant during and after her experiences with IPV. She believes her relationship has improved as a result of the violence she endured. She feels that she is now more affectionate towards her daughters and spends more time bonding with them. Mothers of preschool children in violent relationships have been observed to be more sensitive and responsive to their children than mothers who had not parented through IPV (Levondosky et al., 2003). This heightened sensitivity and responsiveness in relationships may be significant to the successful development of some children exposed to IPV. This theory however, remains unexplored (Levendosky et al., 2003).

Besides an enhanced mother-infant relationship, Jane claims she was not affected personally by abuse. She felt she had the coping mechanisms to get through it and was not emotionally or physically harmed because of it. This could in part, be due to that fact that she too, endured violence as a child and went through very similar situations with her own mother. While no literature was found relating to how one may become immune to violence as a result of experiencing similar circumstances as a child, there were some similarities between Jane's situation and other literature. More specifically, Levendosky and Graham-Bermann (2001) discuss how the female child who experiences family violence may adopt the role of abuser or of the victim, depending on the circumstances. For instance, girls whose mothers exhibit only a victim role will generally take on this role themselves, thus increasing the possibility that they will become victims of violence if no intervention takes place. This is similar to Jane's situation, as her mother was a

victim of violence. Additionally, as the cycle of violence repeats itself, these women are often faced with the stresses of a marital relationship and motherhood at a young age. This too, is similar to Jane's case, as she had two children in her late teen years.

Theme Two: Supporting Mothers in Violent Relationships

Support Resources for Mothers Affected by Intimate Partner Violence

Of the 604 cases of domestic violence reported to PEI police in 2002, children were known to be present in 50% of the cases (R. Brown, personal communication, May 27, 2005). In addition, the majority of the women who flee abusive situations are not only protecting themselves from the abuse, but protecting their children from witnessing the abuse of their mother (Statistics Canada, 2002b). When asked specifically if their children were a priority during the violent episodes, all three mothers expressed that their children were their main priority during these stressful times. Furthermore, they stated that their main reason for leaving their abuser was the safety and well-being of themselves and their children.

As presented in chapters one and two, a variety of resources exist for women victims of violence in PEI. One of the most notable associations that provide services for abused women and their families is the Transition House Association of PEI. There are five Community Outreach Programs, coordinated by the Transition House Association of PEI, for women victims of violence that are located in five different areas across PEI. All three participants sought the services of this association. Susan and Vanessa sought the services of the Community Outreach Program in their area, while Jane utilized the services of the association itself, specifically Anderson House, which is the women's shelter located in Charlottetown. More specifically, Susan and Vanessa both sought

service and advice from the Family Violence Prevention Coordinator for their area. They were both very satisfied with the guidance and encouragement they received from this individual. The literature states that while battered women's shelters and support groups are the most specialized services offered to abused women, they are often the least contacted (Hollenshead et al., 2006). This is not the case with this pilot project as all three women sought the services of a shelter or support group intended specifically for abused women.

The fact that this service was offered free of charge and in an open and non-judgmental environment made it a positive experience for both of these women. This is consistent with the findings in the literature, as most women welcome support if it is non-judgmental (Bosch & Bergen, 2006). Bosch and Bergen revealed that many women who sought formal and informal support services were negated, discounted, blamed, misunderstood, and judged, thus taking away from the benefit of the support and having a negative impact on freeing the women from the abusive situation (Bosch & Bergen). Additionally, Susan expressed her satisfaction with the way in which a particular outreach coordinator provided advice and guidance. Nothing was made to look better than it was and any information was always presented in a realistic manner, which was greatly appreciated by all women. It has been found that these types of services are the most effective in helping abused women cope with the abuse (Hollenshead et al, 2006).

While Jane also used the services of the Transition House Association, she was a resident of the women's shelter, Anderson House. She spoke very highly of this shelter and the staff that run it. She felt very comfortable and safe at Anderson House, as she

had also been a resident of this shelter as a child, with her own mother. This was the first place Jane escaped to when she left her abuser.

Vanessa was not as aware of the support resources available to women victims of violence as Susan and Jane were. She expressed disappointment in the way she was treated, because no professionals from whom she had been seeking support notified her of the specialty services available for abused women. She did however, seek these more specialized services at a later time.

When discussing social support in relation to women victims of violence, Davis et al. (2003) reported that 65% of women surveyed state that, for a variety of reasons, there was no value in seeking help from family. These reasons include feelings of fear and shame, history of abuse within the family, and not wanting to disappoint other family members (Davis et al., 2003). Interestingly, this was not the case for Susan. She was overwhelmed with the support she received from her family and friends. It was her family and friends that were there for her in times of need and her friends were her confidants. The situation wasn't quite the same for Vanessa and Jane.

Vanessa had difficulty seeking help from her family, as they all reside in another province, making it difficult for her to be in contact with them on a regular basis. In addition to that, her in-laws did live in PEI; however she was not comfortable sharing her story with them, for the same reasons as listed above. She did not want his family to have to pick sides. She did not have any friends with whom she felt comfortable talking. In addition to the abovementioned reasons for women not sharing with family and friends, Davis et al. (2003) also found that women experienced difficulty in sharing this because if there was no evidence of physical abuse, for example, bruises and scars, then they are

often not believed. Vanessa experienced this, as she was not physically, but sexually and emotionally abused and had no visible evidence of violence.

Jane's experience with a social support network was similar to that of Vanessa's and more consistent with the literature. With the exception of two family members, Jane was isolated in her experiences with violence. The history of abuse within Jane's family played a large role in this. According to a study done by Cox (2003), when abused women feel isolated, it may lead to further isolation and make the woman more dependent on the perpetrator. Also, women living in rural areas were found to experience far greater isolation than women living in urban areas (Cox). It is hard to say whether or not Jane was more dependent on her abuser because of the extreme isolation she experienced. Her help-seeking behavior was obviously compromised by her isolation as she unwillingly remained with her abuser for a longer period of time than she had hoped.

Barriers to Support for Mothers Affected by Intimate Partner Violence

The secretive nature of the topic of abuse itself is a barrier to support for abused women. In a study conducted by Wolf et al. (2003), it was found that the abuser himself is one of women's greatest barriers in seeking support for the abuse. Overwhelmingly, the mothers interviewed in this study identified their abuser as one of their main barriers in seeking help. All three women were either emotionally or physically prevented from seeking support. Economic dependence is also reported as a barrier for women seeking support for abuse (Wolf et al., 2003). Leaving a relationship and learning to cope and live as a single parent is a daunting and frightening thought for most women. All of the participants were home-makers and did not work outside of the home, relying solely on their partners' income. Two of the three mothers interviewed are now receiving social

assistance, but all participants expressed their financial concerns time and time again throughout the interviews. Some examples of their financial concerns related directly to transportation and child care. More specifically, the women expressed their inability to participate in support activities if they had to pay for child care. In a study conducted by Bosch and Bergen (2006), participants discussed their need for physical support, which was similar with women in this pilot project. The needs of those in Bosch and Bergen's study included support with child care, household chores, transportation, and financial assistance however, it was found that these types of physical support were not helpful in freeing the women from abuse (Bosch & Bergen, 2006).

Another barrier to support as reported by the participants, are the feelings of guilt, shame, and embarrassment associated with being a victim of violence. According to the literature, this is common in most abused women. Krishnan et al. (2001) found that community attitudes, norms and outlooks prevent women from even acknowledging violence in their lives, let alone seeking support for such. Susan did express during the interview that when she was first approached by the outreach program coordinator, she hesitated to reply because she did not feel her case warranted intervention. It wasn't until she was a short time into the program, that she realized the desperate need and importance of help in her case. One study found that women who experienced emotional abuse, in the absence of physical or sexual abuse, consistently reported a lower level of comfort in seeking any type of support (Fraser et al., 2002). Women surveyed in a study by Davis et al. (2003) reported that emotional or psychological abuse was the most difficult to discuss with family and friends because "...without the bruises and scars women have little evidence of their abusive reality" (p. 339). Once she realized the

importance of accessing support, she was faced with feelings of shame and embarrassment. The resource center which she was supposed to attend was located in a local mall. She feared seeing someone she knew while entering this office, and thus her quest to obtain help was delayed yet again. This is a common concern of abused women, as evidenced in the literature which states that women seeking support for abuse are often faced with disapproving, or discomforting judgments because of their experiences with abuse (Bosch & Bergen, 2006).

Vanessa said she simply was not aware of any services available to her, which hindered her from finding support in a timely manner. She had to do some research of her own to seek the appropriate services. As noted above, Vanessa was overcome with exhaustion and her lack of energy prevented her from doing this necessary research in the early stages of the violence. Finding support was not a priority at the time. As the literature proves, abused women often suffer from depression (Browne, 1993; Coker et al., 2000; Levendosky & Graham-Bermann, 2001; Power, 2004;), which is characterized by a lack of energy and fatigue that hinder women from continuing with their day-to-day lives in the ways that they would like (Levendosky & Graham-Bermann, 2001). Additionally, Jaffee et al (2005) found that women victims of IPV have less access to important social supports.

One of Vanessa's other barriers that she spoke of was that of the law enforcement system. She felt law enforcement officials were not prepared to deal with her case which is still undergoing court hearings. She did not feel protected when she called the police, as they dismissed her complaints, leaving her feeling helpless. This is a common occurrence as reported by V. Campbell (personal communication, February 1, 2007). In

one study reported by Hollenshead et al. (2006), 39% of women surveyed found the police to be helpful, while 19% reported an increase in violent activity due to police intervention. It has only been in recent years that the legal system has changed the handling of IPV from the traditional viewpoint that IPV is a problem that should remain in the home, rather than be addressed in the judicial system (Hollenshead et al., 2006). This author also reported that women victims of violence are continuously seeking more information on judicial processes that surround IPV and that more education is needed in this area.

Law enforcement officials are not properly trained on how to deal with domestic violence cases, and thus the cases are often dealt with incorrectly and the women are not provided with adequate support or safety (V. Campbell, personal communication, February 1, 2007). Vanessa had no faith in the policing system in her area and therefore once again, was prevented from accessing the support she needed in times of crisis.

Jane's case was slightly different because she was aware of the various services available to her, but due to her past experience with violence, she did not believe she needed any type of specialized service. No literature was found to support these feelings. Jane was not able to seek support specifically due to her abuser. This is consistent with other studies that have reported the abuser being a large barrier for women who wish to access support for abuse. Her partner prevented her from leaving the house without him, and she had no phone or car. Wolf et al. (2003) identifies other barriers to seeking police help, with a large barrier being the abuser himself. In this study women revealed that they attempted to seek help and support, but were physically and/or emotionally prevented from doing so by their intimate partner (Wolf et al., 2003). Jane was both

physically and emotionally prevented from doing so. Economic dependence was also reported as being a large barrier for women seeking support, as leaving a relationship and beginning a new independent life, coupled with poor emotional status made it seem impossible to obtain help (Anderson et al., 2003; Wolf et al., 2003). Also, many women feared repercussions from their abuser which would lead to further consequences (Anderson et al., 2003; Wolf et al., 2003). This too, hinders women to seek help and support during times of crisis (Wolf et al., 2003; Anderson et al., 2003).

In addition to the abovementioned, Jane lived in rural PEI, which compounded the problem of finding help, a problem that is not only specific to Jane's case. Isolation is a difficulty experienced by women living in both urban and rural settings; however those in rural areas may experience even greater isolation. In one study that looked at the experiences of rural women seeking support for abuse, these women lacked transportation, access to money, job opportunities, and telephone service (Bosch & Bergen, 2006). Furthermore, "Many rural women with abusive partners have sought help from formal support networks but have been negated, discounted, or treated in a non-supportive manner" (Bosch & Bergen, 2006, p. 312). Moreover, Krishnan et al. (2001) states, "Extreme physical isolation, limited availability and access to appropriate social and health services, patriarchal family structures and views, and strongly held religious beliefs often complicate help-seeking in rural communities" (p. 29).

Mother's Preferences for Support

All three mothers interviewed expressed their desire to receive face-to-face, one-on-one support as opposed to any other means of support, such as group support. The community outreach programs offered just that, face-to-face, one-on-one support. These

programs are "a free and confidential service providing emotional support for women victimized by violence" (Government of PEI, p.2, 2005). While they offer the preferred method of service, one-on-one support, the programs also offer group support, wellness and lifestyle programs, public education, library resource materials, referrals and advocacy to other community services and agencies, and private and confidential appointments (East Prince Family Violence Prevention, n.d.). Jane also believes that support over the telephone would be beneficial to her, while Susan would be pleased to communicate with service providers via the internet, if needed.

Additionally, all participants in this study would prefer to receive support from a woman who has gone through a similar experience. The services of the Transition House Association of PEI are provided by trained women who honor confidentiality (THA, 2006), which was also deemed an important factor by the mothers; in the support they would like to receive. Vanessa specifically expressed that ultimately she would prefer to receive support from a non-judgmental and unbiased person. This is similar to how most women feel when asked about what type of support they would like to receive. Bosch and Bergen (2006) found that regardless of the types of support, women expressed their desire for it to be non-judgmental and that most women actually welcome the help if it is unbiased and non-judgmental.

While there are five community outreach programs spanning across PEI, Jane expressed her need to have more support services available in rural PEI. For example, PEI's only women's shelter is located in Charlottetown, PEI's largest city. When Jane was considering leaving her abuser with her children, she had to find transportation to Charlottetown to get to the shelter. This was a place where she was comfortable going,

where she felt safe from the harm that she might have sustained in the community if she had left her abuser and did not go directly to the shelter. Interestingly, battered women's shelters and support groups are the most specialized services offered to abused women, but these services are often the least contacted (Hollenshead et al., 2006). With no car and very little social support, this contact was virtually impossible for Jane. The acute care needs of this population are not addressed with current services available in rural PEI. The other two participants in this study preferred to seek support in their local area. They were pleased with the location of the services and felt these were easily accessible.

With all of the services offered across PEI, there are numerous programs that are offered with different durations. For example, the PEI Family Resource Centers offer over 65 programs to parents, children, and families (Social Development Canada, 2005). The mothers in this study have varying preferences when it comes to frequency and duration of support. Susan would prefer to only attend a meeting or program one day per month. This would be all the time she could dedicate to this, as she is extremely busy as a full-time university student and a single mother of three children. Any service that is more frequent than this would be unrealistic for her. Vanessa and Jane both felt that something provided on a weekly basis would suffice. These two participants wanted to be in more frequent contact with a service provider and especially Vanessa, felt that it was a necessity for her.

Ultimately, it has been concluded that no matter what services are being offered to abused women, they need to be flexible in terms of the mothers' needs.

There is a gap in programs aimed specifically at children, and in those which educate women on how to maintain a positive mother-infant relationship while enduring

abuse. Vanessa is hoping to see more of these programs in the future, and felt that these would be beneficial to her now as she continues to raise her two daughters by herself. The sixty-five programs offer by the Family Resource Centers across PEI focus on prenatal programs, parenting programs, parent support groups, teen parenting groups, and family management (Government of PEI, 2004). None of these programs address the needs of young children specifically. The PEI provincial government does offer a program, which Susan did attend, called "Positive Parenting from Two Homes". This is offered for parents and also for children aged six and older. However, such a program for younger children and infants does not exist.

Other preferences that the women would like to see in place in the future include transportation to the various services and programs. As noted above, this was one of Jane's barriers in accessing community support. Also, all three mothers indicated their desire to have child care provided for their children while they were participating in the programs. They all felt very strongly about not having their children present while they spoke of their abuse experiences. Another major source of stress for them, specifically Vanessa, was leaving her daughter with her abuser when she was attending her support sessions. It has been recognized that most, if not all of the services accessible to these women are offered free of charge. Once again, finances were a great stressor for these already stress-ridden women.

Limitations

A variety of limitations exist when conducting research. I encountered various barriers and hindrances throughout the course of this pilot project, most notably the

limitations specific to this project include the size and diversity of the sample and participant recruitment.

Sample Size

The sample size of this study was three mothers who had experienced IPV and had infants under the age of 36 months at the time of interview. The three interviews were rich in data and the thick description provides sufficient richness of data for the reader to consider transferring the findings to another setting.

Diversity of the Sample

It was hoped that the mothers would represent a wide range of educational levels, marital statuses, incomes, ethnicities, and be from various geographic locales. While some of these differences occurred, two of the three women came from very similar backgrounds and lived in the same area in PEI. All participating mothers appeared to be in the low to medium income bracket. As probability sampling was not entirely possible in this study, purposive recruitment of participants exhibiting a full range of socio-demographic characteristics would have fostered representativeness of the study sample.

Participant Recruitment

Although it was expected that 5-8 participants would suffice as a sample and would address the needs of the pilot project, only three mothers participated. Despite very aggressive and ongoing recruitment efforts (refer to Chapter Three); there were simply no women willing to participate. One may draw various conclusions from this; however I truly believe that the sensitive nature and secrecy that surrounds the research topic hindered women from choosing to participate. One participant did verbalize her hesitancy in contacting me as she too, was a University of Prince Edward Island student and feared

that I might know her or her family. She did not want to put any of her friends, family, or herself at risk by participating in this pilot project. Another participant mentioned that she was very apprehensive about sharing her personal story with a total stranger, while the third mother was not willing to portray her infant on video camera, which was a portion of the quantitative data collection.

Recommendations for Changes to Greater Research Study

As a result of the pilot project, the following changes have been made to enhance the greater research study.

- A more detailed interview protocol was developed. The interview guide has been reviewed and minor changes have been made to the wording of certain questions for the purposes of clarification. Some questions were eliminated due to repetition, while others were added to seek clarification on a specific point of discussion.
- This pilot project only consisted of collecting information from mothers affected by IPV; however there is a much broader approach that could be taken to obtain a more comprehensive viewpoint. As this study is part of a larger Atlantic Canadian study, it is important that the perspectives of others are obtained. More specifically, in terms of gaining information on the support resources, service providers will be included in the next phase of this study.
- It was decided that a child care worker was to be made available to any participant that felt these services were warranted.
- In an attempt to improve recruitment researchers are giving PEI mothers the option to be interviewed by an interviewer who does not come from PEI.

- After recognizing the importance of collecting field notes, a field note form was drafted.

Recommendations for Future Research

In depth exploration of an issue always leads to more questions and recommendations for future research. Based on the abovementioned findings and conclusions, the following are recommendations for not only future research, but also for communities and parties that deal with IPV in their daily work.

Recommendation 1

Identify the current knowledge and understanding that law enforcement officials have regarding IPV and provide professional training to enable them to better deal with all occurrences of domestic violence. Many times, domestic violence cases are not dealt with by law enforcement officials in the appropriate manner due to a lack of knowledge of the many aspects of IPV.

Recommendation 2

Implement the same study in other Canadian provinces, not only the Atlantic Provinces, to obtain a more holistic and national perspective on this topic. This could include a more comprehensive comparison of cases involving a wide range of socio-demographic characteristics in both rural and urban areas.

Recommendation 3

Identify what other Canadian provinces are doing in terms of support interventions relating to IPV and evaluate the advantages and disadvantages of such. Implement support resources that appear to be successful across PEI.

Recommendation 4

Create an interdisciplinary task force to assess the needs of women affected by IPV to obtain a global perspective on the various issues that surround this topic. This task force could address these needs based on the expertise of various parties and devise a comprehensive plan to tackle these serious issues. Implementation and evaluation of the identified plan could then be carried out and further intervention implemented based on the evaluation.

Recommendation 5

Educate the general public on the signs and symptoms of IPV and provide information on how to recognize IPV, what to do and where to go when faced with a suspected case of IPV of a friend or family member.

Recommendation 6

Implement support resources in rural areas of PEI. Provide access, childcare, and transportation to these services free of charge or at an affordable cost.

Recommendation 7

Develop programs and/or services that specifically address issues related to mothering through violence. This would include education for mothers on how to maintain and nurture the mother-infant relationship in violent situations.

Recommendation 8

Lobby the necessary parties to implement a policy that requires all infants and children who are known to have been mothered through violence to undergo a medical assessment to identify any problems with growth and development at the earliest stage possible. If

needed, refer mother and child to appropriate specialized professionals for additional care.

Concluding Comments

This research has not only provided me with a valuable academic learning experience, but has broadened my knowledge of this taboo subject in more ways that can be described. The significance of this study cannot be denied. It has shown that mothers, infants, and the mother-infant relationship can be drastically affected by IPV in more ways than formerly understood. The lack of support available to women victims of IPV across PEI requires immediate action, and the information learned in this study can be used to address this very issue.

The mothers who participated in this study were very welcoming and willing to help in any way possible. I have learned first hand of the true richness of the data that can be found through qualitative research. The powerful stories shared by these brave women have opened new doors in terms of a call for more effective policy and community development. Their personal stories have proven to be invaluable.

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Appendix A

Mothers' Interview Guide

(to be completed after informed consent procedure)

Now that we have gotten to know a bit more about you (via demographic form), we can begin with the interview.

34. ***Experience in Violent Relationship*** (this section adapted from L. Tutty SSHRC-CURA funded project, and CDC IPV definition, (Saltzman, Fanslow et al. 1999))

After reading the information letter, you know that we need to know about the violent relationship you were in while you had your baby ***(Name index child as there might be more than one child).*** *I need to start asking you about that now. Remember that we can take a break from the interview whenever you want and you can pass on any questions that may make you uncomfortable. I can also put you in touch with services who can provide help if you are interested. I'd like to begin by learning about what the word "violence" means to you and the violent relationship you were in when your baby was less than one year old.*

1. What does the word "violence" mean to you? Probe: Sexual violence? Physical violence? ***Note to interviewer: This discussion helps ensure that participant meets CDC definition of abuse and thus our screening criteria. If participant's definition of violence varies from the CDC definition, participant is ineligible to participate in study. Data collection should be terminated and the mother referred for support as appropriate.***
2. What was your relationship with that partner *at the time you experienced the violence*?
   a. Current spouse (including common-law spouses)
   b. Former spouse (including common-law spouses)
   c. Dating partner
   d. Current boyfriend
   e. Former boyfriends
   f. Separated spouse
   g. Divorced spouse
3. How long were you in the relationship with that partner?

4. When did he start acting abusively toward you? Probe: When did the violence begin?
5. What was the nature of the abuse?
   a. Physical violence
   b. Sexual violence
   c. Threat of physical or sexual violence
   d. Psychological/emotional abuse (including coercive tactics) when there has also been prior physical or sexual violence or prior threat of physical or sexual violence
6. How long did the violence persist? (Probe: did it happen all the time, i.e. chronically, or infrequently?)
7. How long did you stay in the relationship?
8. How old was the baby when you left?

[If the woman seems comfortable talking about the nature of the abuse, you might ask her about:]

1. the most serious incident, and;
2. the most recent or last incident

B. Perceived Impact of Violence on Mother-Infant/Child Relationship

9. What is your understanding of what it means to take care of a baby? (Probe: What do you think babies need?)
10. Do you think that the violence affected your relationship with your infant? (with each probe for examples of situations)
    a. Do you think that it (being the violence) affected your bond or connection with your infant?
    b. Do you think that it affected your ability to soothe, comfort, or console your infant?
    c. Was your desire to be with, play with, talk to, or have fun with your baby affected by the violence?
    d. Looking back, would you have liked help managing the effect of the violence on your relationship with your baby?
11. Do you think that the violence affected you as a mother?

12. Do you think that the violence affected your family environment?

13. Do you think that the violence affected you (probe for self-esteem, confidence, relationship with others, mood/emotions, coping ability)

14. Do you think that the violence affected your relationship with your infant? (Probe for examples of situations when mother was concerned.) If yes, looking back, would you have liked help managing the effect of the violence on your relationship with your baby?

15. If applicable, are there any differences between the relationships you have with your children who were parented through violence compared to those that weren't?

16. How would you describe your relationship with your child(ren) who were in the violent relationship today? How do you expect your relationship(s) to be in the future?

C. Perceived Impact of Violence on Child Development

17. Do you think the violence has affected your child? Probe for:

- Relationships with friends/peers
- Social interactions
- Family relationships
- Behaviour
- Personality
- Anything else

D. Perceived Impact of Violence on Mother-Child Relationship and Child Development

18. Do you think that the way you parented your child *during the violence* affected how your child was developing *then*? If so, how? If not, why not?

19. Do you think that the way you parented your child *during the violence* affected how you child is developing *now*? If so, how? If not, why not?

20. Do you think that the way you parent your child *now* affects how your child is developing *now*? If so, how? If not, why not?

E. Support Needs and Resources for Mother-Infant Relationships

21. *I can only imagine what living through violence must have been like for you. Mothers in these situations may only be able to focus on survival. Having said that,*

were you able to focus on your relationship with your baby (the way you would have liked to)?

[Probes: Why or why not? What prevented you from focusing on your relationship with your baby (the way you would have liked to? How is it that you were able to focus on your relationship with your baby?]

22. *You had many priorities in the difficult situation you faced.* When you and your baby *(Name)* were in the violent relationship, did you know about any support services that could have helped:

- You?
- Your child?
- Your relationship with your baby?

(Note: Provide examples of services if mothers cannot name any. E.g. STEP, Nobody's Perfect, Learning Begins, Lasting Gifts, 1 2 3 4 Parent, Parenting the Zap Family, Rock and Talk)

23. Did you use any of these services just mentioned?

24. When you were experiencing the violence, did anyone else help you with your relationship with your baby, e.g. family, friends, spiritual community member, etc.? (Probe: Who helped you? What did they do?)

25. Did anyone (e.g. family, friends or service professionals) help you with needs related to mother-infant relationships and specifically consider your special circumstances of being in or having recently left a violent relationship? If yes, probe for specific details:

- Who? (e.g. family, friend, professional, other)
- What did they do? (Probe for emotional, affirmational, instrumental, informational support provided.)
- What was helpful? What was not helpful?
- Form (face-to-face, telephone, computer)?
- Length?
- Frequency?
- Duration?

F. Barriers to Support for Mother-Infant Relationship

26. Thinking back, what were the things that made it hardest for you to find/receive support to help you in your relationship while you were in the violent relationship with your baby? Probes:

- Can you describe the types of things that made it hard for you to find/receive support?
- Were there any other barriers to support that you experienced? (e.g. transportation, finances, time, energy, or anything else)

27. What could have been done to make it easier for you to find/receive support to help you in your relationship with your baby?

28. Were you in a situation that required you to accept support? (i.e. child welfare)

G. Preferences for Mother-Infant Relationship Support

29. What could have helped (1) you, (2) your relationship with your baby? (Probe: services, other supports) While it might be difficult for you to separate what could have helped you:

- While you were still in violent situation; and
- After having left a violent situation,

We'd like to hear your thoughts.

30. I have some specific questions about your support preferences. In addition to the support you received, if any, would you have liked: (* Probe each item: Why? Can you tell me more about that?)

- One-on-one support for mother-infant relationships
    - Would you have liked support from one more person?
    - If you could have had support provided to you by one additional person, who would you have liked that to be? [Probe: professional, woman who had experienced IPV; family; friend; someone else?]
- Group support for mother-infant relationships:
    - Would you have liked group support?
    - If you could have had support provided to you by a group, who would you have liked the other members to be? [Probe: professionals, mothers who had experienced IPV, family, friends]

- Who would you prefer to facilitate the group? [Probe: professionals and/or mothers who have experienced IPV?]

31. Support for mother-infant relationships can be offered in various ways: Would you have preferred the support to be:

a. in person/face-to-face

b. online/via computer

c. by telephone

d. some other way?

32. If a program were developed to support mother-infant relationships for families affected by IPV, what would be the most desirable:

a. location

b. duration

c. timing of program

d. frequency

33. If a program were developed, what would be the most important issues to deal with in supporting mother-infant relationships affected by violence? Probes:

a. Affirmation support (encouragement, feedback, providing perspective or a point of comparison on behaviours, thoughts, or feelings)

b. Emotional support (empathetic listening, acceptance, understandings and reassurance, making someone feel cared about and accepted)

c. Instrumental support (tangible support such as child care, preparing a meal, running an errand, or lending money)

d. Informational support (providing useful and relevant information, talking through possible ways to solve a problem, answering questions, sharing personal experiences)

34. Do you have any other suggestions or comments?

Appendix B

Dear Participant,

My name is Julia Campbell and I am a registered nurse and student working towards a Masters degree at the University of Prince Edward Island. I am conducting a research project as part of my studies and would like to invite you to participate. The study is looking at family violence and how this affects mother-child relationships.

This letter will provide you with information regarding the research study. It is meant to help you make an informed decision regarding your participation. The purpose of the study is to examine the impact of family violence on mother-infant relationships and to identify the support needs and barriers for women experiencing such violence in their lives. Information learned from this study may help health professionals to develop new and improved ways to support and help mother-infant relationships affected by family violence.

If you choose to participate in the study after reading this letter of information, I ask that you contact myself by phone (902[redacted] or email [redacted] The information will be gathered using interviews. These interviews will consist of only myself and you, and should take no more than two hours of your time. Child care will be provided and you will be paid $25 for your time and effort in taking part in the study.

Even though you can only participate if you are no longer in a violent relationship, it is important to recognize that there is the possibility that your abusive spouse may find out that you are participating in a research study. I must also emphasize that I will do everything in my power to prevent this from happening. You have the right to withdraw from the study at any time without penalty or prejudice. Your name, the name of your children or any other identifying information will be kept strictly confidential. The interview will be tape-recorded and one short part of it will be video-taped. All tapes and written information will be kept in a locked filing cabinet that is only accessible to myself, my supervisor, Dr. Kim Critchley, Dean of Nursing, University of Prince Edward Island, and Dr. Nicole Letourneau, Principal Investigator of the Atlantic Canadian study. The study findings will be reported in a way that no one answer can be attributed to any one participant. It is important however, that you recognize that in small communities there is the possibility that an individual may be recognized even if no identifying information is included. All efforts will be made to ensure that this does not happen, although it is important that you recognize this possibility and are able to make an informed, voluntary choice regarding your participation. Also, given the possibility of experiencing negative feelings because of your participation in this study, counseling services will be provided free of charge, if needed.

If you have any questions or concerns, please do not hesitate to contact me at the number or email address provided above.

Thank you for you interest and cooperation in this research study.

Sincerely,

Julia Campbell

Appendix C

Consent Form for Participant

Supporting Mother-Infant Relationships Affected by Intimate Partner Violence in Prince Edward Island: A Pilot Project

Introduction:

I am a graduate student currently working towards a Masters in Applied Health Services Research at the University of Prince Edward Island. As part of the curriculum, I am conducting a research study in which I am inviting you to participate. Your participation is entirely voluntary and you may withdraw from the study at any time without penalty. Your participation may be scheduled at a time and place that is convenient and safe for you. If you have any questions, comments, or concerns regarding your participation or the study, please do not hesitate to discuss these with myself.

Purpose of the Study:

The purpose of the study is to examine the impact of intimate partner violence on mother-infant relationships and to identify the support needs and barriers for women experiencing violence in their lives. Information learned in this study may help health professionals to develop new and improved support interventions to promote mother-infant relationships affected by intimate partner violence.

Study Design:

If you choose to participate, this study will involve approximately two hours of your time. The research approach involves meeting with myself for a face-to-face interview. The interviews will be tape-recorded and one small part of it will be video-taped. During the interview I will ask you questions about your experience with intimate partner violence. In addition to the interview, you may be asked to fill some small questionnaires that will discuss issues such as your infant's development, family functioning and experiencing difficult life circumstances.

Possible Risks and Benefits:

This study does not include the administration of any intervention or treatment. The results of the study will be summarized in a way that no information can be attributed to any specific participant. It is important to recognize that you may experience emotional or psychological distress resulting from your association with such a study. For example, one may feel angry or embarrassed when responding to interview questions. Additionally, even though you can only participate in this study if you are no longer in a violent relationship, it is important to recognize that there is the possibility that your abusive spouse may find out that you are participating in the research. I must also emphasize that I will do everything in my power to prevent this from happening. Given the possibility of experiencing negative feelings

because of your participation in this study, counseling services will be provided free of charge, if needed.

There are potential benefits that you may experience. These include: comfort in being able to discuss their situation or problem with a friendly, objective person and increased knowledge about themselves, either through opportunity for introspection and self-reflection or through direct interaction with researchers.

Compensation:

Child care will be provided to allow participants to focus on the interview and measurement processes. An honorarium of $25 will also be provided to acknowledge the time and efforts involved in your participation.

Confidentiality:

Your anonymity will be achieved by not having identifying information in the final report. Results of the study (ie. answers to interview questions) will be reported in a summarized manner with no identifiable information attached. This will ensure that information cannot be attributed to any one participant. The interview transcripts will be locked in a filing cabinet at UPEI and will only be accessed by myself, my research supervisor, and the principal investigator of the Atlantic Canadian study. All contact information is included below. Following a five (5) year time period all information will be destroyed.

It is important to mention however, that in small communities there is the possibility that an individual may be recognized even if no identifying information is included. All efforts will be made to ensure that this does not happen, although it is important that you recognize this possibility and are able to make an informed, voluntary choice regarding your participation.

Questions, Problems, or Concerns:

Questions about your participation in the study can be addressed to: Julia Campbell, Researcher [redacted] or phone (902) [redacted] or Dr. Kim Critchley, Dean of Nursing, University of Prince Edward Island, kcritchley@upei.ca, (902) 628-4300, Dr. Nicole LeTourneau, Principal Investigator, University of New Brunswick, nicolel@unb.ca, (506) 458-7647. As mentioned, counseling services will be offered free of charge, if needed.

In the event that you have any difficulties with, or wish to voice concern regarding any aspect of your participation in this study, or in regards to the ethical conduct of the research, you may contact the UPEI Research Ethics Board at 566-0637 or by email at lmacphee@upei.ca

Voluntary:

You may refuse to participate in this study. You may withdraw from the study at any point during the process without penalty or prejudice. Please indicate to the researcher your wish to do so at any time.

Signatures:

I have read and understand the material in the attached information letter. I understand that my participation in the study is voluntary and that I may refuse to participate or withdraw from it at any time. I also have the freedom to not answer any question. I understand that no person other than J. Campbell will know my answers to the interview questions or any of my demographic information. I understand that I can keep a copy of the signed and dated consent form.

I am indicating that yes, I will participate in the study by taking part in the interview.

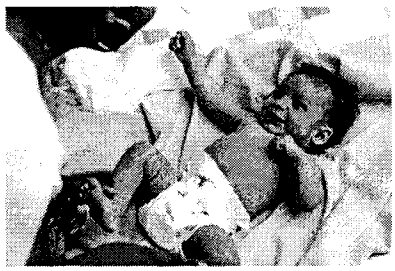
Participant's Signature, Date

I have explained the study to the above participant and have sought her understanding for informed consent.

Researcher's Signature, Date

Appendix D

Family Violence



Research Study

- Are you interested in taking part in a research study on family violence?

- Are you a mother who has a child aged 36 months or younger and have experienced violence in your life, but are no longer involved in a violent relationship?

Purpose of research study: To examine the impact of family violence on mother-infant relationships, infant development and to identify the support needs and barriers for women experiencing violence in their lives.

If you are interested in participating, please contact:
Julia Campbell (RN) at
(902) [redacted]
Or email [redacted]

Information learned from this study may help health professionals develop new and improved ways to support and help mother-child relationships affected by family violence.

Participants will receive financial compensation.

Appendix E

Looking for Participants...

For a Research Study on Family Violence

- Are you a mother who has a child 36 months of age or younger and have experienced violence in your life?

If so, then you may be eligible to participate in this important study looking at infant development and mother-infant relationships.

Participants will receive financial compensation.

If you are interested in participating, please contact:
Julia Campbell RN at
(902) [redacted]
Or email [redacted]

Appendix F

Personal Communication

Name	Position
Rona Brown, MSW, RSW	Prince Edward Island Family Violence Consultant.
Gordon Campbell, BA, MPA, LLB	Prince Edward Island Supreme Court Judge
Valerie Campbell, LLB	Crown Prosecutor with Family Protection Unit Edmonton of Alberta Justice, Coordinator of Family Violence Initiatives for Alberta Department of Justice.
Norma McColeman	East Prince Family Violence Outreach Coordinator (PEI).
Anne Nicholson	Project Coordinator, "Circle of Caring for Children Living in Situations of Family Abuse: A Project of Voices for Children Coalition"
Valerie Smallman	Coordinator for West Prince Family Violence Prevention (PEI).
Dr. Gail Storr, RN, BN, MEd, PhD	Professor, Faculty of Nursing, University of New Brunswick; Professor, Applied Health Services Research, Atlantic Regional Training Center.

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Appendix G

UNIVERSITY of
CE EDWARD ISLAND

5 University Avenue
Charlottetown
rince Edward Island
Canada C1A 4P3

January 27, 2006

To: Ms. Julia Campbell
School of Nursing

Dear Ms. Julia Campbell ,

Re: "Supporting mother-infant relationships affected by intimate partner violence in Prince Edward Island: A pilot project"

The above mentioned research proposal has now been reviewed under the expedited review track by the UPEI Research Ethics Board. I am pleased to inform you that the proposal has received ethics approval.

The approval for the study as presented is valid for one year. It may be extended following completion of the Annual Renewal and Amendment Form. Any proposed changes to the study must also be submitted on the same form to the UPEI Research Ethics Board for approval.

Sincerely,

[redacted]

Malcolm Murray, BA, MA, Ph.D.
Associate Professor of Philosophy
Chair, UPEI Research Ethics Board

cc: Dr. Katherine Schultz, Vice President, Research & Development, UPEI

Dr. Kimberley Critchley, School of Nursing