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**The Complexities of Intimate Partner Violence: Mental Health, Disabilities and Child Abuse History for White, Indigenous and Other Visible Minority Canadian Women**

Leslie M. Tutty, H. Lorraine Radtke, Christine Ateah, E. Jane Ursel, Wilfreda (Billie)

Thurston, Mary Hampton, & Kendra L. Nixon

**Abstract**

This research examines how mental health issues associated with IPV relate to women's intersecting identities of race/ethnicity, disability status, and child abuse history. Data ( $N = 595$ ) from a Canadian tri-provincial study included women who were White ( $n = 263$ , 44.8%), Indigenous ( $n = 292$ , 49.7%), or visible minority ( $n = 32$ , 5.5%). Few demographic differences were found. None of the mental health measures (SCL-10; CES-D-10; PTSD Checklist) were in the clinical ranges. In a MANCOVA on the mental health scales, with IPV severity, racial group, disability status and child abuse history as variables, only disability was significantly associated with more mental health symptoms.

Key words: intimate partner violence; violence against women; family violence; mental health, trauma; disability; racial and ethnic backgrounds

## **The Complexities of Intimate Partner Violence: Mental Health, Disabilities and Child Abuse History for White, Indigenous and Other Visible Minority Canadian Women**

Violence against women is a significant social issue that often results in injury, emotional harm, and, at worst, death (Johnson, 2006). In the General Social Survey on Victimization (GSS) in Canada (Statistics Canada, 2011), with data collected in 2009 (closest to that in the current study), about 5% of women were abused by spouses in the past five years. The three prairie provinces, the sites of the current study, had the highest rates of self-reported spousal violence (national average = 6%; Saskatchewan = 8.2%; Alberta = 7.6%; Manitoba = 7.4%).

Intimate partner violence (IPV) includes physical abuse and sexual abuse (Romans, Forte, Cohen, Du Mont, & Hyman, 2007). Every year across Canada a small number of women are murdered by their partners as the tragic result of violence in their relationships (Dawson, Bunge, & Balde, 2009). In addition, many women endure years of intense psychological abuse that impacts their lives and the lives of their children (Ansara & Hindin, 2011). Women are typically abused in multiple ways, each of which can have a cumulative effect on their feeling trapped and ineffective in either coping with the violence or fleeing their abusive partners. Further, women can be at increased risk of abuse after separating from their partners (Brownridge et al., 2008; Fleury, Sullivan, & Bybee, 2000).

While the rates of IPV are important indicators of its severity as a social problem, considerable research has examined the mental health consequences of IPV, disabilities that may make women vulnerable to IPV, connections between IPV and child abuse, and differences among women from varied racial and ethnic backgrounds (e.g., Hahn, McCormick, Silverman, Robinson, & Koenen, 2014; Lacey, McPherson, Samuel, Sears, & Head, 2013). We view race as a social construct that has been claimed by some to be biological but has more to do with one's

experience in a society with unequal rankings of cultural or biological characteristics. In a dominantly Caucasian society, for instance, people not identifiable as Caucasian for whatever reason are often racialized and suffer discrimination because of that (Bhopal, 2004).

This article takes an intersectional perspective (Sokoloff & Dupont, 2005) in examining concurrently multiple facets (racial and ethnic backgrounds, disabilities, and experiences of child abuse) of the lives of almost 600 women abused by intimate partners who sought assistance from IPV services in Canada's three prairie provinces. It addresses the complexities of their lives, assessing similarities and differences that could suggest unique circumstances and better ways for service providers to understand their needs.

### **Theoretical Orientation: An Intersectionality Framework**

Intersectionality is “a theoretical or analytical approach that simultaneously considers multiple categories of identity, difference, and inequality (such as gender, race, class, sexual orientation, disability, as well as others)” (Else-Quest & Shibley Hyde, 2016, p. 155). Originally conceived as a counterpart to the idea that all women are at equal risk of IPV, intersectionality is becoming a commonly-used framework in IPV (Bent-Goodley, 2007), health (Hankivsky et al., 2010) and disability research (i.e. Cramer & Plummer, 2009; Lightfoot & Williams, 2009). While “giving voice” to marginalized populations is a common goal of research informed by intersectionality theory, it also provides a means of identifying conditions that are particularly advantageous or disadvantageous.

The following sections present a brief overview of research on the variables of interest in the current analysis, highlighting Canadian studies about the intersections of race/ethnicity, disability status and child abuse history as related to IPV and mental health.

### **Racial and Ethnic Origins and Intimate Partner Violence in Canada**

Not all Canadian women face the same risks of IPV or have the same IPV experiences. In the Canadian context, Indigenous people (previously labelled “Aboriginal,” a term originally from government) are a large, important sub-population, and yet, there is relatively little research on IPV among Indigenous Canadians. The term “Indigenous” includes First Nations, Métis, and Inuit peoples and represents about 4.6% of Canada’s population (Statistics Canada, 2013a). According to Brownridge (2008), Indigenous women are at risk of being abused by intimate partners (21%) three times higher than the risk for non-Indigenous Canadian women (7%). As noted by Brenan (2011), Indigenous women often endure the most serious physical and sexual IPV. A number of structural issues in Indigenous communities contribute to the greater risk including high rates of poverty, lack of services, loss of traditional lifestyles, and loss of parental role models because of residential schools and colonization (Brownridge, 2008).

Other than Indigenous women, those who are non-White will be referred to as “visible minorities” and make up a noteworthy portion of the population of Canadian women. In 2011, the percentage of visible minority women and girls was 19.3% of the total female population, according to Statistics Canada (2013b), with South Asian, Chinese and Black the most common visible minority groups, representing a continuous, upward trend since the 1980s. In a study comparing visible-minority Canadian women to White Canadian women, Hyman, Forte, Du Mont, Romans, and Cohen (2009) found no differences in the self-reported rates of physical and or sexual violence in the last five-years. Further research examining these groups is needed to more adequately understand both the risks of IPV and how it is experienced.

### **Women with Disabilities and Intimate Partner Violence**

The World Health Organization (Bank, 2011) takes a bio-psycho-social perspective of disability, using Leonardi et al.’s (2006) definition as, “the umbrella term for impairments,

activity limitations and participation restrictions, referring to the negative aspects of the interaction between an individual (with a health condition) and that individual's contextual factors (environmental and personal factors" (p. 4). Given the physical nature of much IPV, many women suffer long-term physical consequences (Dutton, 2009). In a recent national US study, Breiding and Armour (2015) found that, compared to women without disabilities, women with disabilities were significantly more likely to report each type of IPV measured, including physical violence, stalking, and rape, a finding generally supported in US research (Barrett, O'Day, Roche & Lepidus Carlson, 2009; Hahn et al., 2014) and in Canada (Brownridge, 2006; Cohen, Forte, Du Mont, Hyman & Roman, 2005; Yoshida, Du Mont, Odette & Lysy, 2011).

*Mental Health, Intimate Partner Violence and Child Abuse History*

Research that considers mental health status shows that women affected by such disorders are more vulnerable to being abused by intimate partners than women without mental health issues (Du Mont & Forte, 2014). Women who have experienced chronic and ongoing abuse from their partners are often diagnosed with mental health issues such as depression and anxiety (Ferrari, et al., 2014; Perez, & Johnson, 2008; White & Satyen, 2015). Researchers have also found high rates of Posttraumatic Stress Disorder (PTSD) (Coker, Weston, Creson, Justice & Blakeney, 2005; Dutton, 2009; Woods, 2004), which Perez and Johnson (2008) note can compromise women's safety after leaving abusive partners.

Another variable associated with disabilities is a history of child abuse, which is correlated with mental health concerns (often among victims of child sexual abuse), or physical disabilities (often because of child physical abuse) (Ballan et al., 2014). Abused children are at high risk for further victimization as adolescents or adults (Barnes, Noll, Putnam, & Trickett, 2009; Widom, Czaja, & Dutton, 2014). While PTSD has been associated with childhood abuse,

especially child sexual abuse (Clemmons, Walsh, DiLillo & Messman-Moore, 2007) and IPV (as noted previously), given that many women experience both (Widom et al., 2014), the interconnections are important (Becker, Stuewig, & McCloskey; 2010 Nicolaidis, McFarland, Curry & Gerrity, 2009).

### **The Current Study**

The current study adds to our understanding of these issues by presenting descriptive data from almost 600 women using an intersectionality framework (Bent-Goodley, 2007) that focuses on a number of social identity variables including racial and ethnic background, childhood abuse history, and mental and physical disabilities in combination. More commonly, these social differences are presented as though they are independent and separate. For example, national studies that focus on racial background and IPV seldom collect standardized assessments of mental health symptoms (e.g. Du Mont & Forte, 2014) or studies that focus on disability status and IPV may not collect information on race and ethnicity (e.g. Cohen et al., 2005).

The Healing Journey data set includes information about numerous background variables as well as scores on standardized mental health measures and allows for a more complex picture of how women's social locations are related to their experiences of IPV. Because Canadian statistics suggest differences in the context of abuse in White, Indigenous, and visible minority populations, it was of interest to examine potential group differences in mental health functioning. Lacey et al. (2013), Bent-Goodley (2007) and White and Satyen (2015) all suggest the importance of comparing abused women from different racial/ethnic groups because of structural factors that differentially affect their lives and help-seeking. As one example, in the Canadian 2005 General Social Survey, Indigenous women had much higher rates of post-separation IPV than non-Indigenous women (Pederson, Malcoe & Pulkingham, 2013).

Women abused by partners often seek counselling and health professionals need to understand the context of their presenting symptoms. Understanding their mental health concerns in conjunction with disability status and child abuse history could assist them in providing more appropriate support and interventions.

The current study had three objectives: (1) to provide a descriptive profile of women identified as having experienced IPV in the prairie provinces of Canada taking into account their social locations as Indigenous, visible minority or White women; (2) to explore the abuse experiences and mental health of women reporting disabilities compared to those who did not report a disability; and (3) to examine possible intersections of these key variables.

## **Method**

### **Research Sample**

“The Healing Journey” is a longitudinal, Canadian study of 659 abused women from the three western provinces of Alberta, Saskatchewan and Manitoba. Both academics and community agency members of the research team assisted in designing the research, recruiting participants, and interpreting the results. Data for the entire study were collected in seven waves between 2005 and 2009, although the current manuscript only analyses data from Waves 1 and 2.

The research protocols were approved by the six universities associated with the academic research partners. To identify possible organizations from which to recruit, each province conducted an environmental scan of IPV agencies. The intent was to recruit broadly so as to access women seldom included in research such as those from remote communities. The organizations included violence against women shelters and counselling agencies, some with specific IPV programs, across the three provinces and chosen to cover urban, rural, and northern sites. Volunteers were recruited through information sessions at agencies, sealed envelopes

containing information about the study provided by agency staff, and posters. The criteria for inclusion were: being a minimum 18 years of age; the most recent incident of IPV no sooner than three months prior to recruitment; commitment to stay in the study for the full four years; and no serious or debilitating mental health issues.

### **Research Measures**

For the Healing Journey study as a whole, four surveys were created to address demographic background and history of abuse, general functioning and service utilization, health, and parenting. These surveys included standardized measures as well as open-ended and closed-ended questions developed specifically for the study. We also included questions asking the women to self-report physical and mental health conditions (whether or not these were formally assessed by medical personnel is unknown) and whether these conditions affected their employability or kind or amount of daily activity. These data were used to create a “disabilities” variable; women were identified as having a disability if their physical or mental health conditions affected employability or other activities. Child abuse history was collected via structured questions, “Were you abused as a child or adolescent? a) physical, b) sexual, c) emotional/psychological, d) witnessing abuse among family members, etc.

The nature of the IPV was assessed by the Composite Abuse Scale (CAS) (Hegarty, Bush, & Sheehan, 2005). This screening measure consists of 30 items, rated for frequency in the past 12 months on a six-point scale from “never” to “daily,” with a possible total of 150. The four subscales are: Severe Combined Abuse (8 items; possible score 0-40; suggested cut-off of 1); Physical Abuse (7 items; possible score 0-35; cut-off of 1); Emotional Abuse (11 items; possible score 0-55; cut-off of 3); and Harassment (4 items; possible score 0-20; cut-off of 2). The suggested clinical cut-off for the total score is 3 or 7 to minimize false positives (Hegarty &



Valpied, 2013). The scale has demonstrated convergent and discriminant validity (Hegarty et al., 2005). Cronbach's alpha for the CAS in the current study is .93.

The Symptom Checklist, Short Form (SCL-10) (Nguyen, Attkisson, & Stegner, 1983) is a screening tool to assess global mental health functioning and psychological distress in the previous week. This short form of the SCL-90 (Derogatis & Cleary, 1977) includes six depression questions, two somatization items, and two phobic/anxiety items. Items (e.g., "In the past week, how much were you distressed by feeling lonely?") are endorsed with a 0 to 4 Likert scale, with zero indicating "not at all," and four indicating "extremely." Higher scores indicate more psychological distress. ). Suggested clinical cut-off scores are one standard deviation above the mean (Jacobson, Follette, & Revenstorf, 1984). With an average of 7.8 and *SD* of 6.3, in Müller, Postert, Beyer, Furniss and Achtergarde (2010), which used the SCL-10 identically to the current study, the clinical cut-off score is 14.2. Cronbach's alpha in the current study is .89.

The CES-D-10 (Centre for Epidemiological Studies - Depression), a measure developed for research purposes, is a short form of the CES-D-20 (Radloff, 1977) to document depression symptoms in the previous week (Andresen, Malmgren, Carter, & Patrick, 1994). Ten items (e.g., "In the past week I was bothered by things that usually don't bother me?") are rated on a 0 to 3 Likert scale, with zero as "rarely or none of the time (less than 1 day)," and three as "all of the time (5-7 days)." Internal consistency and test-retest reliability are good (Björgvinsson, Kertz, Bigda-Peyton, McCoy, & Aderka, 2013). Cronbach's alpha in the current study is .84. Björgvinsson et al. suggest that a cut-off of 15 has the best "sensitivity" and "specificity."

The PTSD Checklist (Blanchard, Jones-Alexander, Buckley, & Forneris, 1996) is a 17-item self-report questionnaire that measures the three symptom clusters of posttraumatic stress disorder (PTSD), as defined by the Diagnostic and Statistical Manual of Mental Disorders

(American Psychiatric Association, 1994) in the previous month. The symptom clusters are re-experiencing (5 items), avoidance/numbing (7 items), and hyperarousal (5 items). The questionnaire was developed with a sample of primarily women sexual assault and motor vehicle accident victims. Items (e.g. “In the past month how much have you been bothered by repeated, disturbing memories, thoughts or images of abuse or violence?”) are endorsed with a 0 to 4 Likert scale with zero meaning “not at all” and 4 meaning “extremely.” Blanchard et al. recommend a clinical cut-off of 44. The scale has good psychometric properties (Cronbach’s  $\alpha = .94$ ; Blanchard et al., 1996). Cronbach’s  $\alpha$  in the current study is .92.

### **Research Procedures**

The first wave of The Healing Journey data collection commenced in 2005, with five additional waves of data collected every six months over 3.5 years. To provide a baseline for the subsequent longitudinal data analysis (author citation, in preparation), the current descriptive data were from the first two waves, with demographic characteristics and information on the nature of the IPV experienced coming from Wave 1 and mental health measures collected in Wave 2. At each wave, the questionnaires were administered face-to-face, with female interviewers reading the questions and recording the answers to ameliorate any problems with literacy. The more than 50 interviewers were a mix of upper-level undergraduate and graduate university students and professionals from the communities surveyed, with training the responsibility of each province. The interviews lasted from one to two hours and the study participants were provided an honorarium of \$50 each time. To minimize attrition, interviewers contacted the women at least once between waves and each interviewer interviewed the same women as long as both remained part of the study.

### **Data Analysis**

Categorical descriptive data were analyzed with Pearson's chi-square analysis with effect sizes calculated with Cramer's V, computed when the chi-square is significant. Standardized residuals were calculated to identify the category differences responsible for the statistically significant chi-square (Field, 2009). Numerical data were compared with analyses of variance with Bonferroni procedures as post hoc tests when findings were statistically significant. Effect sizes were interpreted using Rea and Parker's (2002) suggested benchmarks of under .10 as a "negligible" association; between .10 and under .20 as a "weak"; between .20 and under .40 as a "moderate", and between .40 and under .60 as a relatively "strong" association (p. 203).

Because of the interactions between many of the variables of interest, the final analysis was a multivariate analysis of covariance on the scores on the standardized mental health measures, with the Composite Abuse Scale-Total score as a covariate and racial group, disability status and child abuse history as independent variables.

## **Results**

### **Racial and Ethnic Populations and the Experience of Intimate Partner Abuse**

With attrition of 70 women from Wave 1 (N=665) to Wave 2, the total sample for the current study is 595, with 205 from Manitoba (34.5%), 185 from Saskatchewan (31.1%) and 205 from Alberta (34.5%). The 70 women who recidivated between Waves 1 and 2 differed from the women who remained in the study in the following ways: (a) they were significantly younger (33.7 vs. 36.7 years on average), (b) they had lower yearly incomes (\$14,964 vs. \$22,429), (c) more of them worked full-time, (22.6% vs. 7.5%) (d) more were from medium sized centres (30,000-99,999) (25.7% vs. 12.6%) and (e) more had disabilities (57.1% vs. 42.5%). Notably, though, the information presented from both Waves 1 and 2 represents the first full data capture.

PUT TABLE 1 ABOUT HERE

The women were from diverse, self-identified racial and ethnic origins: 263 (44.8%) White (self-reported as European origins, White or Caucasian), 292 (49.7%) Indigenous (First Nations = 218, Métis = 73, Inuit = 1), and 32 (5.5 %) visible minority (the largest groups being African-Canadian = 13, South Asian = 7, and Latin American = 8). As can be seen in Table 1, the average age of the women was 36.7 years ( $SD = 10.9$ ), however, the White women were significantly older ( $M = 38.4$  years,  $SD = 11.4$ ) than the Indigenous women ( $M = 35.1$  years,  $SD = 10.5$ ), with the women from visible minority origins in the middle ( $M = 37.8$  years,  $SD = 10.3$ ) ( $F = 6.6$ ,  $p < .001$ ) but not statistically different in age from either White or Indigenous women. The majority (90.3%) had children, with 70% ( $n = 370$ ) of these aged 18 years or below ( $M = 9.2$  years;  $SD = 5.1$  years). The 162 adult children were an average of 27.8 years of age ( $SD = 8.2$ ). There were no differences between the race/ethnic groups in either the percentage who were mothers or the percentage with children above and below the criterion for adulthood.

The majority of women (87%) no longer lived with their abusive partners, being either ex-common-law ( $n = 195$ , 32.8%) separated/divorced ( $n = 186$ , 31.3%), ex-boyfriend/girlfriend ( $n = 98$ , 16.5%), or partner deceased ( $n = 5$ ). The minority who remained with abusive partners (13%) included 41 (6.9%) married, 36 (6.1%) common-law, and 33 (5.6%) boyfriend/girlfriend. More women of Indigenous origins were still with their abusive partners compared to the other two groups, although this was a weak effect ( $\chi^2 = 9.2$ ;  $p = .01$ ; Cramer's  $V = .13$ ).

Total average yearly family income from all sources in the last year was \$22,504 ( $SD = \$25,256$ ), but there were significant differences between all three groups ( $F = 6.4$ ;  $p < .001$ ), with visible minority women reporting the highest average total yearly income ( $M = \$27,300$ ,  $SD = \$36,804$ ), White women next ( $M = \$26,109$ ,  $SD = \$26,272$ ), and then women of Indigenous descent ( $M = \$18,504$ ,  $SD = \$21,867$ ). Poverty lines are complicated to calculate, however, in an

analysis of the economic circumstances of a subset of 414 women from this study at Wave 6, DeRiviere (2014) calculated that 52.2% of the women lived under the poverty line.

Highest level of education attained varied considerably across the sample; 40% of the women had not completed high school, while 38% had some post-secondary education ( $\chi^2 = 44.6$ ;  $p = .000$ ; Cramer's  $V = .28$ ). More women of Indigenous origins than White women had not completed high school and not attended post-secondary education, a moderate effect. Similarly, significantly fewer women of Indigenous origins than White women were working full-time, also a moderate effect ( $\chi^2 = 24.9$ ,  $p < .000$ ; Cramer's  $V = .21$ ). More than one-third (37.8%) of the women had never stayed in a violence against women (VAW) shelter. A higher proportion of the women from visible minority populations had resided in a shelter (81% compared to 64% Indigenous and 59% White) ( $\chi^2 = 6.4$ ,  $p = .04$ , Cramer's  $V = .10$ , a weak effect).

Because of the previously acknowledged long-term consequences of child sexual abuse, the women were classified as reporting no child abuse, any child sexual abuse (54.3%), and child abuse excluding sexual abuse (including physical abuse (56.2%), emotional/psychological abuse (66.4%), neglect (40%) and/or witnessing violence between parents or other family members (57.6%). While 79.5% of all women had been abused as children in some or multiple ways, significantly fewer from visible minority groups experienced child abuse compared to women of Indigenous backgrounds and fewer had been sexually abused, a weak effect ( $\chi^2 = 21.7$ ;  $p < .000$ ; Cramer's  $V = .19$ ).

Almost two-thirds (63.7%) reported having some serious medical conditions and/or long-term illnesses. A complete list of the self-reported conditions is beyond the scope of the current submission, especially since a number of women disclosed multiple conditions. However, to highlight the serious and life-threatening nature of the medical concerns disclosed by some

women, the most often mentioned physical illnesses were Irritable Bowel Syndrome/Crohn's disease ( $n = 36$ ), Chronic Fatigue Syndrome/Fibromyalgia ( $n = 28$ ), and Hepatitis C and HIV ( $n = 25$ ). Of the mental health issues identified, the most common were depression ( $n = 170$ ), PTSD/anxiety ( $n = 103$ ), and addictions ( $n = 74$ ). As well, 13 women mentioned Bipolar Disorder and four others self-disclosed a diagnosis of Borderline Personality Disorder.

The illnesses or mental health conditions reported by the women were coded as disabilities if women noted that they affected their mobility or employability, resulting in 244 of the women (42.4%) being classified with a disability. Of these, 71.4% attributed the disability to their abuse history: 6% to childhood abuse, 31.9% to partner abuse and 33.5% to both partner and child abuse. Of the women who linked the disability to an abuse history, the largest proportion ( $n = 113$ , 45%) described both mental health and physical conditions, 61 women (24.3%) described only mental health issues, and 77 women (30.7%) listed only physical illnesses. Race/ethnic group was not related to disability status.

As can be seen in Table 2, all average scores on the Composite Abuse Scale subscales were significantly higher than the suggested cut-off scores (Hegarty et al., 2005). With respect to average scores on the mental health scales, none (SCL-10; CED-10; PTSD checklist) were in the clinical range for any of the race/ethnic groups. Moreover, few differences were identified between the three race/ethnic groups on the CAS; visible minority women reported the most emotional abuse compared to women of Indigenous origin, who scored lowest. Indigenous women reported higher CAS-physical abuse scores than White women, who scored the lowest.

PUT TABLE 2 ABOUT HERE

### **Interactions Between Disability Status, Intimate Partner Abuse, and Mental Health**

The mental health scales and the Composite Abuse Scale-Total were correlated and the

SCL-10, CES-D-10 and PTSD Checklist scores were all significantly interrelated (with  $r$ 's of from .716 - .749). Correlations with the mental health scores and the Composite Abuse Scale-Total were numerically lower ( $r$ 's of from .14-.28) but still significant ( $p$ 's of .01). Because of the interconnections between these main variables and their possible associations with the mental health measures, we conducted a MANCOVA on the standardized mental health measures as dependent variable, with the Composite Abuse Scale-Total score as a covariate and disability status (yes/no), child abuse history (yes/no) and racial/ethnic group as independent variables.

#### PUT TABLE 3 ABOUT HERE

As seen in Table 3, disability status was the only significant variable, with women without disabilities reported significantly less dysfunctional scores on the SCL-10, CES-D-10 and PTSD checklist than women without. Neither racial/ethnic group nor child abuse history nor any interactions (including interactions with disability status) were significant.

#### **Discussion**

Consistent with the extensive literature on women whose partners have abused them, those in The Healing Journey study have complicated lives with many reporting childhood abuse histories (79.5%), physical illnesses/mental health conditions (63.8%) and disabilities (42.4%). Intersectional studies usually anticipate finding differences in the variables associated with vulnerabilities and disadvantage, but similarities are also of interest (Cole, 2009). The general lack of differences between the three racial/ethnic groups either descriptively or on scores on the standardized measures is notable, but important not to overlook given that the women shared a history of IPV. Exceptions were that more women of Indigenous origins had lower incomes, were unemployed, still resided with an abusive partner and reported higher levels of physical abuse (similar to Brennan, 2011). Visible minority women reported more serious emotional

abuse, less child abuse and a larger percentage had stayed in VAW shelters, which may be an artefact of how women from diverse cultures were recruited for the current study. As well, the subsample of visible minority women is relatively small and, therefore, caution in interpreting the significance tests is warranted. Despite these few areas, some of which can be attributed to structural factors such as poverty, discrimination, and Canada's colonial history of oppression toward Indigenous people, there were no statistically significant differences across racial/ethnic groups on measures of depression, general mental health, or PTSD symptoms.

As noted, the women in the current study were not, on average, in the clinical ranges on the depression, symptom checklist or PTSD measures. This result differs from articles implying that abused women commonly have serious mental health concerns, but that did not use clinical cutoffs (i.e. Lacey et al., 2013; Perez & Johnson, 2008). Our finding is consistent with studies that used clinical cutoffs. Specifically, depression and anxiety scores below clinical cut-offs were reported in one study (Ferrari et al., 2014), and in others, only 24% of the sample reported clinical levels of PTSD (Coker et al., 2005) and 38% reported mild depression (Nicolaidis et al., 2009). Together, these studies and ours contrast with an impression from a cursory read of the literature that women abused by partners have numerous mental health concerns. It underscores the importance of using valid cutoffs in research on mental health and IPV to identify those who may require the attention of mental health professionals.

On the face of it, the mostly non-clinical scores on the depression and PTSD standardized scales may seem to contradict the women's self-reports, which identify depression and PTSD as the most common mental health problems. However, depression and anxiety symptoms do not necessarily result in diagnoses of these disorders. Moreover, mental health symptoms improve substantially for many women in a relatively short time with interventions such as VAW shelters



or support groups (Rinfret-Raynor & Cantin, 2007; Tutty, 2015; Tutty, Babins-Wagner & Rothery, 2015). As the women were recruited through VAW shelters and other services for women who have experienced IPV, one could anticipate some “healing” by the time we interviewed them. Thus, it is important not to stereotype women whose partners have abused them as having long-standing mental health problems.

The high proportion of women in the Healing Journey study who reported histories of child abuse (79.5%), particularly child sexual abuse (54.4%), and disabilities (42.5%) is congruent with other research (Ballan et al., 2014). While Indigenous children are acknowledged to have suffered significant child sexual abuse (Libesman & McGlade, 2016), in the current study there were only differences in the proportion of Indigenous and visible minority groups reporting a child sexual abuse history, with no statistically significant difference between the samples of White and Indigenous women.

Having a disability was the only social location in the current study that was significantly related to more dysfunctional mental health scores and severity of IPV, consistent with a number of studies (Barrett et al., 2009; Brownridge, 2006; Breiding & Armour, 2015; Cohen et al., 2005; Hahn et al., 2014; Yoshida, et al., 2011). Thus, it is important for professionals to assess disability status when working with women abused by intimate partners. However, Baladarian (2009) has argued that there is insufficient discussion of disability in the IPV literature and few services are specific to women with disabilities and an IPV history (Ballan et al., 2014; Lund, 2011). Professionals such as social workers are not routinely educated about IPV, (Black, Weisz, & Bennett 2010), and women with disabilities have estimated that only 15% of health providers assessed for IPV (Curry et al., 2011). Clearly, this is a large gap in service provision. Finally, women with disabilities are often further disadvantaged by structural inequalities associated with

race, gender, age, and socioeconomic status (Ballan et al., 2014), which could contribute to the lower levels of psychological wellbeing associated with women with disabilities in our study.

### **Limitations and Strengths**

Without random selection of study participants, the results may not be generalizable to other women abused by intimate partners within the Canadian prairie provinces, particularly those not having seeking some form of assistance for IPV. This is the case for much research in the field that relies on convenience samples of women with IPV histories from shelters or counselling agencies. Furthermore, we cannot assume that the self-reported physical and mental health conditions on which the disability classification **was based** had been corroborated by a formal diagnosis. This, however, does not undermine the importance of the results involving disability status. Though a goal of the project was to recruit a substantial sample of visible minority women, the small proportion that volunteered is a limitation. This may be a function of our recruitment methods as some have concluded that racial minority women are less likely to use social services (Hyman et al., 2009). Thus, future researchers should develop alternative recruiting strategies.

One strength of this study is that we used purposive sampling to include a larger number of women associated with marginalized groups than would result had we used random sampling. This afforded a greater representation of marginalized women within the sample and statistical analysis often not possible in studies that use other sampling methods. This is critical for research adopting an intersectional framework (e.g., Else-Quist & Hyde, 2016). For example, we made efforts to recruit in rural and remote locations not ordinarily included in large studies. As well, we recruited a sizable proportion of women from Indigenous origins, as this is an important group in Canada's large and unique prairie provinces. Although they are included in national

studies such as the GSS, Indigenous women are not sufficiently represented in other IPV research. A second strength was the use of standardized measures of mental health functioning as it clarified that, although women self-reported depression, other mental health symptoms and PTSD, on average none were in the clinical ranges.

### **Conclusion**

This research aimed to make visible the experiences of both marginalized and mainstream women. Women abused by intimate partners vary with respect to whether or not they are dealing with mental health symptoms, physical health issues, disabilities, and child abuse histories. This study supports the need to avoid assuming that these women suffer from long-lasting mental health issues to a degree suggesting the need for clinical intervention and underscores the need to assess disability status. While few differences with respect to race/ethnic backgrounds were identified, it remains important to address cultural beliefs and help-seeking behaviors when assisting individual women. The structural inequalities that Indigenous and some visible minority women face must be understood to ensure their well-being.

Though considerable research has documented the traumas and negative consequences for women who have experienced IPV, this puts researchers and service providers at risk of assuming that most such women have mental health disorders. This may blind those aiming to help to the women's strengths and coping abilities to both endure abuse and, ultimately, decide to leave, if that is the best decision. Since the women in The Healing Journey study differed in terms of whether or not they still resided with their abusive partners and, if having left, how long ago that occurred, we cannot know whether any clinically significant mental health concerns were present earlier and were resolving or simply were not present despite the IPV. Finding ways

to support the women's diverse circumstances, histories, and strengths (Anderson, Renner, & Danis, 2012; Tutty, 2006) remains a critical aspect of both research and clinical interventions.

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Table 1

Comparison of Women's Demographics Across Population Backgrounds<sup>1</sup>

Variable		White ( <i>N</i> = 263)	Indigenous ( <i>N</i> = 292)	Visible Minority ( <i>N</i> = 32)	Totals	Sign.	Effect size
Current partner relationship	No longer together	239 (91.6%)	237 (82.9%)	28 (87.5%)	504 (87%)	$\chi^2 = 9.2$ ; <i>p</i> = .01	Cramer's V = .13
	Together	22 (8.4%)*	49 (17.1%)*	4 (12.5%)	75 (13%)		
Children?	Yes	237 (90.1%)	263 (90.1%)	30 (93.%)	530 (90.3%)	$\chi^2 = 0.5$ n.s.	
	No	26 (9.9%)	29 (9.9%)	2 (6.3%)	57 (9.7%)		
Age of oldest child	Children under 18	156 (65.8%)	186 (71%)	23 (82.1%)	365 (69.3%)	$\chi^2 = 3.9$ n.s.	
	Adult children	81 (34.2%)	76 (29%)	5 (17.9%)	162 (30.7%)		
Size of community	Rural (less than 1000)	7 (2.7%)	7 (2.4%)	0 (0%)	14 (2.4%)	$\chi^2 = 3.2$ n.s.	
	Small (1000 to 29,000)	30 (11.4%)	37 (12.7%)	2 (6.3%)	69 (11.8%)		
	Medium (30 – 99,999)	30 (11.4%)	41 (14%)	4 (12.5%)	75 (12.8%)		
	Large (100,000+)	196 (74.5%)	207 (70.9%)	26 (81.3%)	429 (73.1%)		
Highest Education	Not complete HS	75 (28.6%)**	154 (52.7%)**	8 (25%)	237 (40.4%)	$\chi^2 = 44.6$ <i>p</i> = .000	Cramer's V = .28
	Complete HS or GED	59 (22.5%)	61 (20.9%)	6 (18.8%)	126 (21.5%)		
	Post sec-tech	57 (21.8%)	34 (11.6%)*	10 (31.3%)	101 (17.2%)		

<sup>1</sup> Stars represent significant differences between categories based on standardized residuals (contact the first author for these statistics)

	Post sec-univ	71 (27.1%)**	43 (14.7%)**	8 (25%)	122 (20.8%)		
Currently working	Full-time	81 (31.5%)**	41 (14.4%)**	9 (28.1%)	131 (22.7%)	$\chi^2 = 24.9,$ p < .000	Cramer's V = .21
	Part-time/Casual	44 (17.1%)	50 (17.4%)	5 (15.6%)	99 (17.2%)		
	Not working	132 (51.4%)	197 (68.4%)	18 (56.3%)	347 (60.1%)		
Stayed in VAW shelter	Yes	155 (58.9%)	184 (63.7%)	26 (81.3%)	365 (62.5%)	$\chi^2 = 6.4,$ p = .04	Cramer's V = .10
	No	108 (41.1%)	105 (36.3%)	6 (18.8%)	219 (37.5%)		
Child abuse history	No abuse	67 (25.5%)	41 (14.1%)*	12 (37.5%)*	120 (20.5%)	$\chi^2 = 21.7;$ p < .000	Cramer's V = .19
	Any child sexual abuse	129 (49%)	180 (61.9%)*	10 (31.3%)*	319 (54.4%)		
	Other child abuse	67 (25.5%)	70 (24.1%)	10 (31.3%)	147 (25.1%)		
Mental health and/or illness	Yes	167 (63.7%)	180 (62.3%)	25 (78.1%)	372 (63.8%)	$\chi^2 = 3.1,$ n.s.	
	No	95 (36.3%)	109 (37.7%)	7 (21.9%)	211 (36.2%)		
Disability	Yes	107 (41.5%)	121 (42.3%)	16 (50%)	244 (42.4%)	$\chi^2 = .85,$ n.s.	
	No	151 (58.5%)	165 (57.7%)	16 (50%)	332 (57.6%)		
Disability from abuse?	No/unsure	32 (29.4%)	32 (29.%)	3 (18.8%)	71 (28.6%)	$\chi^2 = 7.58;$ p = .26	
	Childhood abuse	8 (7.3%)	7 (5.7%)	0 (0%)	15 (6%)		
	Partner abuse	40 (36.7%)	32 (26.0%)	7 (43.8%)	79 (31.9%)		n.s.
	Both child & partner	29 (26.6%)	48 (29.0%)	6 (37.5%)	83 (33.5%)		
Type of Disability	Physical	32 (28.8%)	41 (33.1%)	4 (25%)	77 (30.7%)	$\chi^2 = 5.3;$	

linked to abuse	Mental health	21 (18.9%)	35 (28.2%)	5 (31.3%)	61 (24.3%)	p =.25
	Physical & mental health	58 (52.3%)	48 (38.7%)	7 (43.9%)	113 (45%)	n.s.

Table 2

## Scores on Standardized Measures by Population Background

Scale	White (N=263)	Indigenous (N=292)	Visible Minority (N=32)	Total (N=586)	F-test
CAS Severe Combined	6.6 ( <i>SD</i> = 6.5)	7.3 ( <i>SD</i> = 6.7)	7.6 ( <i>SD</i> = 6.4)	7.0 ( <i>SD</i> = 6.6)	0.8 n.s.
CAS Emotional Abuse	28.8 ( <i>SD</i> = 14.1)	26.2 ( <i>SD</i> = 13.8)*	33.8 ( <i>SD</i> = 13.8)*	27.8 ( <i>SD</i> = 14.0)	5.3; <i>p</i> < .005**
CAS Physical Abuse	10.9 ( <i>SD</i> = 8.3)**	13.6 ( <i>SD</i> = 8.0)**	12.5 ( <i>SD</i> = 8.6)	12.3 ( <i>SD</i> = 8.2)	7.7; <i>p</i> < .001**
CAS Harassment	7.3 ( <i>SD</i> = 5.1)	7.8 ( <i>SD</i> = 5.1)	8.7 ( <i>SD</i> = 5.0)	7.6 ( <i>SD</i> = 5.1)	1.4 n.s.
CAS Total Score	53.4 ( <i>SD</i> = 27.5)	54.2 ( <i>SD</i> = 28.4)	62.0 ( <i>SD</i> = 27.4)	54.3 ( <i>SD</i> = 28.0)	1.2 n.s.
SCL-10 Total Score	12.3 ( <i>SD</i> = 8.3)	13.5 ( <i>SD</i> = 9.2)	12.1 ( <i>SD</i> = 9.8)	12.9 ( <i>SD</i> = 8.8)	1.3 n.s.
CES-D-10 Total score	12.0 ( <i>SD</i> = 6.2)	12.2 ( <i>SD</i> = 6.5)	11.3 ( <i>SD</i> = 6.4)	12.1 ( <i>SD</i> = 6.4)	0.3 n.s.
PTSD Checklist	26.2 ( <i>SD</i> = 14)	27.4 ( <i>SD</i> = 15)	27.4 ( <i>SD</i> = 17)	26.4 ( <i>SD</i> = 14.4)	0.5 n.s.



Table 3

MANCOVA of Mental Health Scores by IPV, Racial Group, Disability and Child Abuse

Source	Dependent Variable	Mean Square	<i>df</i>	<i>F</i> -test	<i>p</i> -value	Partial $\mu^2$
CAS Total (Covariate)	SCL Total	1227.58	1	17.02	.000***	.034
	CES-D-10 Total	330.52	1	8.46	.004***	.017
	PTSD checklist Total	7597.75	1	43.10	.000***	.082
Racial group	SCL Total	20.612	2	0.29	.751	.001
	CES-D-10 Total	19.60	2	0.50	.606	.002
	PTSD checklist Total	6.16	2	0.04	.966	.000
Disability	SCL Total	655.43	1	9.09	.003**	.018
	CES-D-10 Total	237.92	1	6.09	.014*	.012
	PTSD checklist Total	1735.69	1	9.85	.002**	.020
Child abuse	SCL Total	66.93	1	0.93	.336	.002
	CES-D-10 Total	19.53	1	0.50	.480	.001
	PTSD checklist Total	100.36	1	0.57	.451	.001
Race*disability	SCL Total	12.79	2	0.18	.838	.001
	CES-D-10 Total	19.43	2	0.49	.608	.002
	PTSD checklist Total	48.89	2	0.28	.758	.001
Race*Child abuse	SCL Total	34.56	2	0.48	.620	.002
	CES-D-10 Total	.90	2	0.02	.977	.000
	PTSD checklist Total	16.17	2	0.09	.912	.000
Disability * Child abuse	SCL Total	86.13	1	1.19	.275	.002
	CES-D-10 Total	46.79	1	1.19	.274	.002
	PTSD checklist Total	529.97	1	3.01	.084	.006
Race*Disability* Child abuse	SCL Total	43.79	2	0.61	.545	.003
	CES-D-10 Total	32.18	2	0.82	.439	.003
	PTSD checklist Total	314.51	2	1.78	.169	.007