

Survivor's costs of saying no: exploring the experience of accessing services for intimate partner violence

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ABSTRACT

Intimate partner violence (IPV) is a crucial public health concern with substantial detrimental effects, including poorer physical and mental health as well as increased difficulties accessing formal services. Most research to date has focused on frequencies, barriers, and facilitators of service use among IPV survivors. However, what remains poorly understood is the perspectives of IPV survivors on their experiences of accessing multiple services after leaving the abusive situations. To answer this, six one-on-one semi-structured interviews were conducted with survivors using expanded definition of “services,” which included social services, shelters, health care, police, legal assistance, and so forth. Data were analyzed using Constant Comparison. Four resulting themes were (a) Positive Aspects, (b) Negative Aspects, (c) Impact of Experiences With Services, and (d) Contextual Factors. Within each of these categories, several sub-categories emerged and are discussed within the context of the literature and recommendations are made for improving services for IPV survivors.

Key Words

Anything related to domestic violence; Domestic violence; Intervention/treatment; Perceptions of domestic violence

Introduction

Intimate partner violence (IPV) is a major public health issue globally and encompasses physical, emotional, sexual, or psychological violence (Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002). IPV is of particular concern for women due to high rates of victimization and severity. The reported lifetime prevalence of IPV for women ranges from 21% to 55% in North America (M. M. Cohen & Maclean, 2004; U.S. Department of Justice, 2003). Women report more severe forms of IPV and repeated victimization than men (Statistics Canada, 2009). They also suffer from poor physical and mental health along with multiple social consequences, such as isolation, unstable housing, and financial difficulties (Campbell, 2002; Plichta & Falik, 2001). IPV is also associated with high economic costs for society. For instance, USD \$5.8 billion is spent annually in the United States to assist IPV cases, 70% of this amount is directed to medical and mental health care services (National Center for Injury Prevention and Control, 2003). In Canada, Varcoe et al. (2011) estimated that \$6.9 billion (CAD) is spent annually to support abused women aged 19 to 65 after they leave abusive situations.

Over the last few decades, the complex and chronic nature of IPV has led to the emergence of several services. IPV service provision evolved from a criminal justice perspective, which emphasized women's experience and victim retribution (Kilpatrick, 2004). Subsequently, stark statistics on the chronic and trans-generational consequences of IPV have led to a multi-sectoral approach, and the adoption of a public health perspective (Tjaden, 2005), to address IPV. Current services for the survivors of IPV range from crisis helplines and shelters, transitional housing, legal support, financial assistance and health care (Statistics Canada, 2009). Notably, health care settings are frequently accessed by women experiencing IPV for their health problems but many do not disclose their victimization (Kernic, Wolf, & Holt, 2000; Rivara et al., 2007). And conflicting research about the effectiveness of screening for domestic violence in these settings continues to prevent common practices around early intervention (MacMillan et al., 2006; Wathen & MacMillan, 2003). According to Statistics Canada, only 28% of women with experiences of IPV contact or use any formal service to deal with their experience of violence (Statistics Canada, 2009). The same report finds that 23% of abused women accessed police services, 15% sought legal action, 30%

accessed medical care, more than 30% saw a counselor, and 14% went to a crisis center. Evidence shows that many women experiencing IPV refrain from accessing formal services in a timely manner due to denial, lack of knowledge, social stigma, fear of partner retaliation, concerns about children's custody, lack of financial independence, and low self-esteem (Alaggia, Regehr, & Jenney, 2012; DeVoe & Smith, 2003; Gerbert et al., 1996; Hegarty & Taft, 2001; Peckover, 2003; Petersen, Moracco, Goldstein, & Clark, 2004; Rodriguez, Quiroga, & Bauer, 1996). Specific barriers to accessing formal services among visible minorities and immigrants include: differences in cultural values and gender roles, lack of trust, language difficulties, and fear of deportation (Ahmad, Driver, McNally, & Stewart, 2009; Ahmad, Riaz, Barata, & Stewart, 2004; Dasgupta & Warriar, 1996; Krishnan, Baig-Amin, Gilbert, El-Bassel, & Waters, 1998; Yoshioka, Gilbert, El-Bassel, & Baig-Amin, 2003). These multiple barriers encountered by abused women are compounded by their weak social support (Petersen et al., 2004), making timely access to formal service even more crucial.

Studies with IPV survivors have also examined their sources of motivation to access services. The reported motivating factors include: knowledge about IPV and available IPV services; concerns about children's well-being; supportive family and friends; severity of violence; and reaching an emotional or physical breaking point (Ahmad et al., 2009; Ahmad, Rai, Petrovic, Erickson, & Stewart, 2013; Du Mont, Forte, Cohen, Hyman, & Romans, 2005; Duterte et al., 2008; Gerbert et al., 1996; Hegarty et al., 2013; Petersen et al., 2004). Survivors' expectations of the health care sector have also been examined. In 2006, a meta-analysis of qualitative studies found that women wanted health care providers to be non-judgmental and sensitive, to maintain confidentiality, understand the complex long-term nature of IPV, and acknowledge its social and psychological consequences (Feder, Hutson, Ramsay, & Taket, 2006). Specifically, women wanted services that would increase their confidence and validate their experience of abuse as unacceptable and undeserved. They wanted providers to respect their decisions and to help them work through the complex feelings about their abuse. This meta-analysis provides valuable insights but is limited to health care providers. Little is known about expectations of IPV survivors from *multiple service providers*. Addressing this knowledge gap is important as IPV survivors require diverse services to resolve complex situations post victimization.

The primary aim of the present study was to elicit perspectives of IPV survivors on their experiences of accessing violence-related services after leaving an abusive situation. The term *services* was not restricted to one sector. The expanded definition of "services" included social services, shelters, health care, police, legal assistance, and so forth. This broad definition was

adopted to reflect the broad nature of services that IPV survivors access (Petersen et al., 2004), thereby giving a more complete and holistic picture of the complicated and multi-step process that occurs when survivors leave their abusive environment.

Method

Qualitative in-depth, face-to-face interviews were conducted to elicit and gather experiences of IPV survivors about their access to services after leaving an abusive situation. Interviews were conducted between January and April of 2010 using a semi-structured interview guide. Individual interviews were preferred over focus groups to ensure participant privacy and comfort (Gill, Stewart, Treasure, & Chadwick, 2008). Research ethics approval was obtained from the University of Toronto.

Participants

The eligibility criteria included being a woman who was at least 18 years of age, fluent in English and perceived herself as a survivor of IPV with termination of abusive relationship and a user of IPV-related services after leaving the abuser. The study information was disseminated by flyers placed on community bulletins in women's shelters, and drop-in centers within the City of Toronto. Women interested in participating called the provided phone number for details. Interviews were scheduled at a research office at a time convenient for the participant. Additional participants came forward through a snowballing effect of contact with women already in the study.

Six women participated and all were Canadian-born (Table 1). Two participants had less than high school education and the rest had college or above. Five of the participants were single, three had never been married, and one was married. Three of the participants had children ranging in age from 6 years to 42 years old. One participant had experienced abuse from her siblings and the rest had experienced abuse from their spouse or partner. Self-reported diagnoses included depression, anxiety, and posttraumatic stress disorder (PTSD).

Data Collection

The interviewer (C.R.P.) conducted the interviews and drew from her clinical experience with vulnerable populations. All participants received the study details prior to the interview, and a written informed consent was obtained.

Table 1. Demographic Data.

Characteristic	Number of Participants
Age	
30-49	3
60-69	1
Not specified	2
Marital status	
Single	5
Separated	1
Number of children	
0-1	2
2-4	3
Education level	
<High school	2
College/university	3
Postgraduate	1
Employment	
Unemployed	3
Part-time	2
Retired/disability	1
English speaking	6
Self-reported health	
Poor/fair	3
Good	2
Very good/excellent	1
Social support	
Poor/fair	2
Good	1
Very good/excellent	3
Self-reported diagnoses	
Depression/anxiety	2
PTSD	1
None	1
Abuse experienced	
Psychological and emotional	5
Physical and sexual	2

Note. PTSD = posttraumatic stress disorder.

Each participant was assigned a randomly generated number for identification. The semi-structured nature of the interview enriched the collected data.

Participants were comfortable in discussing the sensitive topic of IPV, and the interviewer had flexibility to explore particular issues in-depth depending on the interviewee's responses. The interview guide included the following questions: (a) Where did you go to get help when you made the decision to address your concerns in relation to your violent/abusive relationship? (b) What types of formal help or services did you feel you needed most and why? (c) Can you tell me about some of the most positive and negative experiences you had when getting help from services? In what way were they helpful/not helpful? (d) From any of the services you have mentioned, is there any experience(s), good or bad, that stands out for you as being significant? (e) Do you feel that you were able to get the help that you needed? Why or why not? (f) Do you have any recommendations to make these services more beneficial or helpful? (g) Overall, for you, what do you think was the personal impact or result of seeking help? (h) Did any of the services you used work together or collaborate? All interviews were audio-recorded for accuracy and detail. Field notes were taken to enhance the transcripts by adding information about non-verbal communication such as body language, affect, emotional responses, and tone of voice. Participants also completed a brief demographic survey.

Data Management and Analysis

All collected data were transcribed verbatim. The transcribed data were analyzed for dominant and unique themes using the "constant comparison" technique, which involves iterative phases of discovery, coding, and discounting (Taylor & Bogdan, 1998). The interviewer (C.R.P.) started to discover patterns and concepts during data collection by reading and re-reading the transcribed data soon after each interview (Kvale, 1996). This led to the development of a preliminary coding scheme. This scheme was then applied to the transcribed data by other team members to identify key themes across and within interviews. The data were re-organized by themes and were re-read by all team members followed by group discussions. In this intense process of analysis, frequent self-questioning or discounting facilitated refinements. This involved paying attention to details such as solicited versus unsolicited information, direct versus indirect statements, and filtration of data through researcher's lens. The end point of the analytic process was defined as achieving saturation of the data—meaning that no new insights, codes, or categories could be produced, and all of the data had been accounted for in the developed core categories and sub-categories (L. Cohen, Manion, & Morrison, 2006).

Findings

Four major themes were identified in relation to women's experience of accessing violence-related services: (a) Positive Aspects with sub-categories of autonomy, empowerment, and identity; (b) Negative Aspects with sub-categories of provider coercion, system discord, and stigma and shame; (c) Impact of Experiences With Services with sub-categories of parent-child relationship, personal resources, and being a good victim; and (d) Contextual Factors with a focus on social environment and type of abuse.

1. Positive Aspects

When discussing the experience of accessing services, women discussed how it led to their enhanced autonomy and feelings of empowerment, impacting their identity.

a. Autonomy

All of the women emphasized how much they had to do for themselves, including finding resources and programs. The women uniformly described these experiences as having a positive emotional effect on them because they had practical gains, such as system know-how and access to the needed resources. As one woman related, "When I go and do my own thing, and make my own decisions, I'm getting a lot farther ahead!"

b. Empowerment

Some women experienced positive interactions with service providers and felt empowered. They discussed that validation of their experiences by some of the police officers, counselors, and/or health care staff boosted their self-esteem and confidence in their choice of actions, which led to feelings of empowerment. In words of a participant:

It's validating for yourself . . . especially somebody who's in a high power position say to you, "you did the right thing . . ." And you think, again "I'm not, I'm not crazy and I'm not stupid, some of the decisions I make are . . . Great!"

Participants appreciated those providers who listened to their concerns in a respectful and non-judgmental manner and followed up with practical actions to assist them. One woman explained,

The most positive experience I had was when I was in the shelter with the counselor there, she was extremely unconditional and she heard you through and through without putting any walls up in her mind . . . she always made suggestions for me, and always followed through. She helped me.”

c. Identity

Accessing services had a significant impact on the women’s identity. Through their experiences, the participants described having to move from denial of the abuse experience to acceptance of their experience, and then onto making a new identity as a “survivor” with enhanced autonomy and coping skills. Some participants became volunteers and advocates to help other women experiencing violence. These participants found these new roles meaningful and fulfilling:

Now I actually, I volunteer at a women’s centre now because I want to—I would have been so grateful for someone to say, “I don’t have the answers for you right now, but I’m not gonna leave you hanging.”

Many of the participants developed new coping skills or other life skills. One woman described how getting involved with a women’s organization allowed her to conquer her fear of public speaking: “And, you’re forced into these situations that you may not have normally done if it was just for yourself and it helps you overcome these fears, you know, that you had.”

2. Negative Aspects

Women discussed provider coercion, blaming the victim, system discord, stigma, and shame as negative aspects of accessing IPV-related services. These discussions were rich in all of the interviews.

a. Provider coercion

Many of the participants described providers’ behaviors as “bureaucratic” or “accusatory.” Five of the participants shared negative interactions with lawyers or staff from the Children’s Aid Society. Participants talked about experiencing providers as abusive when they felt that the power differential within their relationship was exploited. For example, one participant believed her lawyer knew that he or she could influence the court case of the woman and used this to force her to cooperate unquestioningly. She recalled her lawyer’s statement: “you can’t afford a lawyer on your own . . . you do what

you're told because you're trapped." Another woman described her interactions with Legal Aid workers: "So you don't necessarily have all the documentation required in order for you to get Legal Aid. They treated me with very accusatory, you know, questioning; 'why did I stay so long?' 'Where's all my papers?'"

b. Blame the victim

Women discussed their perceptions that some providers blamed them for the violence they experienced. They provided examples of providers' non-responsive and judgmental behaviors or recalled what they said. Particularly, participants identified police officers, as service providers, who often made assumptions or had stereotypes leading them to blame the survivor for the abuse. One participant explained, "A lot of the time, they [police] kind a made me feel like it was my own fault, because they'd say 'why do you keep going back?' That's automatically what they thought."

Some participants described how provider's victim-blaming attitudes permitted the abuser to become a victim by giving the abuser sympathy and support. One woman explained that a worker from Children's Aid Society insisted that she should drop the charges against her partner because "this guy was great" and it would be hard to fight against him.

c. System discord

All participants described substantial discord in the system, limiting the ability of service providers to identify and adequately address the needs of the survivors. Women discussed consequences of this discord in the form of unmet needs or losses, such as income, the family home, employment, and social relationships. Participants described the system discord in two ways: First, they felt their needs were not met by the services offered, and second they identified a lack of coordination between the systems themselves. Women gave multiple reasons for the perceived lack-of-fit with services, such as excessive wait lists and bureaucracy. One woman explained, "There's a lot of red tape. There are rules, because [my child] was still seeing the father I couldn't get any type of assessment done for [my child]." Women described a lack of coordination within the system, particularly for services offered by different sectors. One participant stated, "Agencies are more independent and they don't wanna work together. I think, there's a level of hierarchy in some agencies where one overpowers the other."

d. Stigma and shame

Many women experienced feelings of shame and embarrassment while accessing services, including food banks, legal advice, financial assistance, and mental health care. One participant talked about the experience of needing to use a food bank: “So standing in the food bank was another thing that I had to access right away, and I wanna tell you something, that was the most humiliating experience that I’ve ever personally had to deal with.” Another participant described her worries about the legal system stereotyping her intentions about child custody and visitation, in particular around the issue of parental alienation:

I knew that the first thing that the courts and everybody are gonna think of, is that I don’t want this [visitation]. I know that a lot of people try to stop access [to child], and I didn’t wanna be perceived as one of those people . . . [illustrating that women are receiving strong messages about expectations on them to be supportive of child contact, even when they believe that it might not be safe for their children.]

3. Impact of Experiences With Services

Women identified consequences of having mostly negative experiences with the services they accessed. These consequences affected the parent–child relationship and personal resources along with the formation of a concept of being a good victim.

a. Parent–child relationship

Accessing services had a complex mix of positive and negative effects on participants’ relationships with their children. The effects ranged from custody and access issues, to communication, and finally, to their role as mothers. One woman described how her use of services strained her ability to communicate with her daughter: “Me and my daughter’s relationship has been affected big time, because she doesn’t understand why I get so emotional at times, visit the doctors-go to the doctors all the time, she things ‘mommy’s sick’ so she gets scared.”

Ultimately, all of the participants who were parents described how their experiences had compromised their role as mothers. This was either because they were forced to disclose things to their children that they did not want to or because their ability to protect their children from their ex-partner was limited due to required visitation. One participant perceived this as deeply traumatic and became tearful in stating this as “awful” when “I’m telling [my child]: What you went through and what I went through is okay because now you have to go [to] see him.”

b. Personal resources

Many of the women experienced a significant sense of loss. Participants felt emotional loss by losing a family unit and trust in the system. They described practical loss in terms of finance, employment, and housing. One woman experienced extreme poverty: “I didn’t have any food, I didn’t have any money—he closed everything [through lawyer] in the end.” Another woman explained that her financial status had been a source of pride for her and its loss went beyond the loss of funds: “I’ve prided myself on being independent and I’ve, I’ve made the income I need to make and I don’t wanna lose it all just so that I can try and protect us, you know?”

Because of their substantial losses, many of the participants felt that they would have been better off had they not accessed services. As one woman commented, “I think I’m in a worse-off situation now than I was before I got legal help.” Another participant explained, “I lost my trust in the system. You know, in the legal system and the criminal system, family and civil.”

c. Being a good victim

All women experienced mental stress due to the negative experiences they had in accessing services. Some felt that the lack of coordination within services and poor interaction style of the providers added time to achieve optimal resolution. One participant stated, “I felt that so much time had . . . slipped away when things could have been done, and they weren’t being done.” This led some women to try and present themselves in the “right” way to service providers to receive the help that they needed: “Basically begging and pleading . . . I had to know how to market myself accordingly in order for them to, to have a clue or understanding of what they needed to do.” Another woman felt that her access to timely assistance was compromised because she did not present herself as the “right” kind of victim: “Because I wasn’t comfortable talking about that kind of thing [violence]. Because I just can NOT portray myself as a victim, I couldn’t get the help that I needed.”

4. Contextual Factors

Women’s experiences in accessing the services were influenced by contextual factors, which existed *before* the woman accessed the services. To this end, women especially discussed their level of social environment and the type of abuse.

a. Social environment

Several participants described how the escalation of partner violence led to a decline in their social network. Participants felt that it also led to limited practical and emotional social support from friends and family. One participant explained that her friends were too frightened of her partner to call or visit. Some women disclosed or made related comments about exposure to IPV as children. They discussed how previous experiences of abuse compared with their current experience led to their delay in seeking help. One participant stated, "I thought well, what I had was not so bad compared to what my mother had." Another woman explained that she was unable to turn to some of her family members for support because of their previous abusive and violent behaviors.

b. Type of abuse

The type of abuse endured played a key role in participants' experiences of getting formal help. All of the participants disclosed the type of abuse they had experienced, despite the fact that this was never asked in the interview. The type of abuse affected participants' formal help-seeking in two ways: First, it influenced the types of services they needed to leave the abusive situations. For example, participants with experiences of physical and sexual abuse discussed accessing services for medical care, safety, and housing. Conversely, participants who experienced psychological and emotional abuse discussed seeking counseling, emotional, and legal support to know their rights.

Second, the type of abuse affected whether the woman was believed and how service providers treated her. Some participants explained that their experiences of physical and sexual abuse were believed by providers and taken seriously because of their visible injuries and/or provider's witnessing of the incident. A survivor of sexual abuse explained,

When they came to the assault, they showed up in all marked cars . . . The third time, when he came back, that's when they took him into custody. The third time was when the sexual assault happened and they actually caught him in the act.

A survivor of psychological abuse described a very different experience with the police: "They dismissed everything. Everything about my daughter, all the things that he had done to me, and his brutality, because I wasn't physically abused . . . they just couldn't quite get it, about mental abuse."

Discussion

This study explored experiences of IPV survivors in accessing diverse IPV-related services. Participants discussed police and legal systems more often than the health care system. They described both negative and positive aspects of seeking formal help, but their discussions predominantly focused on the negative experiences, which is alarming. The undesirable effects of service use included provider coercion, provider attitude of blaming the victim, system discord, and women's feelings of shame and stigma. Experiencing undesirable effects of service use compromised women's parent-child relationship, personal resources, and trust in the system. This caused some participants to navigate service use by portraying themselves as a "good victim." Here, we discuss the key findings in the context of the existing literature followed by implications.

Participant experiences of accessing services reveal that provider's preconceived judgments, blaming attitudes, disbelief, and lack of response were prominent with police and legal services, including lawyers and staff in courts and in children's aid agencies. These findings are consistent with earlier research illustrating the need to consider women's experiences of abuse to effectively provide service support (Dunn, 2005; Harrison, 2008; Henderson, 2001; Leisenring, 2006). Although participants in our study made few comments about health care providers, other studies report health care staff allowing preconceived understandings of IPV to affect provision of care (Easteal & Easteal, 1992; Haggblom, Hallberg, & Moller, 2005). Participants in our study felt stigmatized by stereotypes of IPV victims held by police and staff in legal sectors. This coincides with the recent findings that women's experiences are largely negative with respect to navigating the system after disclosure of their IPV experiences (Alaggia et al., 2012). Participants described that providers' blaming attitudes generated support for the abusive partner who in turn manipulated their access to resources. This led to an amplification of financial, residential, and emotional challenges for the participant women. One woman experienced extreme deprivation of basic life necessities. This is similar to a recent study which documented a novel means of stalking a survivor through the use of frivolous lawsuits and false accusations as a means of exerting power, forcing contact, and creating financial burdens for survivors (Miller & Smolter, 2011). As this form of abuse is only recently coming to light, further research is needed to advance our understanding. Participants' concerns about provider coercion and system discord, and their lost trust in professional help are concerning. Participant's overwhelmingly negative perceptions might be partially caused by their continued interaction with providers in a system built inadequately to resolve their

intertwined concerns. A multi-prong approach through multi-sectoral collaboration is needed to address survivor's concerns. Given the proximity that police and legal service providers have with legislation, they have the power to create the definition of IPV and who is an IPV victim (Department of Justice, 2013; Royal Canadian Mounted Police, 2012). However, given the diverse experiences of IPV, the definition of what IPV is and who IPV victims are needs to be negotiated together with the victim and various service providers (Horwitz et al., 2011).

Participants also experienced some positive aspects of accessing services. They experienced enhanced autonomy, which was also ironically a response to difficulties they had in accessing services. For example, provider's victim-blaming attitudes, system discord, and expectation of being a "good victim" made them more independent in identifying resources and becoming self-advocates. Other scholars also report resilience in adversity by abused women (Ahmad et al., 2013). Another positive aspect elicited by participants was interactions with some empathetic, respectful, non-judgmental and responsive providers from police, legal, and health sector. The validation of women's experiences followed by practical support from providers led to an increase in women's self-esteem and confidence to make decisions; this was perceived as empowering. A similar impact of positive interactions with providers is reported in other studies with survivors of abuse, especially in health care settings (Gerbert, Abercrombie, Caspers, Love, & Bronstone, 1999).

The participants' identities evolved by moving from denial to acceptance of victimization followed by a phase of survivorship. As a survivor, they acquired new coping skills and autonomy along with meaningful engagement in activities. Some participants became volunteers or advocates in IPV-related services and cited a desire to protect future survivors as a primary motivator. Participants' identities were also influenced by perceptions of providers' victim-blaming attitudes and expectations of being a "good victim"; women had to modify their behavior to obtain the services they needed. This is consistent with other research that has shown that stereotypes around women abuse are prevalent in both professional and community settings (Jenney, 2011).

The impact of using services was complex, and often had a net negative effect on the survivor. Participants' complex social situations, characterized by oppression, childhood experiences of abuse or trauma, social isolation, and economic dependency, may have magnified the negative impacts of IPV service use. Accessing services affected participants' ability to fulfill their roles as parents and maintain healthy parent-child relationships. Particularly, issues of access and custody created difficulties in communicating with children. Furthermore, participants' lack of trust in services was compounded by

their significant losses of personal resources. The dissolution of the family unit and the family home along with mistrust of formal help led to both emotional and financial loss. These factors may have contributed to the worsening or continuation of mental illness that many participants experienced. Five of the participants reported having clinical diagnosis of depression, PTSD, and/or anxiety. This is consistent with studies reporting high use of health care among women with experiences of abuse compared with their counterparts (Kernic et al., 2000; Sansone, Wiederman, & Sansone, 1997). Furthermore, Rivara et al. (2007) found 20% higher annual health care costs among survivors, which persisted for more than 5 years after their experience of IPV had ended. This speaks to the ongoing needs of women after they have ended or left their relationship and emphasizes the fact that health does not automatically improve with the termination of the relationship. Notably, none of the participants discussed feeling safer or having a sense of relief that the abuse was over. Instead, some of the participants questioned whether the abuse experienced from service use was worse than what they had experienced from their partners. This is especially concerning as negative experiences while accessing services may contribute to women returning to, or staying in, violent relationships. Increased informal awareness of the detrimental effects of service use may contribute to women's reluctance or ability to leave and stay away from abusive relationship. This finding supports the crucial need for service improvement and further research in this area.

Implications

The findings of this study suggest that IPV services, particularly police and legal services, are not fulfilling their mandate to support women leaving violent relationships. In light of these findings, improvements are needed at several levels. To begin, structural changes are needed to effectively address the multiple needs of IPV survivors. A paradigm shift toward a strength-based approach is needed by highlighting the strengths and success, not pathology and failures, of survivors in their experiences of adversity. An assets-based focus on resiliency was noted as having a positive impact for survivors. Organizational infrastructure and resources need to evolve to be able to facilitate and support survivors' self-help efforts. To facilitate these structural changes, more collaboration is needed between different service sectors (i.e., police, legal, health, and social services). To this end, successful examples of collaboration should be examined for shared lessons (Beeman, Hagemester, & Edleson, 1999; Davies & Krane, 2006; Schechter & Edleson, 1994). More so, the bureaucratic administration of services needs to be rethought. Changes in IPV services are needed, so that victims of IPV can access the needed

services more quickly, and service providers have more time to address IPV cases. Such structural changes also require strategies to document various forms of IPV and sharing of information across sectors to assist the survivors in meaningful ways.

Extensive and ongoing training of service providers is integral to increase their knowledge about abuse and ability to respond in a timely and compassionate manner (O'Campo, Kirst, Tasmis, Chambers, & Ahmad, 2011). Not knowing how to respond to IPV is frequently listed as one of the barriers to encouraging disclosure of IPV (Bacchus, Mezey, & Bewley, 2003; Gutmanis, Beynon, Tutty, Wathen, & MacMillan, 2007; Haggblom et al., 2005). Training programs across all sectors need to focus on provider communication skills with an emphasis on non-judgmental attitudes, respectful listening, and validation of survivor's experiences of violence. Service providers need to be sensitive to their interactions with both the survivor and the perpetrator, which is sometimes required in legal and social sectors. This is essential to mitigate misplaced sympathies given to the perpetrator by service providers. Such training programs would benefit from engagement and collaboration with IPV survivors and diverse service providers.

Limitations

While insightful and informative, the exploratory and qualitative nature of the present study design limits the generalizability to broader population. The findings are unique to the characteristics of the participants who were all English-speaking women. Furthermore, there is a possibility of volunteer bias where women who had more traumatic experiences with service use agreed to participate. The eligibility criteria of having left the abusive partner may have shifted the focus to services accessed more frequently after leaving. This may have caused participants to focus less on health services. To enhance generalizability, future research with larger samples is therefore needed. Future research should also examine perspectives of male survivors and survivors belonging to diverse communities, such as ethnic minority, immigrant, or same-sex relationship sub-groups.

Conclusion

The study revealed survivors' experiences while accessing IPV-related diverse services. The extent of their negative experiences from the use of services, especially from police and socio-legal sectors, is worrisome. There is a strong need to improve IPV services through structural changes, resource allocation, and training programs. To this end, a multi-sectoral collaborative

approach with involvement of survivors, frontline staff, policy makers, and researchers is likely to generate effective models of service provision for survivors of violence.

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