PATHOLOGIZING ABUSE: EXAMINING APPROACHES TO ADDRESSING INTIMATE PARTNER VIOLENCE IN CANADA

MANASI NANDAKUMAR

Supervisor's Name: Dr. Dennis Raphael

Advisor's Name: Dr. Farah Ahmad

Supervisor's Signature: __  ___

Date Approved: __September 24, 2018_

Advisor's Signature: _____

Date Approved: _____

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Graduate Program in Health
York University
Toronto, Ontario
M3J 1P3

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ABSTRACT

This paper aims to examine the medicalization of intimate partner violence (IPV) using critical political economy, feminist political economy and Foucault's theory of power. A critical discourse analysis of publications released by public health and medical associations reveal explanations of IPV that avoid addressing the socio-political context in which family violence takes place. Additionally, the limiting epistemological frameworks guiding medical and public health disciplines give rise to professional and societal discourses that remain uncritical of larger political and social structures that perpetuate inequalities. Biologically and psychologically rooted theorizations of violence are shown to perpetuate a victimization model that places the locus of change at the individual. Drawing from concepts of decommodification and defamilisation, the MRP will explore the role of the Canadian welfare state in facilitating women's dependency on the family. I argue that current approaches and initiatives proposed in the Chief Public Health Officer's (CPHO) Report on the State of Public Health in Canada 2016: A Focus on Family Violence in Canada, A Year in Review: Canada's Strategy to Prevent and Address Gender-Based Violence, the Screening for Intimate Partner Violence and Abuse of Elderly and Vulnerable adults: U.S. Preventive Services Task Force Recommendation Statement and the Intimate Partner Violence Consensus Statement by the Society of Gynecologists and Obstetricians of Canada fails to address the overall poor social standing of women that arises from inequitable macro-social policies. Findings of the analysis elucidate the ways in which abused women are further disenfranchised by policies informed by medical and public health discourses.

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LIST OF ABBREVIATIONS

CTFPHC Canadian Task Force on Preventative Health Care

CMHC Canada Mortgage and Housing Corporation

CPHO Chief Public Health Officer

CST Critical Social Theory

GBV Gender Based Violence

IPV Intimate Partner Violence

PHAC Public Health Agency of Canada

VAW Violence Against Women

USPSTF United States Preventive Services Task Force

INTRODUCTION

Overview

The World Health Organization defines intimate partner violence (IPV) as a set of behaviors within an intimate relationship that cause physical, psychological or sexual harm (Ellsberg et al., 2008). The causes of IPV are complex and multifactorial and not limited to involved individuals. A vast amount of domestic violence literature and research links IPV to a number of physical and mental illnesses that victims develop due to prolonged abuse. Depression, substance abuse, chronic pain and impairment, suicidal behaviors, sexually transmitted infections, dysmenorrhea, and spontaneous abortions are adverse health outcomes associated with sustained IPV (Taylor, 2016). The negative consequences of IPV extend beyond the victims and include children, families, communities, and society at large. According to Statistics Canada (2011), the social and economic cost of personal violence in terms of public funding is estimated at 6.9 billion dollars (Varcoe et al., 2011).

Several approaches to address IPV have been developed starting over the last few decades. The origin of policy level attention has been linked to the violence again women (VAW) movements. The strides of first wave feminists established suffrage, maternal and child welfare as areas of political concern. Second-wave feminism refers to women's activism in the 1960s to 1980s that garnered attention towards reproductive rights, IPV, marital rape and women's shelters (Rothenberg, 2003). Advocates employed feminist discourse to promote the Battered Women's Movement, however it was met with public skepticism due to inability to understand why women stayed with their abusers (Rothenberg, 2003).

IPV, like other forms of violence, is difficult to measure as it is often self-reported by victims. Moreover, the most prominent source of IPV data is drawn from police, health and

shelter services (Maki, 2017). For instance, Statistics Canada draws on data from the Transition Home Survey (THS), which is a study surveying residential services providing support to abused women. This data excludes less severe violent episodes and instances of IPV that did not ultimately result in the victim presenting injuries at an ER, seeking housing at a shelter, or reporting the abuse to protective services. Often the economic burden of violence against women is used as an indicator to measure IPV, through the estimated loss of productivity, income and costs to taxpayers through resources allocated to funding protective, health, legal, children's aid, and community-based services to support victims (Maki, 2017).

There are multiple theories that attempt to explain the root causes and offer different solutions to IPV. Various frameworks and conceptual models offer different policy implications for health care providers, protective services and legal proceedings. This section outlines the theoretical frameworks used by IPV scholars and health researchers to conceptualize IPV (summarized in Figure 1, APPENDIX A). Note that this ecological framework for explaining IPV does not include the macropolitical and economic environment that shapes the conditions in which women live and work. The societal factors listed refers to cultural elements (patriarchal attitudes, beliefs and practices) that contribute to male dominance over women. I have classified the various theories into clusters based on the etiological causes and proposed responses to addressing IPV; individualist, community-based and structural.

Individualist approaches characterize IPV as a problem that arises due to deficits at the individual level, and IPV is situated within one's lifestyle choices, genetics, behavior, biology, and psychology (Bell and Naugle, 2008). Such approaches call for responses that target individual behaviours and assume implementing changes in individuals will reduce the prevalence of IPV. Community-based approaches to addressing IPV involves examining

community and cultural perception of violence in relationships. Approaches at this level are predicated on the assumption that cultural attitudes enabling male aggression are the primary drivers of IPV. Community-level approaches aim to strengthen community partnerships, disseminate information and raise public awareness as effective preventative measures to reduce IPV (Bell and Naugle, 2008). Structural approaches advocate for systemic changes and contextualize IPV within broader economic, political and social structures. Such approaches locate social structures as sites of change rather than individual micro- and community meso-level systems (Bell and Naugle, 2008). Structural approaches hypothesize that IPV arises as a by-product of other social problems such as poverty, unemployment, home insecurity, and systems of oppression (racism, sexism, colonialism, imperialism etc).

As this major research paper is concerned with the way IPV is conceptualized in documents published by various health and government agencies, a comparison between public and clinical health approaches is provided to illustrate differences in health promotion and prevention as well as to highlight the concepts of health referenced by each discourse. Clinical and public health agencies are seen as being responsible for improving the health of populations in somewhat different ways, both branches share a general epidemiological approach—detailed below -- to addressing diseases and health problems (Krishnan and Pandav, 2014). The discipline of public health aims to prevent illness and promote the health outcomes of populations by improving aspects of society, communities, and individuals. Public health approaches aim to define the health problem, identify risk factors and test and evaluate interventions to improve population health (Krishnan and Pandav, 2014). Additionally, public health organizations have a directed focus on public health promotion and population surveillance, which includes the dissemination of health information to improve the awareness, competency and health literacy of

the lay population (Krishnan and Pandav, 2014). In public health discourse, IPV is defined as the absence or presence of physical force in intimate relationships. Prolonged exposure to such violence is associated with injury, psychosocial dysfunction, and mental illness. Defining what constitutes abuse presents challenges to public health professionals as it is culturally specific, subjective and is also underreported (Krug, 2002).

However, definitions of IPV employed in clinical settings are often limited to physical and sexual violence. According to Krishnan and Pandav (2014), clinical medicine does not significantly differ from public health approaches from an epistemological standpoint. Both health disciplines are informed by evidence-based practices and biomedical knowledge. However, physicians are trained to address diseases among individuals and concentrate on the curative nature of illnesses. Whereas public health agencies focus on predictors and risk factors for IPV, clinicians are accountable for secondary and tertiary prevention which are concerned with detecting and addressing IPV at the subclinical stage or mitigating harm from injuries after the occurrence of violence (Stark and Flitcraft, 1991). Despite the good intentions of several scholars contributing to the medical and public health initiatives, the social construction of IPV as a medical phenomenon is problematic and needs to be further unpacked critically.

Aims and Methodology

This Major Research Paper (MRP) will explore the ways in which both medical and public health fraternities have distorted the concept of IPV through the process of medicalization. This undertaking will be informed by theoretical frameworks of political economy (critical and feminist streams), welfare state regimes and concepts of power drawn from Foucault. A critical discourse analysis will be conducted on the IPV related key policy-making public health and

medical documents as exemplars. I will employ Fairclough's three-stage Critical Discourse Analysis framework (2001) in the following sequence: (1) social practice analysis to examine the historical, social and political undercurrents that informs the text; (2) textual analysis of the text data where the terminology is the object of inquiry; and (3) discursive practice analysis with a focus on the production, dissemination and consumption of texts and maintenance of structural relationships.

This feminist social inquiry is oriented by critical materialism which focuses on the distribution of economic and social resources. A critical materialist lens considers the organization of society and class differences to explain the living conditions individuals are subjected to (Scambler, 2008). A critical political economy approach was used to identify and critique the economic and political structures and processes in society that contribute to the conditions that shape the social determinants of health.

Part 1: Historic, Social and Political Context Analysis

Dominant professional and social discourses on IPV disproportionately concentrate on individual and community level risk factors associated with family violence (Bell and Naugle, 2008; Rothenberg, 2003). Critical political economy analyzes capitalist economic structures and associated ideologies that produce social inequalities and influence the social determinants and health outcomes of the population. Feminist political economy refocuses critical political economy to include the informal economy and the role of gender in social and political organizational structures and household practices. The following section describes key concepts from critical political economy, feminist political economy and Foucault's theory of power, which will be employed to deconstruct prevailing IPV discourses held by medical and public health bodies. Critical political economy and feminist political economy are informed by the

ontological considerations of critical theory as the former two theories study how asymmetrical power relations (in the market and household) produce differential social and health outcomes.

Through Lens of Political Economy

Critical political economy recognizes the role of the economy in shaping the political and social environment of the nation-state, and how political-economic systems afford privileges to certain groups and disadvantages to others (Wilde, 2008). This approach posits that social and health inequalities are politically determined by macro-level policies that dictate the distribution of power, material goods and services (Mantoura and Morrison, 2016). Inequitable economic and political configurations can be argued to contribute to a social context in which women are reliant on a male partner to secure their well-being. Consequently, women experiencing IPV or desiring to dissolve a marriage are incentivized to remain in a relationship due to their poor economic prospects outside of the household.

Welfare states have the potential to afford women with protection from market forces through the transfer of funds in the form of services (e.g. healthcare, education, childcare) and benefits (e.g. old-age pensions, unemployment benefits). For women who have lower financial and social capital relative to men, welfare services promote their social and economic well-being. However, different welfare regimes offer varying levels of protection to women and thus can wean or reinforce women's dependence on the male breadwinner. Esping-Andersen's typology of welfare states distinguishes nations on the extent of decommodification, stratification and the role of the state, market and civil society in distributing wealth and resources (Esping-Andersen, 1990). Decommodification refers to the social entitlements offered by a welfare state which substitutes for income earned through the market. Scandinavian nations

represent the social-democratic regime; welfare states that provide members with protection from market forces through universalist social policies, low economic stratification and more equitable income distribution (Esping-Andersen, 1990). Conservative welfare states (generally continental European nations such as France and Germany) afford an intermediate level of decommodification, in which benefits depend on past contributions and family is recognized as an important source of welfare provision. Canada and other Anglo-Saxon western nations (UK, USA, Australia, and New Zealand) fall under Esping-Andersen's final welfare state cluster; a liberal governance model consisting of minimal public expenditures decreased market regulation and social benefits targeted towards the most deprived individuals (Esping-Andersen, 1990).

Another relevant concept to understand the larger political context of IPV is neoliberalism. It is an ideology that promotes the idea of individuals acting out of self-interest, managing risks independently and attaining maximum wealth generation (Bezanson and Luxton, 2009). Neoliberal policy models are informed by a laissez-faire approach to governance and favor policies based on deregulation, free-market, austerity and privatization (Coburn, 2000). Neoliberal sentiments of individualism are contingent upon family solidarity and responsibility, in which members within a household are expected and encouraged to exercise cooperation and altruism in order to advance the economic and social success of the family as a collective unit (Iversen and Rosenbluth, 2010). What neoliberal policies fail to acknowledge, is that the welfare families are expected to provide is usually the product of women's unpaid labour. In comparison to men, a woman's human capital is directed towards children and the family which reduces her participation and by extension the value of her labour in the formal economy. Furthermore, while women's labour is critical for the daily functioning of the family- men's formal labour is assigned greater value and they have increased access to social and financial capital, ultimately

enabling them to secure a better quality of life (Giles, 2014; Iversen and Rosenbluth, 2010). Thus, women who have invested a greater proportion of their human capital towards family have a greater disadvantage when leaving a marriage as they have reduced earning capacity and will most likely be restricted to menial employment. In cases of IPV, women are likely to remain in an abusive relationship as they do not have sufficient support to maintain an adequate standard of living.

The influence of neoliberalism has played a significant role in the retrenchment of the Canadian welfare state since the 1970's. This period was marked by cutbacks to social programs and public expenditures as well as easing market regulations implemented with the previous Keynesian-oriented welfare system. The family was positioned as a source of welfare for members of the state, which coincided with cutbacks to public service provisions. Cutbacks to Canada's welfare state has led to numerous challenges for Canadian women who are reliant on social programs. As Coburn (2000) argues in his work, the influence of neoliberal ideologies on Canada's policy model contributed to greater income inequality which leads to health inequities. The implications are particularly severe for women who represent a large proportion of underemployed and minimum wage earners (Galabuzi, 2006; Statistics Canada, 2016). Building off the insights of Bambra (2004), a weak welfare state will encourage women's dependence on the family as they cannot afford a decent standard of living without the pooling of income, resources and human capital to ensure their social and economic well-being. Thus, income distribution is an important determinant of the quality of life women can lead in terms of protection from poverty when seeking independence from the family and the male breadwinner (Bambra; 2004; Coburn, 2000).

To advance its ideological goals, neoliberalism has co-opted feminist ideologies to maintain and reproduce existing social relations that may acknowledge gendered inequalities but marginalizes class politics, racial discrimination and the experiences of lower-class women. Neoliberal feminism assumes that market-centric economic structures have afforded women greater agency through increased participation in the paid formal economy (Giles, 2014). This theoretical perspective does not consider how market deregulation aggravates income inequality or unpaid labour demands women are subjected to (Giles, 2014). Gender refers to the normative societal roles assigned to men and women, which manifest in multiple spheres from the household to the role of the State in dealing with gender-related issues. Gender differences are produced and reproduced by the state and market through policies that reinforce economic gaps and women's differential access to market success and individual social capital (Hyman and Meinhard, 2016). Reduced financial capital restricts women from purchasing commodities such as shelter, childcare, educational support for themselves and their children (Giles, 2014).

Bambra defines defamilisation as the extent to which welfare states facilitate the economic independence of women from the family rather than the economic security of the collective family unit. Bambra identifies female labour participation, maternity leave compensation and duration and average female wages in comparison to male wages as indicators of defamilisation (Bambra, 2004). A welfare state that favors the market by offering little protection to individuals places women in a vulnerable position both economically and socially. Women must rely on the market to purchase housing, food, childcare, and other material goods to secure their own well being and their children. The commodification of necessities to sustain a decent quality of life ultimately shapes household economic structures, strategies and relationships. Canadian macro-level policies will be examined in relation to the four indicators

identified by Bambra to further elucidate the impact of inequitable economic systems on internalized social norms and marital practices in the private sphere. The social and economic organization of society is conducive to women's impoverishment and therefore promotes marriage and unity of the family. Consequently, women experiencing IPV face the potential loss of income and shelter upon leaving an abusive partner, which is dissuasive in terminating a relationship. Social processes such as marriage, the decision to have children are arguably impacted by economic factors such as unemployment and poverty. I argue that due to a minimalist welfare state model, women currently experiencing or having escaped IPV are subjected to barriers to economic and social security which increases their risk of having to return to an abusive partner.

Through Lens of Welfare Regimes

In *Social Determinants of Health: Canadian Perspectives,* Armstrong (2016) emphasizes the importance of the social and economic contexts which influences peoples' risk of developing certain diseases. Raphael and Bryant (2003) identified a number of key themes to ensure a decent standard of life for women, which includes; political rights, health, health care, education, environment, social programs, community, economy and employment, and government. From their comparative analysis of the aforementioned indicators, Raphael and Bryant argue that nations with comprehensive welfare systems that afford a greater degree of protection to its citizens are the most conducive to women's overall health and well-being (2003). The overall physical, social and economic security of women is inextricably linked to poverty and the social conditions that give rise to IPV. The themes previously identified by Raphael and Bryant require government action in the form of policies and state transfer of funds to finance universal programs and services that would promote the well-being and economic autonomy of women.

Comprehensive welfare systems that encourage women's economic independence from their sexual partners and spouses would be a strong preventative and proactive measure against IPV and buffer the effects of market forces. When examining the poor social and health outcomes of women, it is important to recognize that we are analyzing their poor status relative to men (Mikkonen and Raphael, 2010; Turcotte, 2011). Women occupy lower paying jobs and work fewer hours than men and tend to earn less regardless of career field and education level (Mikkonen and Raphael, 2010). According to Mikkonen and Raphael (2010), Canada ranks 19 among 22 OECD nations in rectifying the gendered wage gap (p. 44). Lower income for women means a reduced capacity relative to men in being able to afford necessities to ensure their well-being. Additionally, a lack of accessible and affordable childcare presents another barrier for women's full economic participation in the paid labour market (Giles, 2014; Mikkonen and Raphael; 2010). Canada ranks second to last among 37 OECD nation's public expenditure on child care and early childhood spending (Bryant, Raphael, Schrecker and Labonte, 2010).

Thus, cutbacks to social benefits and public programs disproportionately impact women who are more reliant on such services due to unequal opportunities for gainful employment and decent wages (Raphael et al., 2010). As a nation, Canada also falls behind other developed nations in terms of maternity leave, offering an average of 35 weeks of standard parental benefits and a maximum of 61 weeks in comparison to the OECD average of 55.2 weeks. It should also be noted that women are only eligible for employment insurance when they have accumulated at least 600 hours of continuous insurable employment, and even then are paid a weekly benefit rate of 55% or 35% of weekly insurable earnings depending on whether they opt for standard or extended parental benefits (Government of Canada, 2018). In such cases where women are ineligible for parental benefits, they must rely on family members (often their spouse or partner)

to provide for themselves and any dependents in the household (children and elderly persons). Canada's maternity leave model illustrates how state policies can influence social behaviors and practices within family units. In western democracies with weak maternity leave models, women are unable to live independently without being at risk of falling into poverty– which forces unity of the family and dual-earner households (Larsen, 2016).

In contrast to Canada's minimalistic benefits offered to mothers, Denmark's social democratic welfare regime offers women 52 weeks of maternity leave and 100% of average insured earnings upon completion of 120 hours of work in the last 13 weeks (OECD, 2018). The father is also entitled to two weeks of parental leave after the child's birth and is able to share parental leave with the mother in subsequent weeks, promoting an equitable distribution of childrearing responsibilities. Additionally, it is the Nordic nations (Iceland, Finland, Denmark, Sweden and Norway that rank the highest among OECD nations in terms of public expenditure on child care and early childhood development, spending well over 1% of the GDP compared to a 0.7% OECD average (OECD, 2016, p. 1). A lack of affordable childcare is especially burdensome to women impacted by IPV and single mothers, who upon leaving their spouse or partner may also experience a loss of income. In such circumstances, women will need to obtain employment to finance housing, utilities, food, transportation and childcare. Inability to access high quality licensed childcare produces further restrains on the women's ability to attain gainful employment as they must uptake precarious jobs that can accommodate their child care demands (Adelman, 2004).

As Raphael (2011) points out Canada ranks as one of the highest in public expenditure on healthcare but falls well below the OECD average for other supports that address labour policies, elderly care, family, poverty etc. Canada's failure to support these sectors aggravate the social

and economic conditions of women, who already occupy low earning jobs that do not offer employee benefits (Boyd and Yiu, 2009; Raphael, 2010). As Larsen (2016) notes, 'the welfare state balances social provisions between the state and the market' and also influences the level of decommodification afforded to individuals on the basis of citizenship (p. 62). Moreover, the structure of the welfare state contributes to social stratification, in which people fall within a social class gradient according to access to resources (e.g. income, power, wealth) (Larsen, 2016).

From a political economy perspective, women with a higher social status have a greater capacity to mitigate social and health risks associated with IPV as they have the agency and resources to do so. However, women with limited resources are more vulnerable to IPV exposure and adverse health outcomes as they do not have the same financial and social capital to ensure an adequate standard of living independently from their partner. Lastly, the political economy approach to health would posit that women have a differential vulnerability to IPV and associated health and social outcomes due to an inequitable distribution of resources– which are determined by macro-level social and economic policies (Larsen, 2016, Raphael, 2006).

Through Lens of Feminist Political Economy

While a political economy approach to health focuses on the implications of economic and political arrangements on society, feminist political economy challenges the dominant neo-liberal economic model through a lens that considers gender, social reproduction and lived experiences (Giles, 2014; Bezanson and Luxton, 2006). Social reproduction is defined as the processes involved in reproducing people, social structures and relations and tending to human needs (Bezanson and Luxton, 2006). Marx introduced the concept of social reproduction as an essential mechanism by which the dominant mode of production is able to reproduce itself.

Women have traditionally engaged in unpaid labour within the household to meet the demands of social reproduction (Vosko, 2006). Women's informal labour is an important consideration in this MRP as the documents selected for analysis examine the impact of IPV on women, families and the Canadian economy. Feminist political economists recognize that the informal reproductive labour performed by women is often rendered invisible, despite the fact that capitalist accumulation requires this work to maintain labour processes in the market (Vosko, 2006). Therefore, it is imperative to relate women's unpaid work to gender and labour relations in the household and the formal economy when discussing the complexities of IPV.

Social economic theorists explore how social and economic processes interact and influence each other and traditionally study the family as an economic unit (Farmer and Tiefenhaler, 1997). Becker's (1974) early work on the theory of marriage analyzes the relationship between market conditions and marital patterns, recognizing that micro-decisions such as marriage have macro-implications in terms of population growth, labour force participation and growth. Marriage is conceptualized as a voluntary relationship two individuals enter with the anticipation of maximizing utility or "value" above what either spouse could achieve alone (Becker, 1974). Hence, anticipated economic losses or benefits play a critical role in household formation (through marriage and the establishment of families) and the gendered division of productive and reproductive labour. However, the marriage model used by social economists is contingent on families functioning as a cooperative unit. The notion that marriage is an economic arrangement that affords certain social provisions to individuals (who have lower market power and would be unable to afford a decent standard of living independently) is absent from dominant IPV discourses. Families in which violence takes place, as Farmer and Tiefenthaler (1997) note disrupt this model as they exhibit a noncooperative relationship. The

work of McElroy and Horney (1981) introduce spouses as individual actors who engage in bargaining and have different preferences and needs. The previously mentioned economic models suggest that the maximization of a woman's utility (in terms of earning capacity and income) is associated with a reduced threat of violence in an intimate relationship (Farmer and Tiefenthaler, 1997).

Thus, the greater market power a woman possesses through higher education and income level, the greater likelihood of her dissolving the marriage without jeopardizing her current living standards (Farmer & Tiefenhaler, 1997; Iversen and Rosenbluth, 2010). The expected economic losses that arise from family breakdown (loss of dual-earner income, childcare, housing) become critical deterrents to women rationalizing their decision to leave an abusive partner. Whatever the consequences of family breakdown for IPV and non-IPV affected women is an area of focus in the analysis section of this MRP.

Through Lens of Power

Foucault's viewpoint on power informs his analysis of social structures and relationships. Foucault argues that various social institutions function to maintain a "disciplinary society" in which an individual's actions, behaviors and thoughts are regulated (Habermas, 1986). Foucauldian approaches recognize power as a diffusive entity that operates to produce and maintain social discipline. Consequently, systems of surveillance arise that socialize individuals to regulate and conduct themselves in a socially desirable manner (Habermas, 1986). Acceptable behaviors and acts of deviance are internalized such that the structural influences of everyday life appear to be far removed. Power is inherent in all social relations and institutions Thus, hospitals, schools and prisons are sites of disciplinary exercise where authoritative bodies are responsible for managing illness and delinquency among the population (Habermas, 1986). In the context of

IPV, certain knowledge is produced and suppressed as a result of disciplinary power and communicates particular messages about society's responsibility towards abused women. Notably, Foucault emphasized the opportunity for discourse to serve as a site of resistance by unveiling and challenging dominant ideologies conveyed in discourse (Habermas, 1986). In accord with Foucault's theory of power, this feminist social inquiry examines commonalities among dominant IPV discourses in the medical and public health fields that shape public perception, behavior and attitudes towards victims of IPV.

Medicine as a Social Institution and Agent of Social Control

In the *Birth of The Clinic* Foucault delineates the history of medicine and the implications of the restructuring of medical knowledge and practice that took place in the late eighteenth century during the French Revolution (Foucault, 1963). Foucault introduces the medical gaze and the language of medicine as critical concepts in reconceptualizing scientific medical practice as a political act that drives particular economic, social and political interests. He argues that medical practice is based on the observation and classification of diseases located within the body of the patient, thus the patient becomes the site of observation under the physician's gaze (Foucault, 1963). The medical gaze subsequently gave rise to the exclusionary medical discourse that secured the authoritative role of clinicians and enabled them to pathologize and describe phenomena (Foucault, 1963). The pathologizing of victim's bodies contributes to the individualization and depoliticization of a social problem, which alleviates government institutions from undertaking action to address systemic drivers of violence in women's lives.

Medicalization is a process in which a social phenomenon is defined, described, managed and treated under a biomedical framework (Zola, 1972). Conrad (1992) described the various levels at which medicalization takes place (Figure 2, APPENDIX A) Medical social control

describes the way the institution of medicine operates to maintain existing social norms and hierarchies through the minimization, normalization and eradication of undesirable deviant behavior (Conrad, 1992). Different typologies of medical social control have been identified by Conrad (1979) and Foucault (1963). Medical ideology refers to the application of the medical framework that conveys dominant social messages. Management of medical technologies such as clinical procedures and screenings is another form of medical social control. Physicians are able to exert control through medical collaboration as producers and distributors of knowledge, and gatekeepers who are able to label, treat and normalize deviances in the lay population (Conrad, 1979). Lastly, the medical gaze renders the body as a site of observation thus detaching the patient from their identity (Foucault, 1963).

Warshaw (1986) provides an analysis of the language deployed in medical institutions that define IPV and how it subsequently shapes the interactions between physicians and victims of IPV. Warshaw argues that medicine's epistemological approaches fragment and obscure domestic violence knowledge, which becomes evident at the interactional level between physician and patient. Warshaw examined the medical records documented by clinicians of women presenting injuries consistent with IPV. The results of the study suggested that although physicians would address the physical symptoms of abuse through prescribing pain medication and tending to wounds. They were less likely to further investigate what had caused the injury (Warshaw, 1986). The tendency to reframe the symptoms of IPV victims within a biomedical context is an attempt to coax the individual to appropriate the sick role (Williamson, 2000).

Warshaw (1993) goes on to warn of the implications of medicalizing social issues and pathologizing aspects of women's lived experiences. Objectification is an inherent aspect of the medical model which trains practitioners to make observations devoid of emotion and constructs

individuals as patients that fit a particular "sick" role (Warshaw, 1993). In the context of IPV, women's experiences are captured as individual cases and the larger social causes of family violence remain external to medical jurisdiction. Despite the quest for clinical objectivity, the findings of qualitative interviews with physicians reveal practitioner frustration with abused patients due to the belief that women have the capacity to remove themselves from the abusive environment (Williamson, 2000). Thus Williamson (2000) argues that victims of IPV are not considered "ideal patients" and are deemed a burden on the healthcare system who divert resources from "deserving patients" with "organic illnesses".

Warshaw's work concentrates on the role of the individual clinician and their responses to a women experiencing IPV, in other words the implications of medicalizing IPV at the interactional level (Figure 2, APPENDIX A). The present study examines the language employed to define and address IPV in public-facing documents authored by public health and medical agencies. Such documents are produced and disseminated to the public to raise the profile and inform Canadians of pertinent health issues. Thus this research is concerned with the medicalization of IPV at the conceptual and institutional level, and how language is used to divorce women's experiences of violence from the socio-political context in which they live.

PART 2: TEXTUAL ANALYSIS

Textual analysis was employed according to Fairclough's Framework for critical discourse analysis. In this approach, Antonio Gramsci's concepts of cultural hegemony and observations of how power differentials are reproduced in capitalist societies formed the foundations. This lens explores the relationship between language, ideology and power (Guba and Lincoln, 2005). A Critical Discourse Analysis approach views language as a vehicle that not only transmits information but also produces and disseminates dominant ideologies and can be

employed as a tool of social control (Guba and Lincoln, 2005). Language is an agent that legitimizes existing power relations and circulates certain narratives which become normalized and accepted as true, unchanging or natural (Wodak, 2001). According to Wodak (2001), the approach defines ideology as a mechanism that establishes and maintains unequal structural relationships.

Critical discourse analysis critiques texts and reframes problems through the perspective of groups with less power, and also considers the role of elites who have the resources to resolve or further aggravate the problem (Wodak, 2001). Critical discourse analysis does not only examine language but also inquires about the systems of power and theories that produce such texts and situating the object of inquiry within a historical context (Wodak, 2001). Discourse analysis reveals the ideologies embedded in the health beliefs of the lay population, the relationship between physician and patient and the dissemination of health information (Lupton, 1992). Power is encoded in the syntax, production and consumption of official texts such as government reports, clinical guidelines, health promotion strategies and health policy documents. This paper uses the term discourse to refer to the professional approaches, knowledge and language employed in official texts published by medical journals, public health organizations and federal health agencies.

The following documents were selected for discourse analysis : (1) the Chief Public Health Officer's (CPHO) Report on the State of Public Health in Canada 2016: A Focus on Family Violence in Canada, (2) A Year in Review: Canada's Strategy to Prevent and Address Gender-Based Violence, (3) Screening for intimate partner violence and abuse of elderly and vulnerable adults: US Preventive Services Task Force Recommendation Statement and (4) the Intimate Partner Violence Consensus Statement by the Society of Gynecologists and

Obstetricians of Canada the using critical feminist political economy as the guiding analytical framework.

The following research questions informed the textual analysis:

- How is health and IPV defined and what are the causal factors for IPV outlined in the official texts?
- Do the proposed recommendations acknowledge addressing structural inequalities that contribute to IPV?
- Do any of the documents selected for analysis discuss the implications of family breakdown for women experiencing IPV?

Each document was reviewed to identify the concept of health employed and the extent which the social dimensions of health were acknowledged in the framing of the problem, approaches to addressing IPV and policy recommendations. To perform the critical discourse analysis, each document was printed and reviewed to identify salient themes and dominant approaches to addressing IPV mentioned earlier in the paper. The concept of health and role of government was critically examined from a feminist political economy and political economy of health lens. Each document was reviewed to determine if indicators related to the overall social well-being of women such as equitable income, economic and political participation, housing insecurity, social programs and benefits, childcare were acknowledged in the explanation of the problem and policy recommendations.

Description of Data

The Chief Public Health Officer's (CPHO) report is commissioned by the Public Health Agency of Canada and will be analyzed in the present study. The purpose of the CPHO report is

to raise awareness of pertinent public health issues and issue calls to action to improve the health of Canadians. The Public Health Agency of Canada (PHAC) is the federal agency responsible for health promotion, chronic disease prevention and emergency preparedness (Taylor, 2016). PHAC employs a population health approach to improve the health outcomes of communities and quantifies health through evaluating various indicators that are influenced by social, economic and environmental factors (PHAC, 2001). The population health approach "recognizes health is a capacity or resource" rather than the absence of disease (PHAC, 2001). The PHAC maintains that their concept of health is based on the Frankish et al. (1996) description as "the capacity of people to adapt to, respond to, or control life's challenges and changes" (as cited in PHAC, 2001). The CPHO report under investigation in the present study focuses on family violence in Canada, which includes IPV, child abuse and elderly abuse (Taylor, 2016). The report offers a definition of IPV and potential root causes, as well as potential preventative measures and intervention programs that are anticipated to reduce the prevalence of violence among Canadian families.

A Year in Review 2017-2018: Canada's Strategy to Prevent and Address Gender-Based Violence outlines developments since the 2016 launch of *It's Time: Canada's Strategy to Prevent and Address Gender-Based Violence.* The strategy is described as a 'whole-of-government approach' to preventing and ending gender-based violence, which includes family, relationship and sexual violence. The federal government allocated $200 million into the national GBV strategy to execute initiatives under three priorities; prevention, support for survivors and promotion of responsive justice and legal systems (Status of Women Canada, 2017a).

The U.S Preventive Services Task Force (USPSTF) publishes recommendation statements on the efficacy of clinical preventive services for asymptomatic patients by reviewing

and evaluation evidence of potential benefits and harms of such services (Moyer, 2013). The Screening for Intimate Partner Violence and Abuse of Elderly Vulnerable Adults The recommendation statement on Screening for Intimate Partner Violence and Abuse of Elderly and Vulnerable Adults provides a description of IPV and various instruments used to screen women for abuse in addition to suggestions for clinical practice. Currently, the USPSTF supports IPV screening in women of childbearing age and indicated that research on the benefits of screening elderly women for abuse are inconclusive. Additionally, IPV screening and short-term counselling services are available as a free preventive service for women through the Affordable Care Act (Miller, McCaw, Humphreys and Mitchell, 2015).The Domestic Abuse 2013 Critical Appraisal Report authored by the CTFPHC is a review of the Screening for IPV and Abuse of Elderly and Vulnerable Adults Recommendation Statement by the U.S Preventative Services Task Force. Unlike the USPSTF the Canadian Task Force on Preventive Health Care (CTFPHC) does not recommend IPV screening for women, citing insufficient evidence on the benefits of screening Canadian women for abuse and advises practitioners to be aware of symptoms of IPV or elderly abuse (CTFPHC, 2013).

The final document selected for analysis was the Intimate Partner Violence Consensus Statement released by the Society of Obstetricians and Gynecologists of Canada (SOGC). According to the SOGC, purpose of the consensus statement is to provide health care professionals with information on IPV and best practices to 'improving the safety and health of all women' (SOGC, 2005). The consensus statement focuses on providing a framework to guide clinical practice and appropriately respond to victims of violence.

PART 3: DISCURSIVE ANALYSIS AND DISCUSSION

This section discusses the salient themes that emerged upon performing the critical discourse analysis. The proposed causes of IPV, approaches to addressing IPV, whether the issue was medicalized, the concept of health used in the document and the solutions offered in each report was identified. The findings of the analysis illustrate the dominance of certain discourses surrounding IPV over perspectives that raise the role of the state in distributing economic and other resources.

Proposed Causes of IPV

The CPHO report on family violence acknowledges there are competing explanations and theories about the root causes and definitions of IPV. The report describes IPV as a complex issue in which "[…] different combinations of factors at the individual, family, relationship, community and societal level affect the risk for family violence. Examples of factors include beliefs about gender and violence, and relationship characteristics such as power and control" (Taylor, 2016, p.3). The report can be commended for including societal level factors as a contributor to IPV and other forms of family violence, the examples of societal factors cited in the report include 'beliefs related to gender, mixing of cultures, […] lack of services (e.g. legal, health care), lack of community connectedness, support and control of behavior, social disorder, neighborhood disadvantage (e.g., poverty)' (Taylor, 2016, p. 24). Yet, the societal factors listed in the document are confounded with community-level causes of IPV. Although poverty is mentioned it is referred to as a 'neighborhood disadvantage' as opposed to an outcome of inequitable macro-level social and public policies. The CPHO report asserts that the relationship between poverty and individuals' risk for family violence 'is conflicting or complicated. It may depend on other factors such as the type of abuse, neighborhood socioeconomic status and beliefs and attitudes on gender and violence' (Taylor, 2016, p.22). This claim localizes the issue

of IPV to the individual, family and community level, and downplays the role of economic insecurity in increasing an individual's susceptibility to violence. This quote from the report obscures the role of government and social policies in offering support to promote the living conditions and overall well-being of IPV-affected women. Macro-structural arrangements are central to the political economy of health approach, which would position housing insecurity, labour market conditions, weak social safety nets and increasing levels of poverty as more influential on family breakdown and violence than individual level explanations of IPV. In Canada, low-income cut-offs are defined as 'income thresholds below which a family will allocate a larger proportion of its income to basic necessities such as housing and foods than the average family (Statistics Canada, 2016). Women represent 71 percent of permanent part-time workers, and are noted to work fewer hours than men further reducing their income due to having to tend to care work (Statistics Canada, 2016). Rates of low income are particularly high in single-parent households with 23.7 percent of families living in poverty in 2014. The gendered dimension of poverty is particularly staggering as 26.8 percent of female-led single-parent families live in low income compared to 12.8% of male-led single-parent families (as shown in Figure 3, APPENDIX A). (Statistics Canada, 2016, p. 17). Canadians with lower income levels have a greater probability of being a victim of a violent crime. The rate of violent crime for individuals in households with an annual income of $149,000 to 179,000 is 54 for every 1000 people, compared to 79 victims per 1000 for low-income households earning less than $20,000 (Statistics Canada, 2016, p. 27). Contrary to the inconclusive remarks made in the CPHO report, one can conclude that where an individual is positioned on the income ladder is related to their probability of being a victim of violence– this holds particularly true for women and female-led single-parent households who possess reduced earning capacity.

The CPHO report also fails to acknowledge that in Canada, the family institution is upheld as the primary source of welfare and social security for women and children, which is threatened by family breakdown regardless of the presence of IPV. The key assertions from the CPHO report insinuate that domestic violence is a phenomenon that takes place in the home thus it requires government responses to be directed towards the individual level.

Similar to the CPHO report, *A Year in Review: Canada's Strategy to Prevent and Address Gender-Based Violence* states that violence against women 'grows out of a culture that devalues women, girls and femininity, and holds misinformed views about other diverse populations' (Status of Women, Canada, 2017b, p.6). The policy document suggests that culturally informed beliefs and attitudes drive various types of violence against women, and does not include the broader socio-political and economic explanations of why IPV takes place. The strategy acknowledges that particular women are more vulnerable to violence and experiencing barriers to accessing services in the following excerpt:

> Knowing that some populations living in Canada experience disproportionate levels of violence and greater challenges to accessing services, the strategy places survivors at its center. The Strategy is working with stakeholders to respond to and support the unique needs of survivors, including indigenous women and their communities and other underserved populations, such as those who are more at risk of GBV and/or are facing barriers to accessing services. These include but are not limited to: children and youth, ethnocultural women, LGBTQ2 communities and non-binary people, non-status/refugee/newcomer women, seniors, women living in northern, rural and remote communities, and women living with a disability (Status of Women Canada, 2017b, p.8).

Although the strategy acknowledges that some women are disproportionately impacted by violence and experience barriers to accessing services, there is no mention of what drives this difference – and why certain women are more likely to experience violence within the home. The CPHO report and Canadian Strategy to Address GBV both identify 'underserved' and 'vulnerable populations' but the latter does not attempt to explain the relationship between existing structural factors that contribute to inequalities in terms of poverty, lack of power and agency which underpin violence. No attempt is made to explain that differential vulnerability to IPV is socially and systematically produced by unjust policies at the macro-level, most like because it would require substantial policy changes to create a more equitable distribution of resources to elevate the poor social standing of 'at risk' populations.

However, the CPHO report acknowledges that indigenous populations '[…]experience inequalities such as less access to health and support services, higher rates of poverty, lower life expectancy and higher rates of some diseases and conditions. These inequalities result as part of a broader context that includes marginalization, discrimination as well as social, economic, political and historical factors' (Taylor, 2016, p. 27). While the report recognizes the historical and socio-political undercurrents that have led to disproportionate rates of violence against indigenous women in Canada, no explicit connections were drawn to the policies imposed by the Canadian federal government that ultimately produced an inequitable distribution of power, influence and material goods between Indigenous men and women. Prior to the imposition of colonial policies, social and economic structures, Indigenous societies were organized by a matriarchal system in which women upheld important economic roles and were key decision makers in the home and community (Halseth, 2013).

Upon the enforcement of the *1867 Indian Act*, Indigenous women experienced gender discrimination as their status rights were denied upon marriage to a non-status man. The denial of Indigenous status stripped women of their property and political rights (ability to vote in band council). Thus, Indigenous women were positioned in a subordinate role with limited agency and access to resources relative to Indigenous men, increasing their vulnerability to poverty, various forms of violence and other poor social and health outcomes (Halseth, 2013). The Indian Act represents one of the ways in which government policies can impact the conditions in which women lead their lives and contribute to negative social outcomes such as vulnerability to poverty and abuse. Indigenous women are reported to experience poverty rates double that of non-Indigenous women, and their poor economic status is further exacerbated by family breakdown in which most single-parent households are headed by an Indigenous woman.

The poor social standing of such populations are presented in an isolated manner in the CPHO without reference to the idea that power, influence and socio-economic status are relational concepts, in which those with greater power (such as the corporate and business sectors) have greater political agency and influence over policies that can either improve or aggravate the social, political, economic and health status of Indigenous women. The report fails to make clear that the direct determinants on Indigenous women's health (such as living conditions, income level, education and health behaviors) are produced by past and existing social and economic policies that perpetuate the inequities they face. Thus, from a political economy lens– one would be able to deduce that policies and socio-economic structures would be the most appropriate and effective site of change to improve the conditions in which Indigenous women live thereby reducing their susceptibility to IPV.

The *Screening for Intimate Partner Violence and abuse of elderly and vulnerable adults attributes USPSTF's Recommendation Statement* attributes IPV along with other forms of family violence to risk factors at the individual to societal level:

> The CDC has developed a comprehensive list of risk factors for IPV, which are organized into 4 categories (36): individual (such as low self-esteem), relationship (such as marital conflict and instability), community (such as poverty and associated factors), and society (such as traditional gender roles) (Moyer, 2013, p. 482).

The rhetoric of the risk factor paradigm promotes the idea that certain deficits in individuals are the cause of their vulnerability to undesirable social and health outcomes such as IPV. Additionally, the risk factors cited as examples at the individual, relationship, community and social levels are consistent with Ellis' Ecological Framework for Explaining Gender-Based Violence (Figure 1., APPENDIX A).

The *Intimate Partner Violence Consensus Statement* by the Society of Obstetricians and Gynecologists of Canada (SOGC) provides the following definition of IPV:

> … the pattern of abuse of a woman by her partner, her family members, her caregivers, or others with whom she has intimate, familial, or romantic relationships.[18] These terms having in common an understanding of violence as an expression of power, control, and domination that is expressed through a range of ongoing and escalating behaviors (Chemiak et al., 2005, p. 266).

This excerpt from the SOGC IPV consensus statement recognizes the role of power at the micro-level (intimate and familial relationships), but fails to explain gendered power differentials on a broader scale. The SOGC can be applauded for including various forms of IPV (that may not be

outright considered a criminally chargeable act) such as ‘emotional and psychological, verbal, environmental, social, financial, sexual, religious and (or) spiritual, or ritual abuse,’(Chemiak et al., 2005, p. 266). By doing so, the SOGC recognizes that violence manifests in different ways that do not directly cause physical injury.

The document also highlights the increased IPV prevalence rates among Indigenous, LGBTQ, disabled, women of colour and immigrant and refugee women. Unlike the CPHO report, the GBV Strategy and the USPSTF recommendation statement, the SOGC consensus statement details the barriers marginalized women encounter such as ‘lack of access to English or French language acquisition’, ‘lack of access to social or community services’, and institutionalized racism (Chemiak et al., 2005, p. 270). For instance in the backgrounder on Women of Colour, the document acknowledge that women’s responses to abuse and violence are influenced by ‘the social contexts in which they live,’ which ‘often provide them with different opportunities for and restrictions on their resistance to violence’ (Chemiak et al., 2005, p.271). Among the data selected for analysis, the SOGC consensus statement is the only document that acknowledges women’s ability to respond and resist IPV is influenced greatly by their social location. However, the document reverts to a community-level focus on their recommendations for Groups with Special Needs, stating that normative behaviors are cultural specific:

> The experience of violence is framed by cultural understandings of “normal” relations between intimate partners. It is important to note that there are variations among different cultures “in the amount, frequency, and severity of aggression against women and in what is condoned or disapproved (Cherniak et al., 2005, p. 269).

The absence of the social context that influence women’s vulnerability and responses to IPV can be interpreted as an indication of the primary focus of medical agencies and clinicians, in terms

of addressing the immediate and acute needs of women experiencing abuse. The implications of such discourses are extremely damaging for women experiencing IPV because it atomizes as social issue and divorces the social and political context that significantly shapes the experiences and health trajectories of women.

It is apparent from this critique that all of the documents selected for analysis reference theorizations of IPV that do not directly relate to socio-political and economic arrangements at the macro-level that contribute to the precarious nature of women's lives not only within the home but in the market economy. One can deduce that the documents uphold institutional and cultural hegemony by avoiding critique of powerful interest groups such as the private sector who profit off of women's unpaid labour and the positioning of the family as a primary source of welfare for individuals. The critique further reveals that the dominant health discourses raised in the analysis fail to draw a relationship between direct violence perpetrated against women and the inequitable system in which women lead their lives and have reduced access to power, influence and wealth.

Approaches to Addressing IPV

The CPHO report extensively chronicles the various factors that may increase the risk of experiencing violence within the home. As noted in the earlier section on theoretical frameworks used to address IPV, the CPHO report draws on community-based approaches to provide targeted solutions to address and prevent IPV. These approaches include 'changing societal beliefs so that family violence is less socially acceptable and not seen as a normal part of everyday life,' creating safer communities 'that have community members who are willing to intervene,' and 'relationship education' initiatives that can 'reduce negative behavior and less severe forms of abuse' (Taylor, 2016, p. 34). The community-level solutions proposed primarily

focus on changing beliefs, attitudes and raising IPV awareness. No policy solutions are offered to address the systematic inequalities ‘at-risk populations' such as LGBTQ members, Indigenous peoples and women experience which are noted as risk factors. In fact, in the concluding statements of the Preventing Family Violence Section of the report an explanation is offered as to why approaches to mitigate risk factors and promote protective factors are not included:

> What about targeting risk and protective factors? Programs exist that show promise by targeting factors that increase the risk for family violence, but it is not clear if they are effective at preventing it. There is little research on how approaches to prevention can target protective factors (Taylor, 2016, p. 35).

This extract from the report serves as an example of an epistemological barrier for public health authorities to advocate for broader, systemic changes to address the social inequalities women experience. As approaches for preventing violence by addressing risk factors such as low socioeconomic status, education, poverty ‘not been evaluated, and need more study or evidence on their effectiveness is conflicting'(Taylor, 2016, p. 35). It is clear that the report follows a traditional socially uncritical line of thought with positivist tendencies, in which proposed solutions to address IPV must yield improvements that can be measured in order to be valid (Brassolotto et al., 2014).

The quote illustrates the epistemological limitations present in the public health field which relies on evidence to inform policy decisions. It is assumed that strengthening evidence and generating knowledge is the most effective tactic to reducing IPV, which dismisses the

broader socio-political and economic factors that would require institutions and professionals to take a political stance and advocate for larger systemic changes at the policy level.

Canada's Strategy to Prevent and Address Gender-Based Violence appears to miss the mark in explaining why IPV takes place. In alignment with other global movements taking place such as the 'Me Too' and 'Times Up' movement, the strategy frames IPV as by-products of a toxic culture and patriarchy within the home. The strategy describes itself as a 'whole-of-government approach to ending GBV informed by grassroots activism and feminist action' (Status of Women Canada, 2017b). The strategy offers actions to address IPV that is categorized under three pillars.

The pillars include *Prevention* which consists of initiatives to facilitate 'a national conversation to raise awareness about GBV;' *Support for Survivors and their Families* through the creation of additional shelter beds and a survivors network*; Promoting Responsive Legal and Justice Systems* by strengthening the capacity of social and protective services to respond to IPV cases. A number of initiatives at the provincial/territorial level are currently underway that aim to address the immediate needs of women fleeing violence and initiating dialogue about GBV among Canadian youth. Examples include the "16 Days of Activism against GBV' campaign launched by the Status of Women Canada in partnership with the Canadian Football League at local high schools and the establishment of a Pan-Canadian Voices for Women in Housing Symposium. Rather than propose policy changes at the national level that could alleviate the threat of homelessness or housing insecurity among women, the solutions detailed in the strategy appropriate a grassroots approach to cultivating a change in cultural attitudes towards IPV and other forms of GBV. It is clear that at the Federal level it is expected for communities and

individuals to promote a culture that condemns violence against women, without providing any concrete mechanisms to operationalize the goals of the strategy.

A number of initiatives are proposed and are currently underway that aim to address the immediate needs of women and children fleeing violence and to initiate dialogue about GBV among the Canadian public. The national strategy represents feminist concepts being appropriated to serve neoliberal agendas, by framing IPV and other forms of gender-based violence as a social problem that equally threatens all women and girls, while failing to recognize gendered-disadvantages are compounded by other inequalities that are systematically produced.

The strategy does not reference the economic standing of women relative to men or propose that there are structural barriers in place that position women to be more susceptible to violence in the home. Rather IPV is positioned as the primary obstacle for women to attain their full potential and that 'continuing to work in partnership with frontline advocates and activists for greater awareness, greater action and greater momentum to end GBV' are adequate responses to address the issue. The strategy promotes an individualized approach in which the general public are encouraged to exercise agency and push for gender equality in their neighborhood and communities. While raising public consciousness around IPV is critical, one should be mindful that policy reform is critical to alleviating the threat of violence against women- requiring not only a change in cultural attitude but the political mobilization of the general public to drive such change. In light of the one-year anniversary since its' establishment, the strategy highlights its milestones towards 'eradicating' GBV in Canada, which includes increased funding opportunities and support towards strengthening the capacity of legal and response systems

directly responsible for victim support and protective services. One of the year-end goals of the strategy to support victims and families are detailed below.

> The National Housing Strategy launched by the CMHC will help reduce homelessness and improve access to quality housing. As part of its focus to meet the needs of women and children fleeing family violence, 4000 new and repaired shelter beds will be created or repaired for a total of 7,000 (Status of Women Canada, 2017, p. 9).

A sustainable, long-term solution to the lack of access to affordable, quality housing is not provided, rather the document calls for 'targeted research on women's housing needs' (Status of Women Canada, 2017, p.9). Secure housing is a critical concern for women impacted by violence and fleeing from an abusive partner. An estimated 1.5 million Canadian households are impacted by housing insecurity and would qualify for having a severe housing need. According to the Canadian Mortgage and Housing Corporation (CMHC), affordable housing is defined as when less than 30% of pre-tax income is allocated to shelter costs. Income expenditure from 50% or more on shelter qualifies as a severe housing need. Statistics on women's homelessness often exclude data on IPV victims for multiple reasons.

Data is not incorporated from women's shelters nor for those residing with a friend or family considered homeless by many housing insecurity reduction programs (Maki, 2017). Consequently, abused women attempting to access homeless shelters will not meet the program's eligibility of being homeless for at least 30 days (Maki, 2017). IPV victims with children are also turned down from shelters that do not accept dependents, which forces with women and their children to return to their abuser to avoid living on the streets. This presents a barrier to single mothers who represent a growing number of homeless shelter users (Maki, 2017). The income of

single-mothers can be further impacted by the removal of children by Children's Services which would disqualify mothers for monthly children's benefits and income supplements (Maki, 2017). Applications to qualify for affordable or social housing are part of a lengthy process that requires women to prove that they have a low-income and does not account for women whose financial assets are controlled by their partner. A discussion paper published by VAW Shelters of Canada posit that newcomer women experience further housing marginalization when fleeing an abusive sponsor who may be withholding documents required to qualify for social assistance programs (Maki, 2017). Additionally, immigrant families are disproportionately impacted by housing insecurity, as they represent a majority of the demographic that spends well over half of their pre-tax income on housing (Maki, 2017; Sokoloff and Dupont, 2005). Moreover, research also indicates that individuals who experience marginal housing by seeking accommodation at shelters, rooming houses and hotels are associated with higher mortality rates, chronic diseases and contraction of acute illnesses (Maki, 2017, p. 7).

The USPSTF Recommendation Statement reviews the potential benefits and harms of screening to identify IPV among women of childbearing age who do not display any symptoms of abuse. The guideline follows a traditional medical approach to addressing IPB, in which preventive initiatives focus on the individual patient. A description of various screening instruments to detect abuse when women present themselves in clinical settings are included in the recommendation statement. The following excerpt captures the approach level the USPSTF is undertaking to address IPV:

> The evidence on screening for IPV is based on a bio-psychosocial framework rather than a pure biological model. As described by the CDC, IPV should be considered by using a socioecologic model, based on 4 specific elements: individual, relationship, community and society (36) (Moyer, 2013, p. 484).

The quote from the USPSTF brings forth multiple issues. Bearing in mind that the document is intended as an aid for clinical practice and health care providers (family and emergency room doctors), one would not anticipate broader macro-policy level recommendations to be included in the document. However, the excerpt suggests a bio-psychosocial framework is being applied to address and reduce IPV, without mentioning the social context that plays a significant role in women's ability to respond to IPV. The screening paradigm employed by the USPSTF oversimplifies the complex nature of IPV and ignores the factors that persuade or dissuade women from leaving an abusive relationship. Agency is defined as the capacity to exert power in one's environment and engage with social structure and is associated with the ability to have control or influence over one's social outcomes which impact health (Coburn, 2000). Social outcomes are shaped by determinants identified on the macro level, which impact meso-level and micro-level factors such as housing, education, neighborhood composition, family dynamics and health practices.

Women's limited personal agency in relation to men needs to be considered not only within the household and in relationships but within the public sphere, in which women disproportionately experience underemployment, low wages and marginal housing. Revisiting the work of Bambra (2004) and Iversent and Rosenbluth (2006), women's ability to live independently from family depends on the degree to which the welfare regime of the nation in

which they reside provides protection from market forces. In Western democracies characterized by liberal welfare regimes, individuals that do not have gainful employment are more vulnerable to poverty, housing and food insecurity, and reduced opportunity for upward social mobility. As women represent a majority of the unemployed population, marriage and 'household formation' presents an opportunity for individuals to pool incomes and to act collectively to achieve economic security– and be able to afford an adequate standard of living (Farmer and Tiefenhaler, 1997). Furthermore, given evidence to support that women with lower socioeconomic status experience poor health and social outcomes, medical associations should be wary that women's vulnerability to IPV is one of many adverse social and health outcomes structural violence gives rise to.

The SOGC IPV consensus statement recognizes IPV as a social and public health problem, and unlike the USPSTF does not recommend routine screening as an intervention measure for IPV:

> Because violence, including IPV, is not only a medical problem but a social one, its primary prevention is not a clinical intervention. Even secondary prevention, such as responding to a woman who has disclosed violence, must include interventions outside the scope of a medical clinic (Cherniak et al., 2005, p.273)

> The most important change in how communities approach women battering is the development of a coordinated response that links health and social service providers to develop and implement a comprehensive strategy of service development, policy change, and prevention. This approach is based on the reality that changing one facet of the

service response without changing the system can actually worsen the situation (Cherniak et al., 2005, p. 273).

While the SOGC consensus statement acknowledges that interventions at a societal level must take place to effectively combat IPV, the document does not call into question the political and economic context that influence the resources and services abused women have access to. Instead the SOGC consensus statement advocates for improved coordination at the services level between criminal justice, social service and health care systems. The findings that emerged in this section of the analysis demonstrates that all the of the documents reflect IPV approaches with an uncritical appraisal of the government– and in particular the influence of market-state relations on women's lives. In recent years, standard stable employment, characterized by 40 hour work weeks and employee benefits has declined and been replaced with temporary, part-time status and contract jobs (Kholsa, 2014). Statistics Canada's Labour Force Survey reveals that 75.8% of those working part-time jobs were women (Moyser, 2017). As Kholsa (2014) articulates, the loss of standard employment and emergence of precarious labour are associated with austerity measures and neoliberal governmentality, in which the state outsources its responsibilities towards citizens to the private sector and the family. Cuts to public services such as health care, child care, education programs, community and recreational services exponentially increase the care burden on women, who are already experiencing difficulties accessing gainful employment and a livable wage (Kholsa, 2014). Thus when can argue that a lack of labour regulation and public provision of services aggravates the economic and social prospects for Canadian women, particularly low-income women and single mothers. Neoliberal economic models favor policies and practices that promote the accumulation of capital rather

than the welfare of the worker, consequently an unequal distribution of income arises which positions individuals to have differential access to wealth, power and resources (Wilde, 2008).

Medicalizing IPV

The CPHO report provides a biomedical model of disease that outlines how IPV can lead to adverse health outcomes and the development of diseases (Figure 4, APPENDIX A). As shown in an infographic, it is hypothesized that the stress that accumulates from different types of abuse drives genetic or behavioral changes that can result in chronic conditions and 'risky behaviors' such as 'substance use, disorders, overdose, unwanted pregnancy and sexually transmitted infections' (Taylor, 2016, p.34). IPV is framed as a comorbidity or concomitant to other "organic diseases," which are illnesses that typically arise due to some physiological defect or change in the body. While it is important for the public to be aware of the adverse health outcomes associated with IPV, it is equally critical to recognize the social and political context in which violence is taking place. The report fails to include societal risks such as unemployment, disability, low education in the infographic, which were previously mentioned as factors associated with an individual's increased vulnerability to violence.

The document cites research studies that indicate the role of an individual's genetics as a potential protective factor from the stress effects of trauma that lead to depression or other poor health outcomes:

> Researchers have found that person's genetic makeup (their genotype) can increase the risk that child maltreatment will lead to depression in adulthood or problem behaviors in adolescence. Other genotypes are thought to reduce the risk that abuse will affect health (Taylor, 2016, p. 19).

The CPHO report expressed a need for more evidence to address knowledge gaps concerning effective approaches to addressing IPV through target interventions and programs:

> Surveillance data can provide important information on rates, impacts and risk and protective factors related to family violence. Without quality data, programs are less likely to be successful in achieving their goals (Taylor, 2016, p.33).

The quote is consistent with Foucauldian power theory and the use of surveillance medicine to observe populations and implement interventions to address a health problem. Additionally, the report highlights the risky behaviors that can arise from IPV establishes victims as potentially 'deviant individuals' whose trauma may lead to socially undesirable behaviors (e.g. substance abuse, unhealthy sexual behaviors, criminal activity). As Conrad (1992) stated in his work, this upholds public health agencies as guardians of population health who must raise issues of behavioral deviance to the general public. The CPHO report also emphasizes the importance of the family institution to Canadian society in the following excerpts:

> Families are the building blocks of our society and a safe haven to nurture children and our intimate relationships (Taylor, 2016, p. III).

> Healthy families are the backbone of strong and productive individuals, communities and societies. They come in many shapes and sizes and are safe havens that provide food, warmth, shelter, security, support, safety and love (Taylor, 2016, p.5).

A prescriptive definition of what a ‘good' family should encompass and provide to the children in the household is included in the personal address of the 2016 Chief Public Health Officer, Dr. Gregory Taylor. This quote from the report illustrates that families are expected to be a source of welfare and participate in the production and well-being of children, who from a neoliberal perspective will ensure future economic prosperity. The notion that families should be responsible for the provision of basic necessities and the well-being of children demonstrates the document's normative focus on unpacking the contributing factors of IPV.

Additionally, the financial burden of IPV violence is also cited in the document as a rationale for directing attention towards the issue:

> People who are experiencing intimate partner violence may often miss or be late for work, be less productive at work, and have trouble concentrating on their work or keeping a job (Taylor, 2016, p.18).

The report quantifies the financial costs of IPV on the Canadian health care system using a time-based measure that parallels the burden of disease, a measure which estimates the loss of life, quality of life and health care costs associated with a particular health condition (Michaud, Murray and Bloom, 2001). Operationalizing IPV in terms of costs to the government and the health care system can contribute to stereotyping victims and families as tax burdens and contribute to further individualization of violence in relationships. It becomes easier to place the blame on individuals, women in particular for remaining in abusive relationships and overlooks

the broader economic and social structures that present challenges for women wanting to flee abuse (Johnson and Ferraro, 2000).

The USPSTF appropriates several medical concepts in order to describe and propose solutions to IPV. The USPSTF recommendation statement recommends 'asymptomatic women of childbearing age' are screened for IPV, and 'provide or refer women who screen positive to intervention services' (Moyer, 2013; p. 479). By means of this statement, the USPSTF likens IPV to a disease in which women may not show any indication of illness. From a foucaudian perspective, the screening of presumably health women for their susceptibility to IPV exemplifies the medical gaze (Foucault, 1963). The USPSTF recommendation statement reinforces the paternalistic relationship between physician and patient, whereby women's bodies are made available for inspection by health care providers. A positive result from an IPV screening test would then prompt clinicians to direct 'at-risk' women for further 'intervention' such as 'counseling, home visitis, information cards, referrals to community services, and mentoring support' (Moyer, 2013; p. 479). The construction of the patient (in particular women) as a passive subject is a dehumanizing process that explains her 'deviant behavior' of remaining in an abusive relationship. Furthermore, pathologizing battered women excuses them from neoliberal risk discourse, which places the onus on the individual to uplift themselves, mitigate risks and exert influence over outcomes (Wall, 2013).

The victimization model that centres on medical discourse used to describe IPV stems from a long-held tradition of reframing women's health issues to fit dominant male discourse and position women as incapacitated subjects (Theriot, 1993). An example of the medicalization of female patients was the establishment of female hysteria as a gender-specific mental disorder attributed to women in the nineteenth century. As Theriot (1993) argues, the language of

medicine is inherently male and has been employed to reinforce women's status as subjects available for medical surveillance and exploration.

The SOGC Consensus Statement strongly advocates against the routine screening for IPV among women;

> Asking women about violence is not a screening intervention: victims are not asymptomatic; disclosure is not a test result, it is a voluntary act, and the presence of absence of violence is not under the victim's control; and most interventions required to protect and support survivors are societal, not medical (Cherniak et al., 2005, p. 264).

While the SOGC's condemnation of applying a screening paradigm to IPV should be welcomed, the remainder of the document reverts to emphasis on improved community service delivery and physician sensitivity towards abused women. Clinicians are advised to meticulously record their interaction with a suspected abused patient, the consensus statement includes a body map in its appendices to document injuries (Figure 5, APPENDIX A). The authority bestowed on health care providers to inspect patients, normalizes what Foucault described as the "health police" (1963). Both public health and medical governing bodies are entrusted with the health of the lay-population and are granted access to surveil, document and exert control in the name of safeguarding the health of the state (Conrad, 1992).

This is also illustrated in the recommendations of the CPHO report which advocates for surveillance data and improved research methods to obtain sufficient evidence to implement effective intervention programs (Taylor, 2016; Wathen and MacMillan, 2003). The CPHO report cites that 'there are many theories about family violence, but none of them can fully explain it.

At this time, theories that state that family violence is a result of interactions between individual, family, social and community factors best predict why violence happens' (Taylor, 2016, p. 24). However, the report heavily relies on biomedical and epidemiological concepts to explain how IPV and other forms of family violence contribute to poor health outcomes such as 'epigenetics or genetic predispositions for resilience to trauma' (Taylor, 2016, p. 19). The role of genetics is considered as a plausible reason why certain individuals are more resilient to trauma-induced stress and do not develop chronic health conditions or engage in risky health behaviors. The claims of genetics driving resilience in victims support the tenets of biological determinism, which argue that human behavior and most social problems are determined by hereditary factors.

The premise of Lewontin's (1996) *Biology as Ideology,* in which scientific concepts are appropriated by institutional agents to normalize and explain certain phenomena. Appropriating genetics and risk factor data serves to pathologize victims and their abusers and to construct these individuals as problems to society (Lewontin, 1996). Documents released by the medical associations in this analysis excluded the plausibility of structural inequalities and poverty as a contributor to women remaining in abusive relationships. Instead, medical discourse concentrates on the mechanism by which the trauma of abuse leads to the development of numerous diseases.

As described by Sweet (2014), once diagnosed with abuse, victims bodies become a site in which pathologies will develop in the future. Sweet (2014) argues that this rhetoric frames victims as burdens on the system due to the illnesses they are expected to develop after the initial trauma they experience. The ongoing pathologization of IPV victims' bodies presents women as economic burdens on the health care system. Similarly, the psyche of male perpetrators of spousal abuse becomes the site of exploration for psychologists and provides the groundwork for rehabilitation programs (e.g. Partner Assault Response program). Thus, the process of

medicalization subsumes abuse and remodels a social problem into an etiological agent for multiple diseases.

Observation is enlisted as an essential tool to develop evidence-based methodologies that will guide both public health and medical disciplines to create the appropriate solutions to address IPV. Thus, in this context women's bodies become the site of medical surveillance by population health authorities.

Concept of Health

The definition of IPV employed in the texts under inquiry present a reality in which terminating an abusive relationship or holding the perpetrator accountable will reduce the prevalence of IPV and improve the health and well-being of the woman. Medical discourse presents a monolithic concept of IPV that focuses on "intimate terrorism," which Johnson (2008) describes as a set of dysfunctional controlling behaviors associated with frequent and severe violence (as cited in Ansara and Hindin, 2010).

Although the CPHO report states that it is informed by PHAC's population health approach, which draws on Frankish et al. (1996) concept of health as 'the degree of agency individuals exert over their own life,' this rhetoric is absent from both the Canadian medical and public health documents. No discernible recommendations against policies that contribute to material deprivation and poor quality of living are made. Furthermore, both medical and public health discourse fails to acknowledge the relationship between the abused woman and macroeconomic policies and practices– which limits her ability to exercise agency over her relationship and environment which is shaped by multiple intersecting power asymmetries.

Despite acknowledgment of competing discourses that attempt to explain the root causes of IPV the CPHO report disproportionately elaborates on risk factors; biologically root predispositions, unhealthy attitudes and beliefs and dysfunctional relationship dynamics which locates the problem at the individual level. There was a great degree of overlap between medical and public health approaches in terms of the tendency to conceptualize IPV as a phenomenon that plague 'at risk' individuals, dysfunctional families and toxic cultures. However, the proposed solutions by both disciplines differ in terms of the locus of intervention, the medical model advocates for addressing the immediate clinical needs of the victim and effect program delivery for abusers that are compatible with a legal framework. Public health approaches place the locus of intervention at the community level, in which promoting awareness and community engagement is anticipated to evoke a cultural shift that produces healthy families and relationships. Although public health discourse acknowledges that an association exists between IPV and poverty, there is a failure to advocate for policy reforms that would address material deprivation and challenge existing structures that perpetuate unequal hierarchies.

Canada's GBV Strategy assumes that addressing the immediate needs of victims and families through targeted downstream approaches will reduce the incidence of IPV and proposes initiatives to dismantle gender inequality and sexist attitudes will prevent acts of violence against women. However, as Foucault posits– power operates in a more insidious manner and is embedded in every relationship from the macro-structural level to the household.

Notably absent from the official texts was the concept of structural violence. Structural violence refers to the broader social forces at play that set in motion the harms and individual will encounter (Farmer, Nizeye, Stulac and Keshavjee, 2006). All women are not equally vulnerable to IPV, especially in nations guided by governance models that favor the market. The

gendered dimension to poverty in Canada is largely ignored in all four documents, despite evidence and research that suggests poverty and violence are inextricably linked (Maki, 2017; Gracia and Merlo, 2016). While labour market flexibility in Canada has enabled greater female labor participation, the Canadian welfare state significantly undermines women's economic security through low provision of social benefits. This becomes apparent with indicators such as single-parent poverty, in which 35-40% of single-parent households live in poverty compared to 10% of two-parent households (Maldonado and Nieuwenhuis, 2015, p. 404). Whereas family allowance models in social-democratic welfare states favor single-parent households and have substantially reduced the poverty rates among single parents (Maldonado and Nieuwenhuis, 2015). However, a study conducted by Gracia and Merlo (2016) suggests that Nordic countries have higher rates of IPV relative to other EU nations despite achieving high gender equality. Described as the 'Nordic paradox,' non-Nordic nations have a 22 percent average prevalence rate of IPV, whereas Denmark, Finland and Sweden have an average rate of 32 percent, 30 percent and 28 percent respectively (Gracia and Merlo, 2016). Granted, the disproportionately high rates could also be a result of women feeling more comfortable disclosing their experiences of IPV (Gracia and Merlo, 2016). Additionally, further research is required to determine how IPV is defined and measured in different nation-states, and whether this factor plays a role in the discrepancies in prevalence rates between countries. Whether data collection methods use a concept of IPV that is consistent with a legal definition as a chargeable offense would affects women's comfort disclosing abuse.

However, according to the Gender Development Index (GDI), a measure based on health, education and living standards, Nordic nations have achieved scores of approximately 0.98 –with a score of 1 representative of absolute equality (Gracia and Merlo, 2016). The United States,

Canada and the United Kingdom rank below all five of the Nordic nations in terms of GDI (United Nations Development Programme, 2018). From a political economy perspective, it is the inequitable distribution of power, wealth and material resources that drive the social and health inequalities women experience. Thus, structural violence is imposed on women and prevents them from attaining the basic necessities to ensure their well-being and security, which makes them susceptible to other forms of direct violence. In social-democratic nation states, social programmes and entitlements operate on the basis of universality and egalitarianism, which requires high employment rates to afford the high-level of decommodification afforded to all citizens (Gracia and Merlo, 2016; OECD, 2016). Nordic states are characterized by equal gender participation in the labour force as well as equitable political representation.

For instance, in Sweden women represent approximately half of all government seats (Gracia and Merlo, 2016). Social-democratic welfare regimes are informed by Marxist ideology which promotes market regulation and to eliminate poverty, contrary to the residual approaches of liberal welfare states like Canada that offer minimal support to help individuals cope. As Peter (2006) states social-democratic welfare models are optimally designed to provide support to women who are victims of IPV in comparison to nation states with liberal welfare regimes. Means-tested benefits and targeted programs in Canada provide minimal support to women and require them to demonstrate that they do not have the financial means to support themselves (Raphael, 2012). The social program structure in Western democracies perpetuates stigma towards individuals that seek government assistance and deter individuals experiencing violence within the home. Furthermore, means-tested benefits programs contribute to stereotyping abused women as deviant victims– who are draining the state's public funding.

The texts selected for analysis in this paper represent widely held professional and public discourse on violence against women, with significant emphasis placed on individual responsibility and shifting cultural attitudes. Suggested approaches to addressing IPV from clinical, public health and criminal justice systems include increasing capacity of police and social workers, health professionals and residential services to improve responses to IPV and support victims. Remediation of existing policies that contribute to homelessness, poverty and economic insecurity remain external to mainstream IPV discourse as shown in Figure 1 (True, 2012). Figure 1 illustrates common etiological causes of violence against women cited in frameworks to address IPV. As stated by Jacqui True (2012), there is a tendency for research to focus on the behavioral and family levels, while overlooking the powerful influence of the structural determinants of this behavior and potential policy solutions. The exclusion of political economic factors that shape and contribute to violence against women can be attributed to the fact that rectifying structurally caused inequalities will require systematic policy changes that redistribute wealth and material resources in a more equitable manner (Raphael, 2012). Furthermore, IPV has been adopted as a public health issue and subjected to medicalization– depoliticizing violence in the home and reframing it to fit dominant discourses highlighting individual responsibility and behavioral changes. Iversen and Rosenbluth's (2006) work argues that economic inequality at the structural behavior shapes behaviors within the household– as unequal earning capacities between men and women result in families pooling their income to achieve economic stability. As a result, women are socialized to roles conducive to the larger economic system (Iversen and Rosenbluth, 2006). According to Iversen and Rosenbluth (2010), in societies where women were less dependent on a male patron for survival they were afforded greater status within the home and community.

The relational aspect of women's roles in the family and Canadian society is also largely ignored by the four official texts selected for analysis in this paper. As Bezanson and Luxton (2006) state, women are not only producers of the workforce but they are also held responsible for managing the health and well-being of the family. Nation states with residual welfare regimes increase the unpaid labour demands on women, who are expected to care for the ill, elderly and children in the household, while ensuring the earning capacity of the primary breadwinner (typically the male) remains uncompromised (Iversen and Rosenbluth, 2006; Root et al., 2014). From a feminist political economy perspective, a lack of a robust-childcare and long-term care system contributes to women's occupation of poorly paid and unstable jobs, which fail to offer permanent employee rights and benefits. The maltreatment of women in the home or the workplace is therefore underpinned by failures at the government level to provide adequate support to individuals to wean their dependence on gainful employment.

The individualization and repackaging of IPV as a public health problem aligns with pervading neoliberal discourses which promotes self-reliance in society (Root et al., 2014). As Raphael (2010) argues, powerful interest groups who capitalize off of the inequitable distribution of resources favor social and economic policies that continue to reproduce and maintain inequalities. I argue that in order to rebalance power among men and women within the household, an equitable distribution of power, wealth and resources must take place at a structural level. This requires policy reforms that will increase women's economic participation beyond menial jobs and address barriers such as lack of affordable childcare and housing. Additionally, Canada's welfare regime must operate based on the principle of universalism in order to be able to support the needs of women and potential abuse victims. These policy recommendations challenge the existing governance model in Canada and require political will

to motivate policy reforms that will substantially improve women's social outcomes and reduce their susceptibility to partner violence.

Preceding feminist liberation movements established IPV as a public health issue and incited social and political mobilization to develop response and support systems for abuse victims. It is apparent from the findings of the discourse analysis that Canadian government, health agencies and professional associations are reluctant to address socially rooted health issues such as IPV with a critical lens that identifies and challenges unjust public policies. Identifying material disparities women experience as inequitable and a precursor to violence would challenge the interests of groups favoring market-oriented policies. Thus, public mobilization is crucial to rebalancing power and improving women's economic and social security through motivating policy reform.

POLICY IMPLICATIONS & CONCLUSION

While global health organizations and agencies such as the United Nations and the World Health Organization advocate that women have 'the right to live freely from violence, slavery and discrimination', in violence continues to be perpetrated against women within and outside the home in Western democracies (Maldonado and Nieuwenhuis, 2015; True, 2012). Policies remain unchallenged that profit off of women's labour where they remain underpaid and occupy low-earning jobs with little to no benefits. Current responses to address IPV do not provide sustainable, dignified support to individuals affected by violence, but instead offer targeted downstream support that does not address the housing, childcare and financial needs of women fleeing the violence. Measures must be taken to address both structural and direct violence that

jeopardizes women's lives, and government institutions and policymakers need to be held accountable by the public to motivate effective action.

This major research paper outlines past and contemporary professional discourses in both medical and public health disciplines that attempt to define IPV and propose sites of change to prevent and reduce the prevalence of family violence. Findings from the critical discourse analysis conducted on selected official texts from governing bodies reveal a lack of critical appraisal of the socially rooted factors underpinning violence within the home and coercing certain social practices and patterns that shape women's economic and social lives. As anticipated, the official texts reflect influences from dominant IPV discourses that urge for change at the individual and community level, citing biological and intergenerational factors that lead to the cycle of abuse.

Feminist political economy argues that inequality and violence within the private sphere are directly related to dominant modes of production that profit off of and contribute to women's unpaid labour, socialization of gender norms and marital practices. It is imperative for women's unpaid labour to be recognized and considered in family violence strategies and household (True, 2012). I argue that current approaches to addressing IPV stray public attention away from structurally rooted issues such as poverty, precarious working conditions and housing insecurity which require government responses and policy restructuring. 'The personal is political' is a well-known rallying cry that the Canadian public must be reintroduced to, in terms of understanding the role policies play in wealth distribution and everyday politics.

As C. Wright Mills stated, individuals need to be able to connect the relationship between wider society and their personal experiences and hardships (Mills, 2000). This requires unlearning the values of self-reliance we have been socialized to accept in order to be cognizant

of and challenge social injustice. The policy recommendations proposed in this major research paper counter the interests of interest groups that favor a laissez-faire approach to governance. However, as Raphael (2000) argues it is critical that health professionals acknowledge the role of governments on population health through the working and living conditions formed through inequitable policies. In light of various social movements currently advocating for a response to the sexual violence women experience in the workforce, violence against women has returned to the political agenda of the Canadian government and governing health agencies.

The solutions proposed in the CPHO report and federal strategy to address and prevent violence against women offers solutions that will address the immediate needs of women fleeing an abuser. Additionally, means-tested social programs and services such as legal aid, employment insurance and child benefits exclude women impacted by IPV that do not have a low enough income to qualify for government assistance. The stigma associated with appealing and using government-funded social assistance programs acts as a deterrent for women and single mothers. Additionally increasing the capacity of response systems such as women's shelters and victim's services does not address the long-term needs and support women will require to maintain an adequate living standard for themselves. Moreover, current measures and responses to IPV focus on a particular type of violence- one that presents itself publicly to legal systems, police and health services. Women are also vulnerable to financial abuse, emotional abuse and less severe forms of physical aggression.

In such cases, as noted by Iversen and Rosenbluth (2010), women are forced to outweigh how their standard of living will be affected if they are to leave their abusive partner/family which is also their primary source of welfare. Women disadvantaged by partial citizenship, race and class have a greater incentive to remain with their partner, especially due to their poor

economic prospects and lack of accessible vocational support to secure their independence. I propose that medical and public health professionals and policymakers should leverage their power as well-trusted authorities who safeguard public health to advocate for and challenge social and economic inequities that heighten women's vulnerability to violence.

Although the initial conceptualization of partner abuse stemmed from feminist discourse, it has since become medicalized similarly to other aspects of women's lives such as menopause and childbirth. Under the medical gaze, IPV has been distanced from feminist discourse and repackaged into a chronic condition, a set of “deviant” behaviors associated with a plethora of other illnesses that are burdensome to the health care system and threatens worker productivity (Walker, 2006). Major implications of employing a medical model to explain and address IPV include victim-blaming ideologies as well as the creation of ineffective downstream means-tested social services for victims and punitive rehabilitation programs for perpetrators that will not result in substantial reductions in IPV prevalence (Rothenberg, 2003).

Medicine is arguably one of the most powerful social institutions, that is able to exert its’ power through esoteric discourse and the appearance of being a non-partisan ideological body. However, the medicalization of various social ills– including IPV has enabled policymakers and the public to overlook the social inequities that drive poor health outcomes. Focusing on individual risk factors and the genetic composition of abusers and victims "divorces the social from the individual," deflecting the political will to promote and advocate for substantial social change. Findings from the critical discourse analysis performed on the various medical and public health texts reveal a rhetoric that problematizes individuals and fails to challenge the socio-political context that gives rise to family violence. Lastly, physicians and public health professionals possess the influence to advocate against current structural inequalities and

emphasize the significance of overall social well-being to the health outcomes of women experiencing IPV.

References

American Medical Association. (1992). Diagnostic and Treatment Guidelines on Domestic Violence. *Archives of Family Medicine.* Washington: American Medical Association. https://doi.org/10.1001/archfami.1992.01850010047006/

Ansara, D. L., Hindin, M. J. (2010). Formal and informal help-seeking associated with women's and men's experiences of IPV in Canada. *Social Science & Medicine, 70*(7), 1011-1018.

Bakker, I. (2007). Social reproduction and the constitution of a gendered political economy. *New Political Economy*, *12*(4), 541-556.

Bambra, C. (2004). The worlds of welfare: illusory and gender blind? *Social Policy and Society*, *3*(3), 201–211.

Becker, G. S. (1974). A theory of social interactions. *Journal of Political Economy*, *82*(6), 1063-1093.

Bell, K. M., & Naugle, A. E. (2008). IPV theoretical considerations: Moving towards a contextual framework. *Clinical Psychology Review*, *28*(7), 1096-1107.

Bezanson, K. (2006). *Social Reproduction: Feminist Political Economy Challenges Neo-Liberalism*. Montreal: McGill-Queen's University Press. Retrieved from http://www.jstor.org/stable/j.ctt80rzb

Bierman, A., Ahmad, F., Mawani, F., (2009). Gender, Migration and Health. In. V. Agnew (Ed.), *Racialized Migrant Women in Canada*. (pp. 98–136). Toronto : University of Toronto Press.

Boyd, M. & Yiu, J. (2009). Immigrant Women and Earnings Inequality in Canada. In. V. Agnew (Ed.), *Racialized Migrant Women in Canada*. (pp. 208–231). Toronto: University of Toronto Press.

Bryant, T., Raphael, D., Schrecker, T., & Labonte, R. (2011). Canada: A land of missed opportunity for addressing the social determinants of health. *Health Policy*, *101*(1), 44-58.

Chaufan, C., B. Hollister, J. Nazareno and P. Fox (2012). "Medical ideology as a double- edged sword: The politics of cure and care in the making of Alzheimer's disease." *Social Science & Medicine,* 74(5): 788-795.

Cherniak, D., Grant, L., Mason, R., Moore, B., Pellizzari, R., IPV Working Group, & Society of Obstetricians and Gynaecologists of Canada. (2005). Intimate partner violence consensus statement. *Journal of obstetrics and gynaecology Canada: JOGC*, *27*(4), 365.

Coburn, D. (2000). Income inequality, social cohesion and the health status of populations: The role of neoliberalism. *Social Science & Medicine,* 51, 135–156.

Conrad, P. (1992). Medicalization and social control. *Annual Review of Sociology*, *18*(1), 209-232.

Ellsberg, M., Jansen, H. A., Heise, L., Watts, C. H., & Garcia-Moreno, C. (2008). IPV and women's physical and mental health in the WHO multi-country study on women's health and domestic violence: an observational study. *The Lancet*, *371*(9619), 1165-1172.

Emery, R. E. (1989). Family violence. *American Psychologist*, *44*(2), 321.

Esping- Andersen, G., (2001) Women, Class, and Chronos, *The Nordic Alternative*. Stockholm.

Esping-Andersen, G. (1990). The three political economies of the welfare state and De-commodification in social policy. In G. Esping-Andersen, *The Three Worlds of Welfare Capitalism.* Princeton: Princeton University Press**.**

Fairclough, N. (2001). Critical discourse analysis as a method in social scientific research. *Methods of Critical Discourse Analysis*, (*5*)121-138.

Fairclough, N. (2001). *Language and Power*. United Kingdom: Longman.

Farmer, A., & Tiefenthaler, J. (1997). An economic analysis of domestic violence. *Review of Social Economy*, *55*(3), 337-358.

Farmer, P. E., Nizeye, B., Stulac, S., & Keshavjee, S. (2006). Structural violence and clinical medicine. *PLoS Medicine*.

Foucault, M., & Sheridan, A. (1963). *The birth of the clinic: An archaeology of medical perception*. London: Routledge.

Fox, B. (2006). Motherhood as Class Act: The Many Ways in Which "Intensive Mothering" is entangled with Social Class. In. Bezanson & Luxton (Eds.), *Social Reproduction: Feminist Political Economy Challenges Neo-Liberalism.* Montreal: McGill-Queen's University Press.

Frankish, C. J., Green, L. W., Ratner, P. A., Chomik, T., & Larsen, C. (1996). Health impact assessment as a tool for population health promotion and public policy. *A Report Submitted to the Health Promotion Division of Health Canada.* Institute of Health Promotion Research, University of British Columbia.

García-Moreno, C., Jansen, H. A., Ellsberg, M., Heise, L., & Watts, C. (2005). *WHO multi-country study on women's health and domestic violence against women: initial results on prevalence, health outcomes and women's responses*. Switzerland: World Health Organization.

Giles, V. (2014). Introduction: An Alternative Mother-Centred Economic Paradigm. In V. Giles (Ed.), *Mothering in the Age of Neoliberalism.* (pp. 1–34). Bradford : Demeter Press.

Government of Canada. (2001). What is the Population Health Approach?. In *Public Health Agency Canada* https://www.canada.ca/en/public-health/services/health-promotion/population-health/population-health-approach.html/, accessed 27 March 2018.

Gracia, E., & Merlo, J. (2016). IPV against women and the Nordic paradox. *Social Science & Medicine*, *157*, 27-30.

Halseth, R. (2013). Aboriginal Women in Canada: Gender, socio-economic determinants of health, and initiatives to close the wellness-gap. Prince George, BC: National Collaborating Centre for Aboriginal Health.

Habermas, J. (1986). The Genealogical Writing of History: On Some Aporias in Foucault's Theory of Power. *Critical Theory*, *10*(1-2), 1-9.

Holtzworth-Munroe, A., & Stuart, G. L. (1994). Typologies of male batterers: Three subtypes and the differences among them. *Psychological Bulletin*, *116*(3), 476.

Horkheimer, M. (1982). *Critical theory*. New York: Continuum.

Hyman, I., & Meinhard, A., (2016). Public Policy, Immigrant Experiences, and Health Outcomes. In. D. Raphael (Ed.), *Immigration, Public Policy, and Health.* Toronto, Canada: Canadian Scholar's Press, (pp. 97–132).

Iversen, T., & Rosenbluth, F. (2006). The political economy of gender: Explaining cross-national variation in the gender division of labor and the gender voting gap. *American Journal of Political Science*, *50*(1), 1-19.

Iversen, T., & Rosenbluth, F. M. (2010). *Women, work, and politics: The political economy of gender inequality*. Yale University Press.

Johnson, M. P., & Ferraro, K. J. (2000). Research on domestic violence in the 1990s: Making distinctions. *Journal of Marriage and Family*, *62*(4), 948-963.

Krishnan, A., Kapoor, S. K., & Pandav, C. S. (2014). Clinical medicine and public health: Rivals or partners. *The National Medical Journal of India*. 27(2).

Krug, E. G., Mercy, J. A., Dahlberg, L. L., & Zwi, A. B. (2002). The world report on violence and health. *The Lancet*, *360*(9339), 1083-1088.

Larsen, M. M. (2016). Health inequities related to intimate partner violence against women. *Social Disparities in Health and Health Care*.

Lavis, V., Horrocks, C., Kelly, N., & Barker, V. (2005). Domestic violence and health care: Opening Pandora's box-challenges and dilemmas. *Feminism & Psychology*, *15*(4), 441-460.

Leonardo, Z. (2004). Critical social theory and transformative knowledge: The functions of criticism in quality education. *Educational Researcher, 33*(6), 11-18.

Lewontin, R. (1996). *Biology as ideology: The doctrine of DNA*. House of Anansi.

Lincoln, Y. S., Lynham, S. A., & Guba, E. G. (2011). Paradigmatic controversies, contradictions, and emerging confluences, revisited. *The Sage Handbook of Qualitative Research, 4*, 97-128.

Lupton, D. (1992). Discourse analysis: A new methodology for understanding the ideologies of health and illness. *Australian Journal of Public Health, 16*(2), 145-150.

Maki, K. (2017). *Housing, Homelessness and Violence Against Women*. Ottawa: Women's Shelter Canada.

Maldonado, L. C., & Nieuwenhuis, R. (2015). Family policies and single parent poverty in 18 OECD countries, 1978–2008. *Community, Work & Family, 18*(4), 395-415.

Mantoura, P and Morrison, V. (2016). *Policy Approaches to Reducing Health Inequalities*. National Collaborating Centre for Health Policy. Retrieved from http://www.ncchpp.ca/141/Publications.ccnpps?id_article=1548

McElroy, M. B., & Horney, M. J. (1981). Nash-bargained household decisions: Toward a generalization of the theory of demand. *International economic review*, 333-349.

Michaud, C. M., Murray, C. J., & Bloom, B. R. (2001). Burden of disease—implications for future research. *JAMA, 285*(5), 535-539.

Mikkonen, J., & Raphael, D. (2010). *Social determinants of health: The Canadian facts*. Toronto: York University, School of Health Policy and Management.

Miller, E., McCaw, B., Humphreys, B. L., & Mitchell, C. (2015). Integrating intimate partner violence assessment and intervention into healthcare in the United States: a systems approach. *Journal of Women's Health*, *24*(1), 92-99.

Mills, C. W. (2000). *The sociological imagination*. Oxford University Press.

Morrison, D. R., & Casper, M. J. (2016). Gender, violence, and brain injury in and out of the NFL: What counts as harm?. In *Football, Culture and Power* (p. 174-193). Routledge.

Morrow, M., Hankivsky, O., & Varcoe, C. (2004). Women and violence: The effects of dismantling the welfare state. *Critical Social Policy, 24*(3), 358-384.

Moyer, V. A. (2013). Screening for intimate partner violence and abuse of elderly and vulnerable adults: US preventive services task force recommendation statement. *Annals of internal medicine*, *158*(6), 478-486.

Moyser, M. (2017). Women and Paid Work. Women in Canada: A Gender-based Statistical Report, Statistics Canada. Ottawa: Government of Canada (p. 3-38)

OECD (2016). *Parental Leave Systems. Social Policy Division, Directorate of Employment*. Labour and Social Affairs. 1-18.

Peter, T. (2006, January). Domestic violence in the United States and Sweden: A welfare state typology comparison within a power resources framework. In *Women's Studies International Forum*.

PHAC (2001). The Population Health Template: Key Elements and Actions That Define a Population Health Approach. Ottawa: Health Canada.

Raphael, D. (2000). Health inequalities in Canada: current discourses and implications for public health action. *Critical Public Health*, *10*(2), 193-216.

Raphael, D. (2003). Barriers to addressing the societal determinants of health: public health units and poverty in Ontario, Canada. *Health promotion international*, *18*(4), 397-405.

Raphael, D. (2011). A discourse analysis of the social determinants of health. *Critical Public Health*, *21*(2), 221-236.

Raphael, D. (Ed.). (2012). *Tackling health inequalities: Lessons from international experiences*. Toronto, ON: Canadian Scholars' Press.

Romans, S., Forte, T., Cohen, M. M., Du Mont, J., & Hyman, I. (2007). Who is most at risk for IPV? A Canadian population-based study. *Journal of interpersonal violence*, *22*(12), 1495-1514.

Root, J., Gates-Gasse, E., Shields, J., & Bauder, H. (2014). Discounting Immigrant Families : Neoliberalism and the Framing of Canadian Immigration Policy Change, *Ryerson Centre for Immigration & Settlement (RCIS).*

Rothenberg, B. (2003). "We Don't have Time for Social Change" Cultural Compromise and the Battered Woman Syndrome. *Gender & Society*, *17*(5), 771-787.

Scambler, G. (2008). *Sociology as Applied to Medicine E-Book*. Elsevier Health Sciences.

Sokoloff, N. J., & Dupont, I. (2005). Domestic violence at the intersections of race, class, and gender: Challenges and contributions to understanding violence against marginalized women in diverse communities. *Violence Against Women*, *11*(1), 38-64.

Statistics Canada (2016). A Backgrounder on Poverty in Canada, Government of Canada. p. 1-27

Status of Women Canada. (2017a) *Gender Based Violence Strategy* , Government of Canada, 2017, www.swc-cfc.gc.ca/violence/strategy-strategie/index-en.html. Accessed 29 July 2018.

Status of Women Canada. (2017b). A Year in Review: Canada's Strategy to Prevent and Address Gender-Based Violence. Ottawa: Status of Women Canada.

Sweet, P. L. (2014). 'Every bone of my body:'Domestic violence and the diagnostic body. *Social Science & Medicine*, *122*, 44-52.

Taylor, G. (2016). *Chief Public Health Officer's Report on the State of Public Health in Canada 2016: A Focus on Family Violence in Canada*. Toronto: Government of Canada.

Theriot, N. M. (1993). Women's voices in nineteenth-century medical discourse: A step toward deconstructing science. *Signs: Journal of Women in Culture and Society*, *19*(1), 1-31.

True, J. (2012). The political economy of violence against women. New York: Oxford University Press.

Turcotte, M. (2011). *Women and Health*, Statistics Canada. Ottawa: Government of Canada.

United Nations. General Assembly. (1997). *Declaration on the Elimination of Violence against Women*. United Nations Department of Public Information.

United Nations Development Programme *(2018). Human Development Reports : Table 4 Gender Development Index*.http://hdr.undp.org/en/composite/GDI

Varcoe, C., Hankivsky, O., Ford-Gilboe, M., Wuest, J., Wilk, P., Hammerton, J., & Campbell, J. (2011). Attributing selected costs to IPV in a sample of women who have left abusive partners: A social determinants of health approach. *Canadian Public Policy*, *37*(3), 359-380.

Vosko, L.F. (2006). Crisis Tendencies in Social Reproduction: The Case of Ontario's Early Years Plan. In. Bezanson & Luxton (Eds.), *Social Reproduction: Feminist Political Economy Challenges Neo-Liberalism.* Montreal: McGill-Queen's University Press.

Walker, L. E. (2016). *The Battered Woman Syndrome*. New York: Springer publishing company.

Wall, G. (2013). 'Putting family first': Shifting discourses of motherhood and childhood in representations of mothers' employment and child care. *Women's Studies International Forum.* Pergamon.

Warshaw, C. (1993). Domestic violence: challenges to medical practice. *Journal of Women's Health*, *2*(1), 73-80.

Wathen, C. N., & MacMillan, H. L. (2003). Prevention of violence against women. *Canadian Medical Association. Journal*, *169*(6), 582–584.

Wilde, L. (2008). *Critical and Post-Critical Political Economy*. *Contemporary Political Theory* (Vol. 7). https://doi.org/10.1057/palgrave.cpt.9300320

Williamson, E. (2000). *Domestic Violence and Health: the response of the medical profession*. Policy Press.

Witt, D. D. (1987). A conflict theory of family violence. *Journal of Family Violence*, *2*(4), 291-301.

Wodak, R. (2001). The discourse-historical approach. *Methods of Critical Discourse Analysis*, 63-94.

Zola, I.K., *Medicine as an Institution of Social Control.* Sociological Reviews, 1972. **20**(4): p. 487- 504.

APPENDIX A: Figures

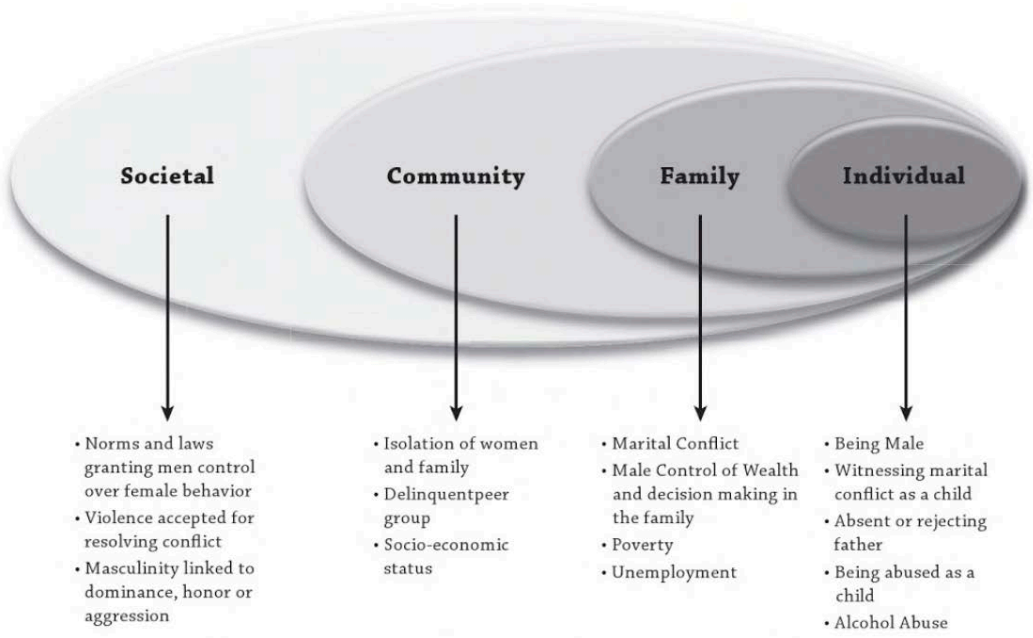
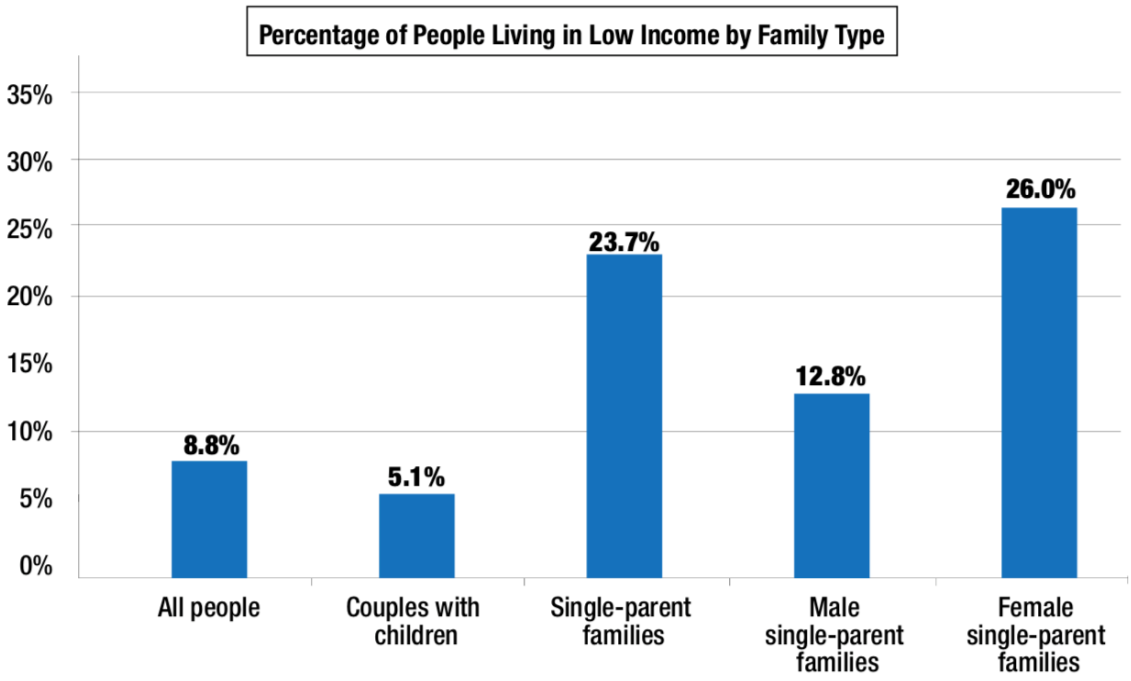


Figure 1. An Ecological Framework for Explaining Gender-Based Violence
Source: Ellsberg, Mary and Lori Heise. 2005. *Researching Violence Against Women: A Practical Guide for Researchers and Activists*. Geneva: World Health Organization and PATH. (p.26)

Figure 2. Summary of Conrad's Typologies of Medical Social Control



Source: Statistics Canada, Canadian Income Survey, CANSIM table 206-0042.
Figure 3. Percentage of People Living in Low Income by Family Type.

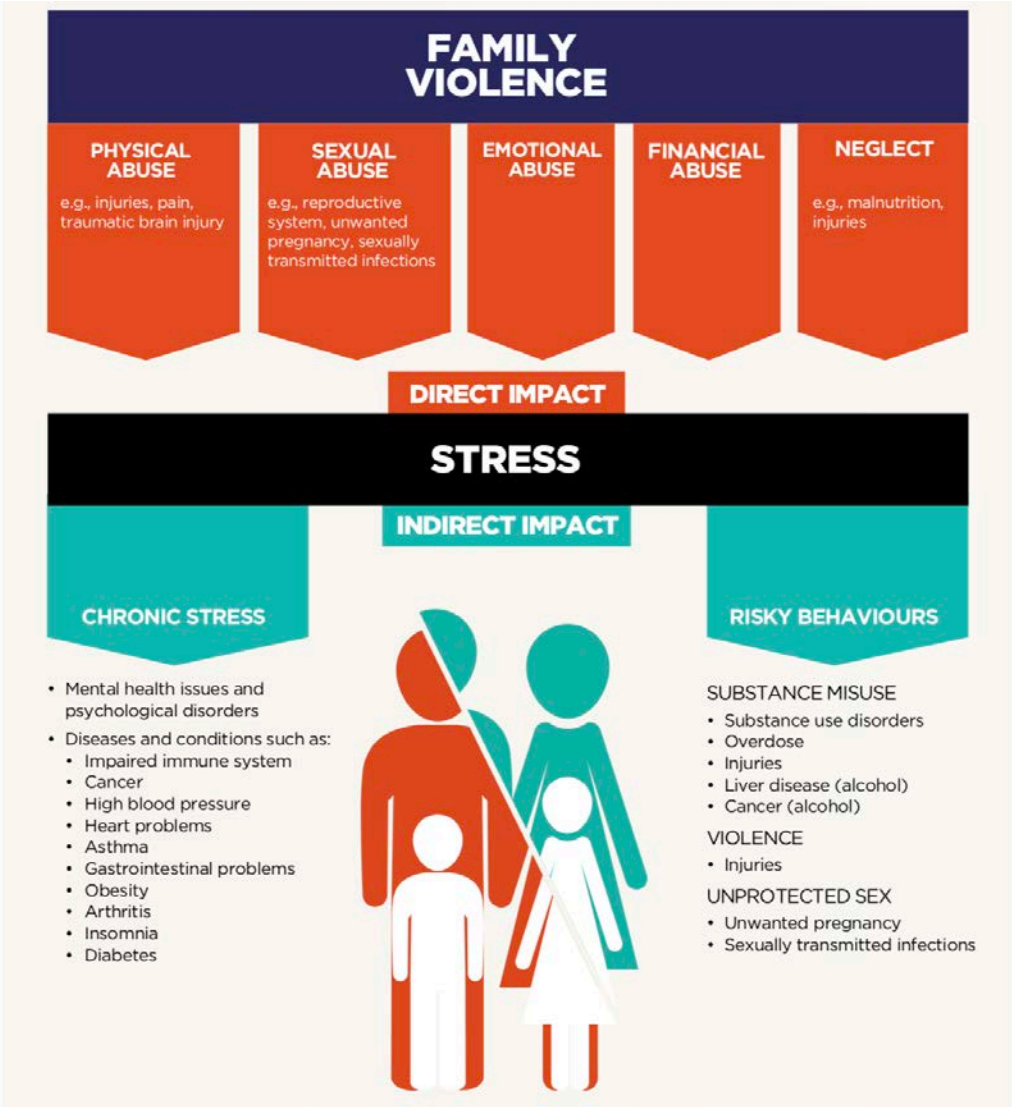


Figure 4. Simplified Picture of How Family Violence Leads to Health Impacts
Source: Taylor, G. (2016). Chief Public Health Officer's Report on the State of Public Health in Canada 2016: A Focus on Family Violence in Canada. Retrieved from the Government of Canada website.

Appendix E

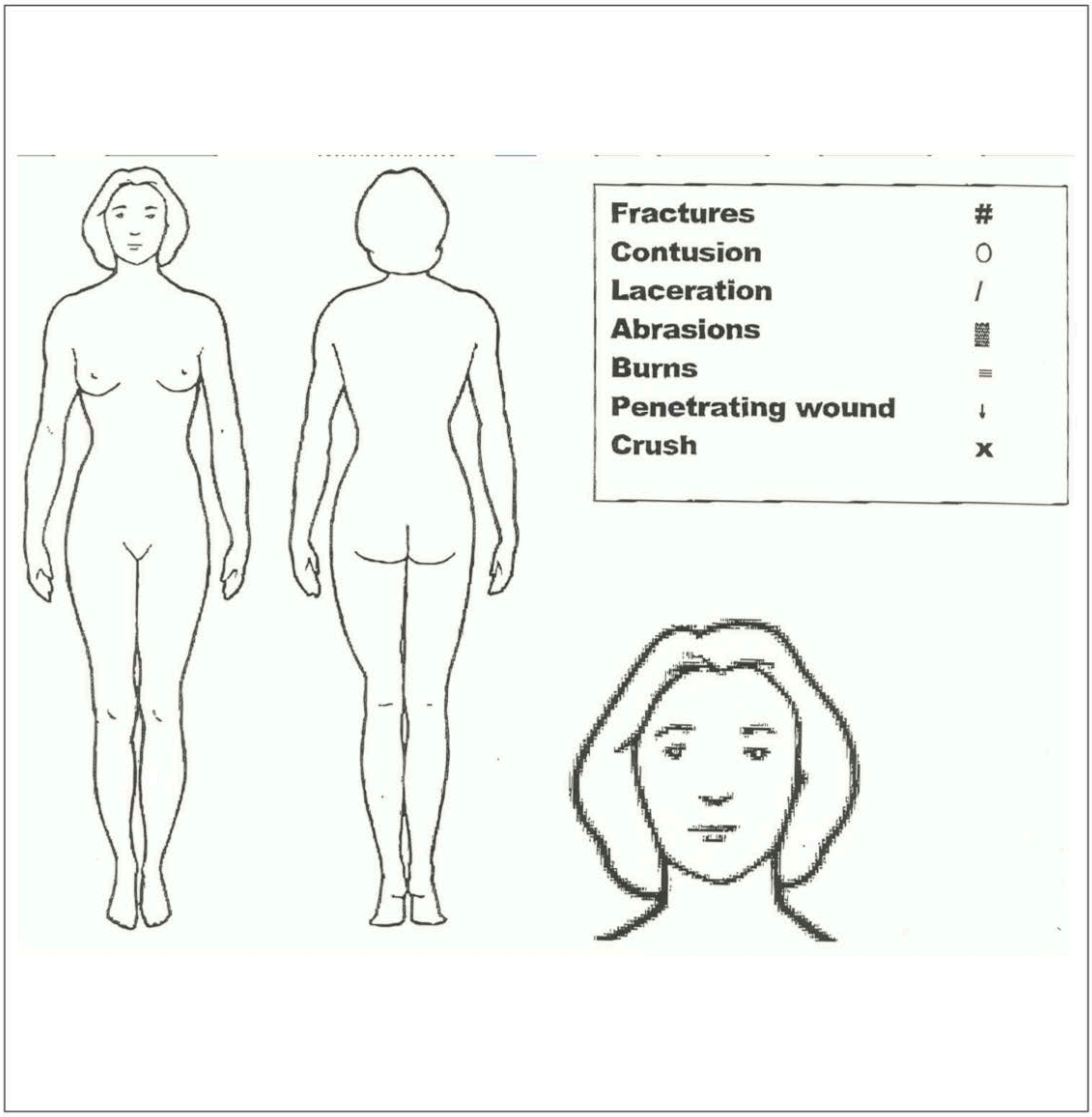


Figure 5. Body Map

Source: Cherniak, D., Grant, L., Mason, R., Moore, B., Pellizzari, R., IPV Working Group, & Society of Obstetricians and Gynaecologists of Canada. (2005). Intimate partner violence consensus statement. *Journal of obstetrics and gynaecology Canada: JOGC*, *27*(4), 365.