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FRACTURED IDENTITY IN THE CONTEXT OF INTIMATE PARTNER VIOLENCE: BARRIERS AND OPPORTUNITIES TO SEEKING HELP IN HEALTH SETTINGS

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ABSTRACT

Intimate partner violence has profound effects on women's identities. However detailed examination of how abuse affects identity is lacking. We interviewed 14 diverse women (Australia), applying Social Identity Theory to analyse their experiences of identity, and help-seeking in health settings. The destabilising effect of violence on social identities was strongly supported. Women concealed abuse to preserve a public identity. However, when the violence threatened the most integrated identities, women unveiled an *abuse identity*, receiving mixed responses from health providers. A healing context where a woman can display an *abuse identity* safely is crucial to enable her to rebuild an integrated self-concept.

INTRODUCTION

Despite increased awareness of the widespread and damaging nature of violence against women, violence by intimate partners persists as a common, hidden problem for women of child-bearing age worldwide (J. C. Campbell, 2002; Krug, Mercy, Dahlberg, & Zwi, 2002; World Health Organization, 2013a). Women's decisions to seek help and their help-seeking behaviours in different sectors can be viewed within an ecological model whereby help-seeking is influenced by several individual, interpersonal, community and socio-cultural factors.

At a macro-level, social norms and cultural beliefs that reinforce gender inequality, gender-role expectations, and acceptance of violence to resolve conflict (Liang, Goodman, Tummala-Narra, & Weintraub, 2005; Ting & Panchanadeswaran, 2009) create conditions that make it very difficult for women to access informal and formal sources of help. These damaging norms and beliefs become entrenched in the social, political and legal structures of society (Jewkes, 2002), often widespread in the very institutions that exist to support those affected by abuse. Numerous studies report on women's experiences of inadequate responses in criminal justice, social, health and other services, reflecting negative attitudes to women and poor understanding of

the problem of partner violence (Keeling & van Wormer, 2012). At the community level, help-seeking is influenced by availability of formal support services (Sullivan & Bybee, 1999), racial stereotyping among service providers and lack of understanding regarding cultural and ethnic diversity (Donnelly, Cook, van Ausdale, & Foley, 2005); opportunities for education and work (Riger, Ahrens, & Blickenstaff, 2000); poverty (Goodman, Smyth, Borges, & Singer, 2009) and economic security (J. C. Campbell, Rose, Kub, & Nedd, 1998); previous experiences of using clinical and community services (R. Campbell & Raja, 1999; Humphreys & Thiara, 2003); and women's immigration status (Bui, 2003; Liang et al., 2005; Ting & Panchanadeswaran, 2009).

At the interpersonal/relationships level, help-seeking is influenced by emotional attachment to the perpetrator (Eisikovits, Buchbinder, & Mor, 1998); patterns of partner violence (Chang, Dado, Hawker, Cluss, Buranosky, Slagel et al., 2010); involvement with the perpetrator (Crawford, Liebling-Kalifani, & Hill, 2009; Macy, Nurius, Kernic, & Holt, 2005); pregnancy (Edin, Dahlgren, Lalos, & Hogberg, 2010) and the presence of children (Chang et al., 2010; Zink, Elder, & Jacobson, 2003); social support (Cluss, Chang, Hawker, Scholle, Dado, Buranosky et al., 2006); attitudes and behaviours of family and friends (Taket, O'Doherty, Valpied, & Hegarty, In Press) and women's ways of relating to others (Liang et al., 2005). Among the individual factors are self-esteem (Tilley & Brackley, 2004), self-efficacy (Cluss et al., 2006), and women's cognitive appraisals of their circumstances (Cluss et al., 2006; Zink, Elder, Jacobson, & Klostermann, 2004). Social identity, the critical link between representation of self and the structure and function of social groups (Brewer, 2001), is another important aspect of self that may influence help-seeking in this context. With the exception of some work with immigrant women (Bui, 2003) and minority ethnic groups (Bent-Goodley, 2007; Donnelly et al., 2005), the role of social identity in abused women's experiences of help-seeking has received limited attention.

The complex nature of exposure to partner violence and women's distinct histories and values suggest a need for individualised, women-defined interventions, which demand more creative ways of understanding women's journeys (Hegarty, Gunn, O'Doherty, Taft, Chondros, Feder et al., 2010; Liang et al., 2005). This includes gaining a better understanding of the role of identity in the cognitive, affective and behavioural aspects of how women seek help to improve their situation (Crawford et al., 2009). Indeed scholars have highlighted the need to address not only gender but how the intersection of other identities – race, surviving abuse, class, immigration status – affects women's experiences of services (Chavis & Hill, 2009). In this study, we focused on the health care environment because the health sector has a key role to play in addressing partner violence (Krug et al., 2002). To this end, recent WHO clinical guidelines (World Health Organization, 2013b) on partner and sexual violence recommend training providers to care for abused women, integrating case-finding into clinical practice, and providing women-centred care to survivors. Furthermore, clinical services need to be responsive and account for the diverse and complex health and social needs of this population (Wathen & MacMillan, 2012). We therefore framed our question about identity and help-seeking in the context of women's health care experiences.

Locating Social Identity within Self-Concept

According to Social Identity Theory, social identity refers to "that part of the individual self-concept which derives from his (sic) knowledge of his membership of a social group (or groups) together with the value and emotional significance attached to that membership" (Tajfel, 1981) (p.251). Brewer extended Tajfel's original definition, distinguishing four levels of social identity. *Person-based* social identities refer to aspects of self-concept that derive from socialisation with specific social groups or categories. This emphasises the acquisition of psychological characteristics, expectations, customs, beliefs and ideologies associated with belonging to a particular group or social category (e.g. gender, ethnicity), and integration into a global self-concept. Next, *relational* social identities derive from interpersonal relationships and

reflect the influence on self-concept of norms and expectations associated with occupying particular roles (e.g. occupational, family, and intimate relationships). These social identities are interdependent in that the traits and behaviours shown by one individual respond to the behaviours and expectancies of others in the relationship. *Group-based* social identities refer to the perception of the self as an integral part of a larger group. Reflecting a depersonalisation of self, it involves common ties to a shared category membership. Finally, *collective* identities (e.g. motherhood) capture meaning, and the content of norms, values and ideologies (as distinct from the process by which group-self representations are formed). Individuals manage multiple identities whereby the individual weighs and examines available aspects of the self to determine which will guide behaviour in a given situation. Awareness of different social identities can have conflicting implications for behaviour, in which case the individual must select from various aspects of the self-concept (Brewer, 2001).

Effects of Partner Violence on Social Identity

Partner violence produces fear and self-doubt, it threatens life goals, safety and even survival, and it is associated with lost agency and ability to control the world (Liang et al., 2005; World Bank, 2012). Evaluative dimensions of self-concept i.e. notions of self-worth and self-esteem (Fleming & Courtney, 1984) underlie women's self-efficacy and have been shown to relate to abused women's capacity to escape violence (Cluss et al., 2006). Although studies have reported on ways in which partner violence 'spoils' women's identities and is damaging to self-concept (Hague, Mullender, & Aris, 2003; Moss, Pitula, Campbell, & Halstead, 1996) the effects of partner violence on the four dimensions of identity outlined above have not been explored in any systematic way. Furthermore, it appears from the literature that Social Identity Theory (Tajfel, 1981) has not been applied in exploring the impacts of partner violence on women's lives.

Applying Brewer's (2001) framework to the literature suggests ways in which social identities are invoked where partner violence is present. Undermining aspects of the *person-based* social identity is a hallmark of emotional abuse whereby deeply integrated and personal aspects of the victim's concept of self are targeted (Stark, 2007; Williamson, 2010). Individuals also self-define (and evaluate themselves) in the context of their relationships with significant others, and based on their performance of role relationships (Breckler, 1986). Thus, it is unsurprising, given the evaluative context of the intimate relationship, that abused women often report a sense of failure (Waldrop, 2004). Unreasonable expectations set by the perpetrator make it virtually impossible to 'succeed' in the partner role (Williamson, 2010). The violence may also target directly other *relational* social identities. Herman describes how the most destructive tactics violate women's basic human attachments (Herman, 1992). At the group level of self-representation, evaluation of the collective self-concept involves intergroup comparison. Here, one strives to associate with groups that are valued and confer benefits for self-esteem (Smith & Tyler, 1997). In the context of an abusive relationship, social participation may be restricted, leading to lost opportunities to derive the benefits of group connections (Liang et al., 2005). Regarding the *collective* identity, partner violence may lead to lost identification with a collective (e.g. religion through spiritual abuse) or identification with an emergent collective of 'abused women' (Crawford et al., 2009). Thus, balancing up the risks and benefits of disclosing and getting help is an ongoing process for women, with implications for social identities even after they have escaped the violence. Analysis at these different levels of identity may offer further understanding of the barriers facing women in finding pathways to safety.

To summarise, whilst a few studies have addressed identity in survivors, this research has not tended to apply Social Identity Theory nor does it systematically examine how aspects of identity may be fractured in an abusive context (Crawford et al., 2009). Further, we know that abused women access help in health settings,

and report a preference for a response that acknowledges the complexity of partner violence and is non-judgmental, non-directive and individually tailored, depending on consultation context, readiness for change, and the nature of the provider-woman relationship (Feder, Hutson, Ramsay, & Taket, 2006).

However, this literature makes little reference to the role of social identity in women's willingness to disclose and seek help. We therefore undertook an analysis, drawing on Social Identity Theory and Brewer's taxonomy of social identity to understand abused women's identity experiences. We also explored how social identity relates to help-seeking within health care settings.

METHOD

Participants were recruited through a convenience sample from the *weave* randomised controlled trial (Victoria, Australia) which was designed to assess whether brief counselling from family doctors trained to respond to women identified through IPV screening would increase women's quality of life, safety planning and behaviour, and mental health (Hegarty, O'Doherty, Taft, Chondros, Brown, Valpied et al., 2013). The participants were women who did not fully meet the inclusion criteria for weave because they experienced fear more than 12 months ago (n=13) or were outside the 16-50 age range for weave (n=1). 21 women were approached for interviews; 14 participated; 4 declined and 3 agreed but later withdrew prior to interview. 14 semi-structured in-depth interviews were conducted by LOD between November 2009 and October 2010, either at the participant's home or in a private room at the University. Participants were asked to read the plain language statement and sign the consent form. All women consented to have their interviews audiorecorded. Women had an opportunity to view/modify their transcript (n=1) and were provided with a $50 voucher as an honorarium. The interviewer was trained in how to support women who have experienced partner violence; safety protocols were followed; and women were offered a list of resources. The University's Human Research Ethics Committee Ethics granted ethics approval.

Data Collection and Analysis

An interview schedule guided the collection of data during interviews. Initially women were invited to tell of a relationship in their life where they had been fearful of their partner. It then moved on to exploring connections between the relationship and identity, past and present. The next set of questions related to experiences and outcomes of disclosure and help-seeking with one question enquiring about the role of sense of self and identity in obtaining help. We probed further to tap into women's experiences of getting help from different health providers. Women were asked about identity without any pre-defining by the interviewer. The researcher/interviewer strived to adopt a reflexive approach and asked open-ended questions to provide the women with opportunities to shape the flow and content of their contributions. This approach furnished rich data whilst enabling women to define the boundaries of the information offered.

Interviews were transcribed, and the transcripts were de-identified using pseudonyms, entered into NVivo 9 (QSR International, 2011) to facilitate coding and analysis, and open-coded through multiple readings. We engaged in a cyclical process of moving between reviewing literature, data collection and coding, linking codes, and reshaping the analysis based on meetings between the authors and re-reading the interviews. We commenced with a deductive analysis framework to organise data according to the first-order relationships of interest: (i) relations between partner violence and social identity; (ii) relations between social identity and help-seeking. Next, an inductive approach to thematic analysis allowed links and patterns to emerge from the data. We further analysed the data using Brewer's taxonomy of social identity to achieve a richer picture of women's identity experiences.

FINDINGS

Table 1 describes the characteristics of the 14 participants. Twelve participants had experienced fear of a male partner from whom they had since separated. Two women were still married to the perpetrator. Nine women were currently working and four had university degrees.

Table 1 about here

Table 1 Characteristics of women

Pseudonym	Age	Marital status	No. of children	Employment	Relationship to person who made them afraid	Education	General health[a]	Country of birth	Severity/ type of violence[b]
Mary	39	Divorced	2, with exhusband	Part-time	Ex-husband	Diploma	Very good	Australia (Anglo)	Emotional
Ellen	38	Never married	None	Part-time	Ex-partner	Degree	Good	Australia (Greek)	Physical/ emotional
Holly	50	Married	3	Full-time	Current husband	Degree	Very good	Australia (Anglo)	Physical/ emotional
Claire	48	Married	2, neither at home, one child with violent exhusband	Part-time	Ex-husband	Diploma	Excellent	Australia (Anglo)	Emotional/ physical/ harassment
Cathy	48	Divorced	3 children, half time with exhusband	Disability benefit	Ex-husband	Diploma	Fair	Australia (Anglo)	Not disclosed
Isabel	37	Married	3 children, 2 from previous violent marriage	Part-time	Ex-husband	High school	Very good	Australia (Anglo)	Emotional/ harassment
Elaine	24	Never married	None	Full-time	Ex-partner	Studying for degree	Very good	Australia (Dutch)	Emotional/ harassment
Sally	48	Widowed	4, from three relationships	Disability benefit	Ex-partners	Did not complete high school	Fair	Australia (Anglo)	Not disclosed
Indira	35	Married	3	Studying	Current husband	Degree	Fair	India	Physical/ emotional
Malaya	55	Separated	5 children live overseas	Benefit, volunteer	Ex-husband	High school	Fair	Philippines	Severe sexual, physical, emotional

Susan	46	Divorced	2, the younger with violent partner	Benefit	Ex-husband	Diploma	Good	Australia (Anglo)	Sexual/ physical/ emotional
Katya	30	Divorced	Pregnant	Full-time	Ex-husband	Degree	Excellent	Eastern Europe[c]	Physical/ emotional
Jane	35	Married	None	Full-time	Ex-partner	Diploma	Very good	Australia (Anglo)	Severe sexual, physical, emotional
Liz	38	Divorced	1 with ex-husband	Part-time	Ex-husband	Diploma	Very good	Australia (Anglo)	Not disclosed

[a]Measured using the general health item from the SF-36 which asks respondents to rate their health on a five-point Likert scale. [b]No pre-specified interview question directly enquired about the type of violence women had experienced. Thus, some women did not disclose the nature of the exposure. [c]Actual country not named to preserve participant's anonymity.

Partner Violence: a Weapon that Fractures Social Identity

In describing the impact of partner violence on identities, women referred to ways perpetrators, as a starting point, created the conditions that would enable them to undermine women's identities. Women commonly described disruptions to their personal interpretation of reality, which had the effect of undermining selfconfidence and sense of judgement.

He constantly eroded it [identity], especially in terms of self-esteem, abilities and just that sense you have where you're fairly sure you're doing the right thing, just eroded that sense of judgement. (Holly)

1. Person-Based Identity

In our detailed examination of identity we commence with how abuse targeted and subsequently affected women's *person-based* identities – those aspects of identity that are most personal and integrated into the self. Behaviours that denigrated her womanhood/gender, race, ethnicity, culture and other dimensions of her background constitute an abuse of her *person-based* social identities. Jane's partner withheld her passport while she lived with him away from her home country. This level of coercive control was not only an infringement on her liberty but also symbolic of sabotaged national identity and lost citizenship, central

elements of *person-based* social identity. Jane described how physical abuse generally interfered with her capacity to project herself to the external world, targeting her femininity, an aspect of her gender construction, and resulted in *my face no longer recognisable.*

It was that experience…where I couldn't recognise myself in the mirror, when I just said this is wrong, because I used to model and I just looked at myself and I said, this doesn't really look like someone who could model. (Jane)

It has been argued that to understand violence against women there is a need to look beyond gender to how various *person-based* social identities, in particular, intersect to compound risk. The experience of immigrant women in our study supports this. Malaya immigrated to Australia with the expectation of marrying her Australian partner; her story was an abysmal reflection of how *person-based* social identity, in her case, ethnicity, could be violated. In it we witness strong use of male privilege.

Before he would say I love you but other times he didn't say it anymore. He looks [at] me like a slave. And I ask him - because I am Filipino, I have brown skin…and you think that I'm stupid and you think that I don't know English. (Malaya)

2. Relational Social Identities

Accounts were replete with examples of how the violence directly or indirectly affected women's *relational* social identities, which derive from interpersonal relationships and reflect the influence on self-concept of norms and expectations associated with occupying particular roles. Women particularly referred to valued parenting and occupational roles and how the abuse undermined and destabilised these. Indira perceived that her husband dictated the nature of her various roles within and outside her home life, routinely judging her performance in these.

Yeah, when it comes to cooking, and when he comes home and if he sees the house a mess, he just can't take it. He is like, what are you here for? With the kids he wants me to do certain responsibilities which he feels I

don't fulfil. He expects that, oh you're supposed to be doing this and you're so educated, why aren't you doing that also. He will just keep judging, you're not a good mum, you shouldn't be doing that. (Indira)

In another perspective, Mary alludes to the impact of the pressures and stresses associated with partner violence on functioning in the relational role of mother.

Especially when you don't feel like you can be a mother anymore. You think you're so beyond it that you're not worthy of that role, and I think that's what I needed to get back. (Mary)

The other major reference was to the *relational* social identity of intimate partner. Abusive partners (and sometimes other family members) dictated the nature of the partner/wife role, which were rigidly gendered, experienced as imposed or threatened and indicative of the use of male privilege.

Just before we got married, he said to me, if you ever refuse to have sex with me that will be the end [of the relationship]. (Isabel)

Sometimes I felt like I was a slave there, because always [I was] cleaning by myself. (Katya)

Katya, who was subjected to severe violence by her partner and at the hands of his extended family, was made to swiftly understand her subordinate position within this new household. To console her, her partner's aunts explained that violence was the norm in the family, and in marriage more broadly; in effect these female family members were shaping Katya's expectations of her role as 'wife'.

Unsurprisingly, violence in the intimate relationship, in all its guises and forms, had profound effects on women's perceptions of themselves as partners.

I didn't have an identity of my own. Yeah, I didn't have my own life, like I was his possession. (Liz) Then when it happens in the face and they keep going, to pulverise you to such a state, you think, they must just hate me; what's next? (Jane)

The *relational* social identity of partner itself was a 'toxic' influence in their lives that created extreme demands on their psychological and other resources. The potential for extreme emotional paradox to accompany intimate terrorism was illustrated in Malaya's account:

I can love him from a distance but I fear for my life. (Malaya)

3. Group-Based Identities

The control imposed on women by their partner's behaviours was one way in which their connections with groups, and related *group-based* identities, were affected. For Ellen, eventually capitulating to the perpetrator's reality meant that his narratives of blame became dominant and led to her connections in the world becoming "cut off."

We decided that I had an anger management problem. I think I was just at my wits end. I think I'd unravelled at that point. I was a mess. I wasn't working. I had no confidence to go out and do anything. I felt quite cut off from the world. (Ellen)

The impact of abusive behaviours on *group-based* identities was also illustrated in terms of the persistent conflict women faced between maintaining their memberships in valued groups. Imposing isolation was a tactic that interrupted social connections, creating a milieu in which abusive partners could destabilise women's identities.

So he kept me sort of, you know, "you're there, I'm there and don't you vary from that." I wasn't allowed to think for myself or shop for myself or even go and put petrol in the car. At one stage he wouldn't even let me have a phone so I couldn't contact anyone. (Susan)

The crippling demands of the 'toxic' partner *relational* social identity and relationship context also created isolation.

[There was] a feeling that I had to be a constant protector of the children, too. Anything I wanted to do like be on a committee I would have to either take them with me or make sure they were asleep or get them babysat because I just couldn't vouch for the fact he mightn't go stupid while I was gone. (Holly)

The 'toxic' partner identity obstructed and subordinated many other potentially 'healthy' identities in women's lives narrowing avenues to safety, access to resources and opportunities to build self-esteem.

4. Collective Identities

Capacities to identify with a *collective* were undermined by partners' suggestions that women had lost rights to participate in particular shared images and meanings. Partners sought to destabilise how women balanced the values invoked by motherhood and the lived role of mother.

My husband just blew his top that I even thought of having an abortion and that I'm [an] embarrassment to his kids. You know, turn around things like that. He told everybody about this. He's like I'm going to tell this younger one that you really want her dead. (Indira)

The *collective* identity of the 'madwoman' was commonly used by abusers to undermine women, both before and after they had sought formal help.

"You're going to a psychiatrist, they're going to find something wrong with you and they're going to put it - you have this problem, that problem and then your career, what you've been trying to build here is just not going to work out and you know they're going to label you some mental. Even if we decide to get divorced the kids will come to me because they will say you're not stable." (Indira)

A final theme which is relevant throughout the next section concerns women's internal self-identifying and/or being identified by others as associated with a *collective* of 'abused women,' reflected in our use of the term *abuse identity*. One consequence of this form of identity was its potential to stigmatise and cut

women off from possible sources of help. Elaine's account suggests the emergence of the *abuse identity* where her peer group, on becoming aware of her situation, distanced itself from her.

A lot of people knew that there was something really weird going on and they didn't want to include me, I suppose, in what they were doing at uni, whether it was study or not. I just think that they didn't understand why I'd put myself in a relationship like that and they couldn't understand me because of that. (Elaine)

Social Identities and Experiences of Help-Seeking

Next, in order to explore some practical implications of fractured identities, we looked at the process of help-seeking relevant to health settings. There were three emergent themes capturing the journey to and through helping-seeking: concealing the abuse to preserve public identity; the balance tips (in favour of unveiling an *abuse identity*); and effects of health care interactions on identity.

Concealing Abuse to Preserve Public Identity

Women struggled to access formal (and informal) sources of help and support in the period during which they concealed an *abuse identity*. Public awareness and stigma associated with a collective *abuse identity* had the potential to intensify feelings of shame and failure and thus living with the abuse 'backstage' was seen as the lesser of two evils. During this excruciating time women experienced heightened identity conflict, various degrees of awareness of their partner's behaviour and a substantial psychological burden.

I didn't want anybody to see my troubled side. So everything was perfect on the outside and crumbling in the middle, until I actually did finally break down and couldn't hold anymore. But still, I'd seek help [from the GP] for depression, but I certainly didn't get help for the cause. I just masked the symptoms. (Isabel)

Liz, keenly attuned to the severity of her circumstances, was motivated to conceal the abuse in order to preserve other valued identities. The drive to protect herself from public scrutiny was a barrier to accessing

formal help. In fact, she only ever got practical assistance from her brother and during the interview she was speaking about her abuse experience for the first time.

That's probably what made it [getting help] that much harder, because I knew what it [the abuse] was and I knew I was stronger than that. I think at the time, no one could have helped, because I needed to believe in myself, that I could make it on my own again, outside the relationship. If anyone said, we know what's going on, I would have denied itI was embarrassed about the life I had. I just felt I was worthless, deserved everything I got. (Liz)

Over time women faced the complex psychological task of weighing up multiple and conflicting priorities within a context of fear, shame and disorder, poor mental health and lacking support. For Holly, the behaviour guide implied by the mother role conflicted with that associated with her role as a partner.

It's just all woven together and I know one thread can pull and the whole thing could fall apart but it's not just a cut and dried decision to leave because you've got kids, and if it was a really violent relationship, the idea that a partner could have custody or visitation rights, I reckon that would almost make you not seek help. It's just incredibly complex and very hard to explain to people who have never experienced it. (Holly)

The Balance Tips (in Favour of Unveiling an Abuse Identity)

Women described how the damage inflicted on their identities by their partner's behaviours ultimately triggered their help-seeking. Susan related how her mothering role was being compromised by emotional difficulties, even if she had not fully 'named' her experiences of violence.

I said to the doctor, you know, what my problem was. I thought I was just suffering from anxiety or postnatal depression, I probably didn't put it down to the relationship, I put it down to everything else. In the end I couldn't say where I was, I was just so sad. I couldn't get a day where I wasn't crying, I was breastfeeding Sarah and I just wanted it to be better. I thought, no, this can't be the way it's going to be. (Susan)

Tension between the partner *relational* social identity and other identities grew over time. Women undertook radical assessments of their circumstances, priorities and goals linked to their various identities.

That was a point for me where I said, I can't do this anymore. I can't be a good mum. If I'm sitting on one side of the door crying, holding the door shut because he's [her son] throwing trucks at me, I need to do something so I can be a good mother because I didn't want to be there anymore. (Mary)

Liz's embarrassment initially crippled her efforts to escape the violence. However, her sense of responsibility to her child and the behavioural guide implied by her 'mother' identity eventually overcame the powerful motivation to conceal the *abuse identity*.

I fell pregnant with Lily. Then I went well, I'm not going to have any child of mine growing up thinking this is normal. It stopped for eight months, then started again. Then one day I just said - when Lily was about three months old - threaten me again and it will be the last time you do…Of course a week later he did, and I set plans in motion to leave. (Liz)

Across different health settings, women increasingly began to seek answers to symptoms, explore the basis of their distress and challenge the accusations of 'madness.'

I did go there [counsellor's clinic] with the hope of clarity. Clarity for the relationship, for myself. My sanity. I needed clarification that I wasn't going mad, that it wasn't normal to be treated like he treated me because I had nothing left. So, I needed someone to say to me, "no you haven't gone mad." (Mary)

Despite the innumerable obstacles, women largely achieved safety and reduced the risk of violence. However, unveiling the *abuse identity* came at a cost; women had to abandon or renegotiate commitments to preserving the family, which led to challenging disruptions to their other social identities.

It's torture. You put yourself through a ridiculous amount of pain. I do know why. Everyone wants to save their marriage and they want to do it for their kids, but when you get to the point where your body's not functioning anymore… (Mary)

For Indira, the cost of getting help (from her GP and psychologist) was the psychological discomfort of deviating from behaviours prescribed by her culture, essentially, compromising aspects of her *person-based* identity. In fact, her story expressed a compromise between different aspects of the self-concept, a weighing up of *person-based, relational, group-based* and *collective* identities.

I come from a family where divorce doesn't happen. It is looked [on] as a taboo. Before I used to fear a divorce. I told my husband any more physical it's going to be out. I don't want to handle it alone anymore. I have help. I think the GP and the psychologist have helped all this because they said, no, you have respect for yourself]. I've come from a family where women don't really stand out and go to somebody else and talk about their husbands so badly. (Indira)

Effects of Health Care Interactions on Identity

Most women could recount times when interactions with health care services had negative and positive implications for their identity. For Susan, her relationship with a supportive GP allowed her to reveal her *abuse identity* which contrasted sharply with the reactions she anticipated from "everyone else."

He was such a kind, thoughtful [man] and this is something he shows and you can just sense it, he's a family man and seems like a good man and I guess, after a while seeing a GP, you get to know them a little bit. I had comfort in, that I could open up to him and not feel embarrassed about telling him what was going on. I was worried about judgment from other people where I wasn't worried about being judged by him. (Susan)

By contrast, Jane's experience of receiving help in an emergency setting is a powerful example of the secondary victimisation that an abused woman can face when her path intersects with a health service. She

sought help for an injury, the nature of which made it highly relevant to identity (a burn with the potential to permanently mark her body).

I had a burn once and I had some of the gauze melted into the skin and they tried to take it off and when I kept telling them that it hurt, they were like, "no it doesn't" and I'm like, "yes it does"; they were like "no it doesn't." I found that kind of thing was quite regular, … So I kind of felt a little ignored. (Jane)

Jane described a positive response from her GP in the period after the separation – *he was very matter fact and there's a problem, we're going to fix it. It's not in your mind, it happens* – showed concerns about his advice on medication, fearing it might alter her sense of self. Thus Jane, at a time when she was negotiating the *abuse identity*, had to actively avoid being identified with collective of Prozac consuming home-makers.

I had this whole stigma in my head because all the internet jokes were all about the housewives at home on Prozac and all that kind of stuff, that it was a sign of weakness. It took him [the GP] ages to convince me that I needed it and I wasn't going to become addicted and it wasn't going to change who I was. (Jane)

Secondary victimisation fulfilled women's fears about revealing the *abuse identity* and being judged externally. With that, it reinforced low self-worth. It was not uncommon for women to visit the GP about emotional health issues, be prescribed medication and afforded no opportunity to discuss the relationship issues. One woman described returning home to her partner who took her script as further evidence that she was the root of the problem. Thus, when women took themselves (and their damaged relationship) to see a health professional, there was a risk the partner's narratives of blame and the 'madwoman' *collective* identity would be reinforced. However, there were also examples of how support led to women reinterpreting their position and exercising greater agency within the partner role.

I went and spoke to a clinical psychologist and explained what was happening and said what can I do? He pretty much said you need to find a bargaining point that will … almost hang over his head where you can say if that behaviour happens again, this will happen. For him at that time it was his work and that was actual violence then. I said to him if it happened again I would contact his employer and that worked for a long time in modifying the really violent parts. That was just the most wonderful key. (Holly)

"Feeling Again Like a New Person": the Recovering Self-Concept

Although a focus on recovery was not central to our original enquiry, an important set of identity themes emerged in the context of women's recovery experiences. This section extends the theme above on 'effects of health care interactions on identity' where we see ongoing positive connections with health providers supporting the recovery process. We also witness individual resilience in the different ways women engaged identities. Women began to recognise the value of building a more positive self-concept.

I think I just really had to believe in myself to start with and then it was the little steps of, okay, what can you do to improve the quality of your life? What can you do to help deal with your ex in the right way so that he doesn't send you around the twist again? It's all that keeping the steps going up instead of the plummeting. That's still a process all this time down the track. (Mary)

Reclaiming former social identities, and gaining new ones, were instrumental in the recovery of selfconcept. Women drew on positive interpersonal and group connections and renewed *collective* identities. In describing her coping efforts with the recent severe violence, Malaya referred often to her mother role and her religious *collective* identity as well as to *group-based* identity derived from her church membership.

I still have my depression, nightmare and so sometimes I don't want to eat, usually I'm restless. I cannot sleep. But now, bit by bit, I'm getting back my senses. Then when my children call me up it makes me strong and I have my church. (Malaya)

By contrast, Jane, who was farther along in her journey, conveyed how she had largely disengaged from the abusive experience. In effect, she could distance herself from the collective *abuse identity.*

The only scar I've got now is the burn that's physical, that you can see. It used to bother me a lot. By the time I got married, I even forgot I had it. It was so not important any more. Before I was stamped with this whole memory and now I couldn't care less. No-one ever asks what it is, so it's not a problem. (Jane)

The abuse and early help-seeking phases had seen a 'shake-up' of identities; similarly, reorganisation occurred during the healing phase and women could reflect on how social identities contributed to their overall self-concept.

Katya, from Eastern Europe, fluent in Greek, who had come to join a Greek-Australia partner, described the impact of receiving help from a counsellor who spoke her first language. The counsellor's support, along with other interpersonal connections, assisted Katya to recover in Australia, ultimately enabling her to continue her life in Australia.

Yeah, she was really good and yeah, it's very helpful. Because I wanted to go back to [country of origin] when I left him, but all this counselling or, you know, in temporary housing, people that looked after me, my case. Like they changed my mind completely and I started feeling again like new person. (Katya)

Women commonly conveyed positive experiences of receiving help in the community, and particularly from women with the lived experience of partner violence. This signified a vital shift from perceiving disclosure as a threat to acceptance, to now embracing a *group-based* social identity defined by the very factor many women had resolutely concealed for so long.

I went for counselling and then I did the battered women's group. That was a very safe place to be. That was probably the most important part for me, was having people understand and listen. It wasn't just the practical support of, you know, here's a little bit extra cash and here's a shopping voucher; it was the

emotional-physical side that I got from those groups and that counselling that made the big difference I think. (Susan)

For other women the healing focused on recovering *relational* identities that represented autonomy and personal achievement. Liz demonstrates how a small proportion of women undertake a recovery journey that is largely independent of formal or even informal sources of help.

No [it did not take long to recover], because not long after leaving, I started working again and I was proud that I had taken a stand and left. Because I've always worked, so I gave up work when Lily was born, partly because I just couldn't work - mentallyI returned to work and that went well, and then I found a better jobIt didn't take long, once I started believing in myself again, that I could do it. (Liz)

Malaya was open to communicating her experiences in the refuge setting and to her social worker in the aftermath of the relationship. However, she actively concealed her experiences from members of her cultural and church groups. It is implied that her abused status represented a risk to certain affiliations. This suggests that women may continue to 'protect' certain identities from their past and the disruptive potential of an *abuse identity*.

I trust Alanna. She's my social worker. I trust her. After that - then I seldom talk to people even if it's my fellow, same culture I have, I don't talk, just my brother. In the church I don't talk about what happened to me, just my past. But in the church I didn't tell anybody. (Malaya)

Women found themselves having to negotiate their history across many different personal and social relationships. Jane explains how the anonymity of strangers was less threatening to identity. Whereas in relating with friends, she felt, even now all these years later, she had to 'sell' a successful version of herself in order to be accepted:

It was a rocky road. The more I talked about it, the easier it got and I found that talking to strangers was a lot easier. I still worry about some of those friends who think I'm still a bit damaged. I constantly feel like I have to say, look how well I'm doing now, I've got this fabulous life. Who am I selling myself to? (Jane)

The Recovering Relational Identity

Of all the identities touched upon in this analysis, women's perceptions of themselves as a partner, and their capacity for an intimate partnership had suffered most and appeared most resistant to recovery.

It ruined my confidence for a long time and I really didn't want to have a relationship ever again. (Claire)

Jane's experience of a new relationship captures the kinds of external challenges that women faced – the potential for new interpersonal connections to actually reinforce the *abuse identity*.

I let him [new partner] read my victim statement report and there was a little segment about how I had an AIDS test because of the sexual assaults that I'd had and he was also seeing prostitutes and cheating on me. So I had this test done and as soon as he [new partner] saw that, he was like, it's over. You're broken, you're dangerous, you're diseased, you're not the kind of person I want to be with. (Jane)

Where women established relationships, they reported difficulties in interpreting their partner's behaviours.

I know this sounds really terrible because every time I think about it I think about my past relationship with Luke and I go oh my God, this isn't the beginning of something - but my boyfriend at the moment, he doesn't believe in psychologists. He doesn't think that there is any need and that they aren't helpful. So I choose - I know that I could go to one because he doesn't put me in the position where he would break up with me if I went to one, but I choose to try and help myself to avoid seeing one, if that makes sense. (Elaine)

As a final reflection, Jane, who had largely disengaged from the *abuse identity*, shows us the longer-term identity-related struggles that face women who have been through the personal and social tragedy of a violence intimate relationship.

I constantly feel like I'm still trying to move away from that whole [experience] - not that I let it happen but I was one of those types of people; I'm in that category of something that they'll still never understand.

DISCUSSION

This study confirms the devastating effects of intimate partner violence on self-concept, in particular adding to understanding about how the experience devalues and spoils identity (Hague et al., 2003), the social dimension of self-concept. Social identity was an important feature of women's journeys, central to selfevaluations and with the potential to thwart or promote help-seeking and recovery. Our primary research question was concerned with women's experiences of social identity in the context of intimate partner violence. Perpetrators used various tactics to destabilise women's identities such as engineering a chaotic relationship context which engendered self-doubt and lack of trust in women's own judgement. Williamson (2010) referred to it as the perpetrator's 'unreality,' characterised by contradiction and incoherence, which serves to reinforce his control. The resulting reductions in agency, self-esteem and mental functioning (Williamson, 2010) lock women into a downward spiral of control and abuse (World Bank, 2012).

Although not common in this domain, the application of Social Identity Theory (Tajfel, 1981) along with more recent work distinguishing different levels of social identity (Brewer, 2001), and the related emphases on the social over the personal self, was effective in generating insights about abused women's identity experiences. The effects of partner violence on *person-based* social identities were particularly damaging because these are core and integrated aspects of the self (e.g. gender) (Brewer, 2001). Social Identity Theory has been used to explain the potential for threats to gender identity to produce behaviour that attempts to accentuate differences between the in- and out-groups (disproportionately observed in males compared to females) (Munsch & Willer, 2012). There is therefore potential for compounding women's risk with increased differentiation between abusers and victims on characteristics such as culture, language, and

ethnicity. The stories of linguistically and culturally diverse women, two of whom said they had been treated liked slaves, illustrated this phenomenon. The 'helping' context has also been implicated in for example showing racial stereotyping in service provision (Chavis & Hill, 2009; Donnelly et al., 2005).

With regard to *relational* social identities, a noteworthy finding concerned how the dominant, demanding, 'toxic' abuse affected the nature of a woman's identity as a partner and could destabilise and obstruct other *relational* and *group-based* social identities. The 'behavioural guide' implied by the damaged partner *relational* social identity tended to be rigidly gendered and increase the abuser's coercive control (Stark, 2007). Consistent with the literature, women felt a sense of shame at failing in roles, especially that of mother (Mullender, 2002) with use of children as a tactic to control (Pence & Paymar, 1993) emerging time and time again. The partner's control along with the burden of having to juggle the partner identity with other identities, and the emotional by-product of living under these stressful circumstances meant that highly-valued *relational* and *group-based* social identities could be lost entirely. This meant relinquishing the associated opportunities to satisfy needs for security, belonging, and self-enhancement (Brewer & Gardner, 1996) as well as financial stability, autonomy, and the social support required to escape the violence (Liang et al., 2005). *Collective* identities were shattered, as seen in violations of embedded cognitive scripts about partnership, marriage, love and commitment, and creating difficulties for women to identify with 'motherhood.' Other *collective* identities emerged, in particular, that of the 'madwoman,' and taking on of what we referred to as an *abuse identity,* also found in Crawford et al. (2009). The extent to which the findings resonate with the power and control tactics used by abusive men as proposed in the Duluth Model (Pence & Paymar, 1993) is noteworthy. In particular, we observed use of isolation; emotional abuse; and male privilege in subordinating women and the perpetrator being the one to define male and female roles. There was also ample evidence of minimising, blaming and denying and using the children.

Our second area of enquiry opened practical questions about how social identity shapes abused women's help-seeking behaviours. Our questions were framed within health care settings although the findings have resonance for different settings in which women seek assistance. Consistent with the survivor hypothesis (Gondolf & Fisher, 1988), women were constantly searching for ways to help their situation. Three themes captured the essence of women's help-seeking journeys. We know that women conceal abuse because they fear ramifications of disclosure (e.g. escalating violence, judgemental attitudes). However our study depicted women attempting to preserve their public identity. They avoided breaking the façade in encounters with health professionals, mirroring the pregnant women in Edin et al.'s (2010) study who resisted the "threat of disclosure." Given the limited opportunities to strengthen self-esteem, women fervently resisted any factor that could threaten interpersonal and group connections. The instability created by the abuser's behaviour (Williamson, 2010) also gave women an incentive to seek the 'normality' that accompanies being involved with other individuals and groups (Edin et al., 2010). Shame accompanied awareness of the abuse, another powerful barrier to help (Crawford et al., 2009; McKie, 2005). Where the internal juggling of the partner with other identities was no longer feasible, women were often compelled to disengage publicly rather than risk humiliation (Williamson, 2010) of revealing the abuse.

For most however, the balance eventually tipped in favour of unveiling an *abuse identity*. Although social identities at different levels of organisation are independent and can include incompatible representations of the self (Turner, Oakes, Haslam, & McGarty, 1994), the women in our study arrived at a point where their experience of the partner identity became irreconcilable with other identities. This is consistent with

Williamson's (2010) description of how negotiating normal life within a chaotic unreality creates an identity crisis for abused women. The process of searching outward for help often commenced when women felt so "weakened" that behaving in ways prescribed by their most integrated identities was all but impossible. These junctures mirror the turning points in Chang's (2010) work. However, leaving the relationship was not an inevitable outcome. One educated, working woman from an Asian background, whose turning point was to recognise her own and children's need for safety, was constrained by family expectations, social norms and cultural beliefs that discourage dissolution of marriage. Hers was a powerful example of a woman at the intersection of different socio-cultural influences, which weighed down on her multiple *person-based, relational, group-based* and *collective* identities. Ultimately her bargaining power within the relationship increased (World Bank, 2012) with the support she received from GPs and counsellors, and the violence reduced significantly. However, she relayed regret and persistent sense of lost identity.

This leads to the third theme – the effect of health care interactions on identity. Accusations of insanity are common to emotional abuse (Hegarty, Bush, & Sheehan, 2005; Pence & Paymar, 1993). Health providers contributed to the abuser's imposition of the 'insane woman' collective by medicating mental health issues without addressing the underlying abuse. This approach could reinforce his distorted perceptions and deepen her sense of disempowerment and loss of self-esteem (Humphreys & Thiara, 2003). Women's narratives contained references to secondary victimisation (R. Campbell & Raja, 1999), for example, the impact of the (public) *abuse identity* in health settings where women were seen as damaged, untrustworthy, and unreliable sources of information about themselves. However, most women could also report a positive help-seeking experience in the health setting: they described the capacity of the relationship/encounter to counter the destabilisation and confusion, and encourage connections with others at relational and group levels. Most importantly for this research, the provider enabled them to engage with the *abuse identity* in a more

constructive way, as well as examine the nature of the partner *relational identity*. Our findings reflect a study of sexual identity disclosure in health care settings among same-sex attracted women (a similarly sensitive area of research) (McNair, Hegarty, & Taft, 2012). They reported that the risks associated with disclosure, the importance of sexual identity, and nature of relationship with health providers were the main factors influencing participants' disclosure patterns (open/telling, waiting to be asked, or private/not telling).

Social identity also pervaded women's recovery narratives. Women highlighted the positive effects of (re-) establishing identities that promoted agency. Embodied aspects of partner violence, such as permanent scars, lost visibility over time. However, we also noted how women faced an unrelenting *abuse identity*. In some settings, she could reveal this identity publicly with no negative reverberations (i.e. in support groups and other therapeutic settings where her connection was almost defined by it). In other, largely group-based milieus, an *abuse identity* often remained veiled as women feared their past could still threaten belonging and acceptance (e.g. community, cultural, religious groups, workplace). Ongoing contact with the perpetrator due to the children had the potential to 'internally' perpetuate the *abuse identity* (Crawford, 2009). In the longer-term, women conveyed the continued confines on opportunities in their lives imposed by an intractable *abuse identity*. Limitations

Our study has several limitations. Conducting retrospective research can challenge the validity of data. However, 8 of the 14 women had been in the relationship within the last 5 years and the majority of the women were still rebuilding their lives. We used a convenience sample, reducing our capacity to draw conclusions about a broader population of women who experience partner violence. Also this study was conducted in metropolitan Australia where abused women's experiences of support services are likely to differ to women in other less developed regions of the world. Despite the potential selection bias, the women represented a wide spread in age, socioeconomic status, education and cultural background. Their

experiences also brought diversity in regards to duration of and time since the relationship, types of partner violence and levels of support.

Implications for Research and Practice

In general, intervention research addressing partner violence in health settings points to the need to shift from universal screening to case-finding (Taft, O'Doherty, Hegarty, Ramsay, Davidson, & Feder, 2013) and on improving the kinds of interventions – advocacy (Ramsay, Carter, Davidson, Dunne, Eldridge, Feder et al., 2009), psychological therapies and organisational interventions such as referral to other specialist support services (Feder, Davies, Baird, Dunne, Eldridge, Griffiths et al., 2011) – that are available to women following identification (Wathen & MacMillan, 2012). This study could inform future interventions for abused women in any health care setting, and Social Identity Theory is proposed as a theoretical lens through which to design interventions and tailor them to particular health environments like primary care. Further research focused on identity and help-seeking in health and other contexts is warranted as this study was primarily concerned with how abuse affected women's identity experiences. This could be conducted in-depth in particular settings such as emergency departments or antenatal services.

The practice implications of this study point largely to service provision contexts. In particular, what do the findings contribute to our understanding about supporting women in health care settings? Firstly, the study adds to the large body of research on the factors that promote and hinder women accessing services in the first place. These issues remain important given ongoing recommendations to foster coordinated care models that allow seamless referral of women from clinical to community-based services (Wathen & MacMillan, 2012). Appreciating women's needs to protect their many valued identities and conceal the *abuse identity* in ways that may seem contradictory or counterproductive is paramount here. Furthermore, the intersection of identities – race, surviving abuse, class, immigration status in addition to gender – has

major bearing on women's capacities to access services (Chavis & Hill, 2009). The vulnerabilities of immigrant women (Astbury, Atkinson, Duke, Easteal, Kurrle, Tait et al., 2000), isolated by language and cultural barriers (Bui, 2003) must be taken into account in identification, referral and support.

Those involved in supporting women need to appreciate that women seek help for a range of life problems without necessarily drawing attention to the violence (Henning & Klesges, 2002), thus it is important to be sensitive to partner violence in different health care settings (Wathen & MacMillan, 2012). The WHO has recently recommended that health providers integrate case-finding into their clinical practice and provide women-centred care to survivors (World Health Organization, 2013b). Thus, appreciating the broad and complex role played by social identity could enhance the response providers offer women, allowing practitioners across health settings to develop interventions that are flexible and individualised to the needs of women and their children, as well as being appropriate to the type of health setting (e.g. primary care and antenatal services offer different opportunities for engagement to those afforded in emergency care). Another important implication is the pharmacological treatment of depression. Prescribing antidepressants for women exposed to partner violence may assist them to improve their situation. However, it may have the opposite effect if done without acknowledging the presence of abuse and supporting her on a pathway to improved safety/reduced abuse. Clinicians need to be aware that women can hold incompatible identities, living with the abuse backstage and motivated to project an outward normality. Health care providers must help women to reveal their *abuse identity* safely and without shame but also respect that in some contexts women may choose to never fully unveil it. Opening up creative formal and informal options to assist women depending on where they are in the journey and which appeal to their own valued identities and promote positive self-image and esteem are likely to be beneficial. In collaboration with women, clinicians need to help women to recognise how their multiple identities interact with their decision-making. Attention needs to be given not only to how women's attempts to help themselves are sabotaged by the coercive tactics

of the abuser, but also to how women's progress is threatened by deeply embedded socio-cultural values and institutional pressures, which themselves bear strong associations to women's identities. It is also important to be sensitive to the immense psychological and emotional significance of relinquishing valued identities. Finally, recognising that stigma persists long after cessation of the abuse and impinges on recovery will be advantageous in any setting. A supportive relationship with the health system – whether it be a GP or specialist support – where she can display the *abuse identity* safely is crucial to enable new strategies for rebuilding her identity.

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