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Cheryl Tatano Beck

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Judith Wuest, Marilyn Ford-Gilboe, Marilyn Merritt-Gray, Colleen Varcoe
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Building on “grab,” attending to “fit,” and being prepared to “modify”

How grounded theory “works” to guide a health intervention for abused women

Judith Wuest, Marilyn Ford-Gilboe, Marilyn Merritt-Gray, and Colleen Varcoe

Grounded theories have unique potential for influencing clinical practice. The theory has grab (Glaser, 1978); it resonates for those who have experienced the situation that the theory explains, or know or practice with those who have. Because grounded theories can explain, interpret, and predict human behavior in specific social contexts, they work and have practical utility (Glaser, 1978). A fundamental premise of grounded theory research is that people actively shape the worlds they live in through the process of symbolic interaction and that their viewpoints are vital to generating useful knowledge of process, interaction and social change (Glaser, 1992; Strauss, 1987).

“Nursing is a practice discipline whose essence lies in processes” (Stern & Pyles, 1986, p. 1). For clinicians, the theoretical rendering of what is most problematic in the study situation and how it is processed by participants offers insights into how and when a clinician might intervene. Thus grounded theory lends itself to conceptual utilization, that is, a rethinking of situational phenomena that may or may not lead to change in action (Estabrooks, 2001). Indeed, the effects of grounded theories on nursing practice appear to have been minor (Hall & May, 2001; Morse, Penrod, & Hupcey, 2000). Poor uptake is not a problem specific to research evidence with qualitative origin (Estabrooks, 2001). However, translation of grounded theories by researchers is essential to facilitate their utilization in concrete applications such as clinical protocols, decision trees or practice guidelines (Estabrooks, 2001; Sandelowski, 2004). Little has been written about how such purposeful translation takes place. Yet, as Thorne (2011) reminds us, nurses need to understand phenomena “in a way that will be applicable to the diversity of context and complexity within the actual real-time setting” (p. 449). Thorne calls upon researchers to mobilize research toward “meaningful social and pragmatic action” (p. 450). Importantly, with grounded theory, the work of knowledge translation not only makes the theory more accessible to practitioners; it also has potential to add breadth and depth to the original theory through the constant comparative process with multiple sources of new data. In this chapter, we discuss the processes, challenges and advantages of translating our theory Strengthening Capacity to Limit Intrusion (SCLI) (Ford-Gilboe, Wuest, & Merritt-Gray, 2005; Wuest, Ford-Gilboe, Merritt-Gray, & Berman, 2003) into
a primary health care intervention, the Intervention for Health Enhancement After Leaving (iHEAL) (Ford-Gilboe, Merritt-Gray, Varcoe, & Wuest, 2011), and conducting initial feasibility studies using the iHEAL with women who have left their abusive partners in the past three years.

**Background**

Grounded theory is distinctive among qualitative research methods in that its goal is the development of substantive theory, that is, theory that accounts for a human behavior within a particular social context (Glaser, 1978; Glaser & Strauss, 1967). Through constant comparative analysis of data from interviews, observations, documents and/or images, researchers conceptually construct what is most problematic and the social-psychological process by which the problem is addressed. The analytic outcome goes beyond descriptive themes or the recounting of individual narratives to the articulation of a theoretical scheme in which key concepts are identified and defined, and the relationships among them delineated. While some grounded theories are reported in terms of a core category, more commonly they are written as basic social psychological processes (BSP), that is, a core category with at least two sequential stages. Vital to their usefulness is the naming of factors or conditions that influence variation in the core category or BSP, not just by their presence or absence, but also by their degree or intensity (Wuest, 2012). Conditions that influence variation are diverse and may include individual attributes such as age or family history, relational factors such as conflict, support, services and resources, and/or structural influences such as poverty or discrimination. Thus, a grounded theory is a substantive theory that accounts for the heterogeneity in how a basic social process unfolds for individual people in different contexts and suggests possibilities for action that previously may have been invisible (Glaser, 1978; Swanson, 2001). Substantive theory helps us transcend our finite grasp of the specific through its potential transferability to other situations (Glaser, 1978). “Analytic generalization and theoretical transferability are the bases for utility in grounded theory research” (Sandelowski, 2004, p. 1371).

**The theory of Strengthening Capacity to Limit Intrusion (SCLI)**

In our program of research focusing on women’s health after leaving an abusive partner, we conducted a grounded theory study of family health promotion after separation from an abusive partner and developed the theory of Strengthening Capacity to Limit Intrusion (SCLI) (Ford-Gilboe et al., 2005; Wuest et al., 2003). We used a feminist grounded theory approach (Wuest, 1995; Wuest & Merritt-Gray, 2001) and analyzed repeat interview data from 40 mothers, ages 22–48 (M = 36) and 11 of their children. The families had been living separately from the abusive partners on average just under four years (range 1–20). As we coded and constructed provisional conceptual categories and the relationships among them, we shared our findings with the women during their second or third interviews, seeking their feedback for modification and confirmation of our emerging theoretical schema. In this way, we identified that the core problem related to health promotion for the families under study was intrusion, that is “external control or interference that demands attention, diverts energy away from family priorities and limits choices” (Ford-Gilboe et al., 2005, p. 482). Intrusion stems from ongoing abuse and harassment from the ex-partner (frequently exacerbated by child custody and access issues), physical and mental health problems of women and their children, the “costs” of seeking help (for example, measuring up to criteria imposed by policies, increased surveillance by income assistance workers or family members), and negative changes to daily life (Wuest et al., 2003). Leaving an abusive partner is a risk-taking act to position the family for a better future. However, increasing intrusion after
leaving forces families to focus on promoting health by creating stability in day-to-day survival. As stability is achieved, women are able to focus again on positioning for the future, an act which may lead in turn to increased intrusion.

Families spontaneously engaged in the process of SCLI in four ways: (1) providing; (2) rebuilding security; (3) renewing self; and (4) regenerating family (Ford-Gilboe et al., 2005). Providing involves meeting basic needs of income, housing, personal energy, food, childcare, recreation, transportation, medication and relief from symptoms. Rebuilding security includes safeguarding from threats to physical and emotional safety and cautious connecting with family, friends, services and the larger community. Renewing self refers to the process of developing personal capacity to make their personal needs a priority, make sense of the past, consider who they are and who they want to be, and find comfort and relief from day-to-day intrusions and distress. Regenerating family entails developing a family storyline to explain their past, increasing predictability in day-to-day life, and naming and using new standards for relationships. Within these sub-processes, the health promotion focus for women shifts from positioning for the future to surviving and back again according to the degree of intrusion the family is experiencing.

Significantly, when we shared the emerging theory with women, they readily connected with the grounded theory conceptualization and offered further data to help refine the theory. Similarly, the theory had grab for other researchers, clinicians, and other helpers. As we presented our work in the community, at professional conferences and in peer-reviewed papers, we discussed the implications of the theory for practice, largely at a level of “conceptual utilization” (Estabrooks, 2001). The theory shaped how we understood women’s experiences of leaving and how we individually interacted with women with abuse histories. At the same time, the identification of intrusion from ongoing physical and mental health problems related to abuse helped us to recognize that, despite the dominant belief that leaving an abusive partner is the solution for abused women, little was known about the trajectory of women’s health after leaving abusive partners. To address this gap, we conducted a four-year longitudinal study examining changes in women’s resources and health after separation from an abusive partner, the Women’s Health Effects Study (WHES). Annually, 309 Canadian women who had left abusive partners in the previous three years took part in structured interviews and health assessments (Ford-Gilboe et al., 2009). Baseline data revealed that the women (who had been separated on average 20 months) had significantly poorer physical and mental health and higher rates of service use than Canadian women of similar age with little relief from their symptoms, and that the annual health system costs attributable to violence were approximately $4,969.79 per woman (Ford-Gilboe et al., 2009; Scott-Storey, Wuest, & Ford-Gilboe, 2009; Varcoe et al., 2011; Wuest et al., 2007, 2008, 2009, 2010).

These quantitative results were useful as comparative data for further development of our grounded theory, particularly to expand the concept of intrusion from physical and mental health problems, “costs” of seeking help, ongoing abuse and harassment, and changes in lifestyle (for example, forced moves, income disruption). Despite the lack of attention to constant comparison with quantitative data in grounded theory scholarship today, Glaser and Strauss (1967) asserted that both quantitative and qualitative data are useful, and sometimes necessary, for the generation of grounded theory through constant comparative analysis. Although the WHES was not a grounded theory study, we found the WHES data to be an important source of secondary data for theoretical sampling, that is, purposefully choosing data for comparison in order to augment the original SCLI theory through the refinement of the properties of concepts and the relationships among them (Glaser, 1978).

Our grounded theory and the WHES findings, along with the dearth of existing health interventions for women after leaving, demonstrated the urgent need to develop a community
health intervention specifically designed to assist women who had experienced the trauma of abuse to promote their health (Ford-Gilboe et al., 2011). This compelling evidence also helped us to garner financial support and partnerships from funding agencies and decision-makers to develop and examine the feasibility of a health intervention for women after leaving. The theory of Strengthening Capacity to Limit Intrusion was the logical starting point for health intervention development. The scope of the theory provides evidence that survivor health is socially determined. Thus, we decided to design the iHEAL to be delivered collaboratively by a nurse and a domestic violence worker. Based on the SCLI theory, we agreed that the aims of the intervention would be to improve women’s health and quality of life after leaving an abusive partner: (1) by reducing intrusion; and (2) by enhancing women’s capacity (knowledge, skills, and resources) to limit intrusion (Ford-Gilboe et al., 2011).

Processes and challenges in developing the intervention

Our theory captures the central pattern of health promotion behavior in mother-headed, single-parent families after leaving an abusive male partner, and its consequences (Ford-Gilboe et al., 2005). Importantly, this theoretical rendering captures the naturally occurring and intuitive actions taken by diverse women and their children to strengthen their capacity to manage intrusion at different points in time after leaving, and consolidates the lessons learned from them. A key principle of the iHEAL is that

women’s own experiences of leaving an abusive partner and those of other women, as reflected in the theory of strengthening capacity to limit intrusion, will be a key source of knowledge to help women reflect on, reframe, and name their experiences, concerns, and priorities.

(Ford-Gilboe et al., 2011, p. 203)

This principle draws on what Estabrooks (2001) called the persuasive power of research evidence which is akin to Glaser’s (1978) grab. Stories of others’ experiences are important “in evoking, persuading, and provoking; in promoting empathetic, feeling or visceral understandings of the people and events; in moving listeners and readers to act” (Sandelowski, 2004, p. 1373). Grounded theories, because they frequently focus on aspects of human experience that have received little attention, can help to mitigate feelings of isolation and alienation. The theory, however, is more than individual stories; it captures a pattern of survivors’ personal and social behaviors in terms of antecedents, consequences, and influencing factors. The theory then has potential to resonate with women’s disparate experiences in different contexts, and to permit diverse women to name their experiences and see new possibilities for limiting intrusion, leading to better health. The SCLI theory presents what women do, with and without help from others, highlighting how contextual factors limit or enable women’s growth. Although this theoretical scaffold directs clinicians to draw upon and augment women’s expert knowledge and skills in supporting them to strengthen their capacity to limit intrusion, a limitation of the SCLI theory is that it does not explicitly explain how clinicians might do this. In short, it is not a theoretical construction of how to practice. However, the theory’s concepts and the relationships among them can shape the underlying philosophical assumptions and practice principles for an intervention. Further, the process of Strengthening Capacity to Limit Intrusion provides direction for the intervention’s structure. Just as the original grounded theory was generated, so the iHEAL was constructed in a series of reflective, strategic, iterative choices about which aspects of the theory should be highlighted in the context of our agenda to improve women’s health. The
discussion that follows is a reconstruction of key challenges and processes in moving from theory to intervention, from our initial attempts to create a rough outline of goals, components and potential outcomes of the intervention (Ford-Gilboe, Wuest, Varcoe, & Merritt-Gray, 2006) to a more complete rendering some four years later (Ford-Gilboe et al., 2011). As with most retrospective accounts, our discussion reflects a more organized, conscious, and polished process of intervention development than was actually the case. It does not fully capture our false starts, dead ends, and stumbling steps in developing the iHEAL.

Theoretical sensitivity, constant comparison and emergent fit: naming underlying philosophical assumptions and principles of practice

Grounded theory analysis is informed by theoretical sensitivity, that is, the researcher’s capacity to use knowledge of theoretical constructions from many disciplines as well as personal and vicarious experiences as a basis for constructing concepts and the relationships between them (Glaser, 1978). Theoretical sensitivity does not drive theory construction but it does open the researcher to theoretical possibilities that are then checked out and refined through theoretical sampling and constant comparison (Wuest, 2012). The philosophical assumptions delineated for the iHEAL reflect the shared perspectives and values that underpinned our program of research (Ford-Gilboe et al., 2011). Our theoretical sensitivity in the grounded theory research that generated the SCLI theory was informed by diverse philosophical assumptions, including a feminist viewpoint of intimate partner violence (Varcoe, 1996), health promotion as a process of enabling people to increase control over and improve their health (World Health Organization (WHO), 1986), health as socially determined (Health Canada, n.d.), and primary health care (WHO, 1978). This sensitivity influenced our theory construction; for example, it enhanced our ability to see women’s agency, our recognition of women’s health promotion taking place on social, relational and individual levels, and how we theorized “costs” of seeking help. As we scrutinized the theory with practice in view, we quickly identified the applicability of these assumptions for our health intervention, with women’s health being socially determined and primary health care being key (Ford-Gilboe et al., 2011).

Some other key assumptions were named much later when the structure of the intervention and activities for the interventionists were under development. Drawing on our theoretical sensitivity, we progressively became aware that some existing expert practice philosophies fit with the theoretical scaffold of the iHEAL such as harm reduction (Pauly, 2008), cultural safety (Browne et al., 2009), and trauma-informed care (Elliot, Bjelajac, Fallot, Markoff, & Reed, 2005). In grounded theory, categories are inductively developed through substantive coding and constant comparison such that the category fits the data (Glaser, 1978). But not all categories must be new. Emergent fit refers to using constant comparison between pre-existing categories and the data to determine whether it fits the data (Glaser, 1978; Wuest, 2000). Using a process of emergent fit between the practice implications of data from both the SCLI theory as well as the WHES findings and expert practice philosophies, we identified philosophical assumptions true to our theoretical conceptualization and reflective of expert practice beliefs. One example of emergent fit is incorporation of harm reduction (Pauly, 2008) as an underlying philosophical assumption that aligned well with the processes in the theory of SCLI.

Our grounded theory process of renewing self conceptualizes how women, relieved from the oppression of abuse, initially relished living free, that is, finding release in a wide range of activities, some of which were potentially harmful such as substance use, extensive partying, overinvestment in children or work, and hasty connecting in new relationships (Ford-Gilboe et al., 2005). Most also continued to use some previously learned strategies to find comfort from the trauma of abuse.
such as smoking, working long hours, eating, sleeping, or using drugs and alcohol. These theoretical findings were supported by the WHES study's findings; of 309 women, at baseline, 44% smoked and 53% were overweight or obese. In the previous 12 months, 27% had used street drugs, 16% overused prescription medication (Wuest et al., 2008) and 26% screened positive for potential high-risk drinking. Just over 3% reported having a sexually transmitted infection in the past month. However, our grounded theory findings also showed that as intrusion levels settled, women found that despite *living free*, they did not feel happy or satisfied and began to position for the future by engaging in the work associated with *living better* (Ford-Gilboe et al., 2005). One way of living better was to begin intentionally to take better care of themselves. The process of *living better* was facilitated by formal and informal support that focused on fortifying women and avoided undermining their dreams. Harm reduction is an intervention philosophy that focuses on engaging non-judgmentally and respectfully with people to help them find ways that they can be safer, healthier and more in control while risk-taking (Pauly, 2008). Our theoretical sensitivity to harm reduction initiated constant comparison with our data for emergent fit. Through constant comparison, we identified harm reduction to be a congruent and important philosophical orientation for supporting women whether they were *living free* or working on *living better*. By making the assumption that risky behaviors are a rational and purposeful response to the trauma and aftermath of abuse, and focusing on supporting women to reduce the health and social harms of such behaviors, we incorporated harm reduction as a key philosophical underpinning of the iHEAL (Ford-Gilboe et al., 2011).

**Principles of practice**

We also developed intervention principles for the iHEAL, that is, key guidelines to ensure that the intervention built on the practice implications of the theory. For each previous publication and presentation of the theory, we had carefully scrutinized and reflected on the theory, considering particularly how practicing from this theoretical base might differ from “usual” nursing practice. Collectively, we reflected and discussed and argued about meaning for practice over time as we did this scholarly work together and used it to inform our policy work related to the grounded theory and the Women’s Health Effects Study. Developing the iHEAL, however, pushed our thinking to another level as we considered how we might articulate interventionist approaches based on the SCLI theory. Although we had worked together successfully for more than ten years, and shared many common values, this exercise made visible differing viewpoints. Notably, individual commitments to the Developmental Model of Health and Nursing (Allen & Warner, 2002) and relational inquiry (Doane & Varcoe, 2005) required intense and lengthy discussion regarding how these nursing approaches might fit with the SCLI theory. As well, because the intervention was being developed for delivery by nurses and domestic violence advocates, current best practices in domestic violence advocacy also were considered. Gradually we realized that rather than choosing an existing practice model or philosophy to guide the iHEAL, we needed a set of general practice principles that would fit with our shared assumptions and the theory of SCLI, and would guide practice by both nurses and advocates.

Some principles were identified readily. Principles such as the intervention being women-centered, that is “women will direct the pace, what is given priority and who is involved,” and strengths-based, that is “women’s strengths and capacities will be recognized, drawn upon, and further developed” (Ford–Gilboe et al., 2011, p. 203) reflected not only our own philosophies of nursing practice but also best practices in the domestic violence intervention sector. Other support for the latter principle stemmed from the SCLI theory demonstrating that survivors habitually had their deficits reinforced by ex-partners, other family members, and helping
agencies, yet were consistently demonstrating creative resourcefulness and successful management of complex day-to-day challenges. WHES study findings reinforced this finding, showing that, after leaving, women’s scores on standard measures of resilience, mastery and family functioning were comparable to those of other women of the same age.

Some principles of the iHEAL are a direct bridge from philosophical assumptions to a practice approach such as the principle of advocacy stating: “The interventionists will work to reduce intrusion from community services and to advocate for improved system responses to women who are situated in varied contexts of social inequity” (Ford-Gilboe et al., 2011, p. 203). The principle of advocacy translates our stated assumption that intimate partner violence “is sanctioned and enabled by broader social, cultural, and political structures that systematically oppress women, the poor, and those from non-traditional cultural backgrounds” (p. 200). However, further support for this principle was derived through constant comparative analysis with our theoretical findings of intrusion experienced by women who seek help, including having to measure up to criteria to access services by repeatedly recounting stories of abuse, submit to ongoing surveillance as a condition of receiving help, or settle for services that do not match their needs (Wuest et al., 2003) and our WHES findings that services accessed commonly meet women’s needs poorly.

Other principles came primarily from scrutiny of the theory and constant comparison to develop a more generalized principle. For example, another practice principle is: “Women will be supported to assess, judge, and take calculated risks necessary for moving forward” (Ford-Gilboe et al., 2011, p. 203). Risk-taking is inherent in the act of leaving an abusive partner in that abuse and harassment intensify after leaving (Canadian Centre for Justice Statistics, 1993; Wuest & Merritt-Gray, 1999). Indeed, 83% of women in the WHES reported ongoing harassment an average of 21 months after leaving (Wuest et al., 2007). Women who left their partners took the risk of experiencing more violence because they wanted a better future for themselves and their children. Thus, leaving is an act of positioning for the future, that is “promoting health through proactive, strategic efforts to develop the skills, assets, and strengths needed to realize their family’s dreams in the long term” (Ford-Gilboe et al., 2005, p. 483). However, within our data, we found countless examples of women taking diverse risks to position for the future; for example, leaving a stable low-paying job in order to go back to school to gain needed credentials for a career that promised more financial security and fulfillment, buying a house using non-conventional or under-the-table financing in order to build equity for children, or involving children in family decision-making about safety strategies, money, and relationships. In usual practice, clinicians may encourage women to maintain stability through the status quo and discourage taking calculated risks that might lead to further intrusion. However, the SCLI theory suggests the importance of interventionists reinforcing the legitimacy of survivors continuing to take calculated risks in order to build capacity and helping women to contain the potential costs of doing so.

Our initial assumptions and principles offered direction for the subsequent development of the iHEAL, a six-month community-based primary health care intervention to be delivered in 12–14 one-to-one meetings, with the majority of client contact with the nurse (Ford-Gilboe et al., 2011) but were, in turn, refined and expanded in response to our further work. We decided that the theoretical processes of strengthening capacity (rebuilding security, providing, renewing self, and regenerating family) would structure the content of the intervention, which we named as components. However, as we began our translation work to develop the components, the need for theory modification became apparent.
Modifying the theory in the process of developing the intervention components

Our work on developing the intervention components began with a review of the original SCLI theory. Often this included returning to the original coded interviews, process tables and memos, particularly to support our choice of language and illustrative examples. Although the WHES study provided additional data for constant comparison, our modification of the theory in response to that data had been largely informal as our common understandings evolved. Thus, as we began our work on the iHEAL, we found ourselves in a process of conscious theory modification in response to theoretical sampling of our WHES findings as well as the original grounded theory data. Modifiability is a key characteristic of grounded theory (Glaser, 1978) and also an aspect of grounded theory application. Glaser and Strauss (1967) noted:

\[\text{The person who applies the theory must be enabled to understand and analyze ongoing situational realities, to produce and predict changes in them, and to predict and control consequences ... As changes occur, his [sic] theory must allow him [sic] to be flexible in revising his [sic] tactics of application and in revising the theory itself if necessary.}\]

\[(p. 245)\]

Although the original theory had been developed with a sample of women with dependent children who had been separated from abusive partners as long as 20 years, 40% of the WHES sample did not have dependent children (Wuest et al., 2008) and had been separated between three months and three years from their abusive partners. Although women who were mothers were more likely to experience some types of intrusions such as harassment and disabling chronic pain, mothering generally did not account for differences in resources or health patterns found in the WHES. We intend the iHEAL for all women in the early years after leaving abusive partners, believing that early intervention has the potential to prevent or ameliorate many health problems identified in the WHES sample. Thus, data from the WHES helped us to modify the grounded theory for wider applicability.

The original theory has four health promotion sub-processes called providing, rebuilding security, renewing self, and regenerating family (Ford-Gilboe et al., 2005). Providing addressed meeting basic needs including those usually identified such as food, money, housing, and childcare, and also ones not usually named such as medication, energy, leisure, and relief from symptoms. However, the WHES findings related to women’s health problems and health service use greatly expanded our conceptual understanding of intrusion related to physical and mental health problems. We learned that women on average reported three current diagnoses by a health professional and 12 current health problems or symptoms, with more than 60% reporting fatigue, difficulty sleeping, back pain, headaches and difficulty concentrating. Rates of high disability chronic pain (35%) (Wuest et al., 2008) and pre-hypertension (42%) (Scott-Storey et al., 2009) were twice as high as those for Canadian women in general in a similar age group. As well, 73% of women had symptoms consistent with clinical depression and 48% reported symptoms consistent with posttraumatic stress disorder (Wuest et al., 2010). Visits in the past month to a physician doctor were more than five times higher than Canadian women in general; and to emergency department 20 times higher (Varcoe et al., 2011). Despite such high levels of service use, women in the WHES appeared to have little relief from their health symptoms. These data enhanced our theoretical understanding of symptom management in the context of intrusion from health problems and increased its primacy in the theory. It also led to our explicitly identifying the principle, “Women’s physical, mental, emotional, and spiritual health will be prioritized” (Ford-Gilboe et al., 2011, p. 203).
Consequently, we divided the process of providing into two components: managing symptoms and managing basics. Managing symptoms focuses on supporting women to build confidence in preventing and managing intrusive symptoms through self-management and support from health professionals (Ford-Gilboe et al., 2011). Managing basics focuses on “assisting women to build the economic, material, and personal energy resources needed to establish and sustain herself separate from the abuser over time” (p. 207). Using similar processes of comparative analysis with WHES data, we also divided rebuilding security into two components: safeguarding and cautious connecting (Ford-Gilboe et al., 2011). We retained the two processes, renewing self and regenerating family, as individual components. Thus, the theoretical model used to guide the intervention included six components or ways of strengthening capacity to limit intrusion (see Figure 3.1).

From theoretical process to practice component

Our next challenge was the translation from theoretical process to practice component. Grounded theory processes are very recognizable to those who took part in the study either as participant or investigator because they can see the fit between the theoretical concepts and the data or their own experiences (Glaser, 1978). However, these processes may be dense and complex for the interventionist who tries to use them, especially if she/he is not familiar with the study domain or, on the other hand, is an expert in the field with an entrenched practice approach. The conceptualization may be contrary to previous understandings and the language may feel awkward, at least initially. Thus it was important to identify and explain what was unique or different about each component for this population of abused women based on our qualitative data. For example, while the concept of managing basics in terms of housing, jobs, childcare and transportation was easily grasped, aspects such as recreation and energy were more unusual. The conceptual understanding that women face the challenge of managing basics while feeling undeserving and often with their energy levels “on empty” is new.

Further, the theoretical construction, not the conceptual indicators from the women’s stories, has the broadest applicability clinically. For example, all women struggled with managing basics related to intrusion from negative changes to daily life after leaving, such as those related to financial losses. However, a conceptual indicator of how a woman managed her current difficulty in paying hockey registration fees for her teenage son may have little meaning for many women, including those who have no sons of hockey age, or those whose economic circumstances have always precluded children taking part in such activities. However, the broader concepts of determining what is basic currently, and the process of managing without are recognizable for all. This is not to say that specific examples of women’s experiences (conceptual indicators) are inappropriate for illustrating ways of managing particular situations. However, the experience used must be matched to the needs and context of the woman, requiring the interventionist to have a range of diverse examples from which to draw. Those who developed the theory will have in their minds a range of indicators of the concepts from the original data. Alternatively, interventionists attempting to practice from this new theoretical lens will take time to amass a collection of diverse indicators that capture the variation in intrusion and the six components (health promotion processes). Hall and May (2001) asserted that because substantive theory is more specific and complex than practice theory, “more mental agility, and a certain amount of experience and knowledge of the substantive area” may be required for its application (p. 214).

As well, grounded theories often include multiple sub-processes and strategies that may be too layered or complex to be readily useful for an interventionist, especially one who has a novice understanding of the theory. Thus, a re-examination of each of the theoretical processes was necessary to ascertain which elements were core to the process and germane to directing practice
Figure 3.1 Theory of Strengthening Capacity to Limit Intrusion (SCLI)
to improve health outcomes. We drew on our presentations and publications in our deliberations, particularly the papers focusing on intrusion (Wuest et al., 2003) and the theory overview (Ford-Gilboe et al., 2005). The process of *regenerating family* had been published as a separate paper detailing the varied strategies used by families (Wuest et al., 2004). Interestingly, we had the most difficulty in developing the core elements of the *regenerating family* component, partially because it required modification to apply to women without children but also because once the detail of variation in process or concept has been explicated, it is difficult to set it aside. This latter issue had similarly challenged Wuest and Merritt-Gray in their work developing measures of caregiving concepts from a grounded theory of women's caring where they learned, for example, that the concept of dependency in the care recipient as reason to take on caregiving had broad application, but the conceptual indicators of dependency such as cognitive difficulties or inability to speak English did not (Wuest et al., 2006). The caveat, then, was to use the more abstract concepts, not the conceptual indicators, so that the interventionist would be free to identify a wide range of indicators for each concept, based on personal experience as well as our original work. Over time, as the interventionist delivers the iHEAL, the repertoire of exemplars grows and provides further data for the ongoing refinement of the SCLI theory. In *regenerating family*, we ultimately focused on three core elements that we believed could be most helpful to women: (1) the storyline or how women construct how they have come to be in their current situations; (2) using routines, new roles, and rules in working with others to increase predictability in daily life; and (3) purposefully naming and using new standards for relationships with others.

For each component, the next step was to determine how these core elements could be best translated as a clear guide to practice while staying true to the original conceptualization. We developed a standard template for developing practice modules for each component that included: (1) defining the component; (2) naming expected outcomes; (3) identifying the theoretical and empirical grounding by linking it to the theory of strengthening capacity to limit intrusion but also to existing related research; (4) developing standard required and optional tools to facilitate exploring intrusion, or sharing options; (5) writing an illustrative script for the interventionist to demonstrate an approach for exploring intrusion and sharing options; and (6) identifying potential actions for strengthening capacity.

In doing this work, we guarded against conceptual drift. Despite efforts on the part of grounded theorists to choose conceptual labels that fit, the meaning given to words varies widely according to individual contexts and experiences. As we worked together on components, we found that among ourselves our understandings of concepts were sometimes different, and we needed to revisit our analysis of the original data. As well, common disciplinary understandings can intrude. The component of *cautious connecting*, for example, on first glance seems to focus on women's needs for support from family, friends, community and formal services and the interventionist could see the principal focus on helping women make the needed connections. But the theory shows that when women seek support, especially when they have an urgent need for help and few connections, the consequence is often increased intrusion from having to retell their story to justify their need for help, ongoing surveillance from people or agencies, and help that does not match needs well. Thus, some key elements of *cautious connecting* are that it is healthy and important for women to withhold trust from potential helpers until they feel ready, and that agencies and individuals may misinterpret and try to violate the woman’s limits. The focus of *cautious connecting* then is supporting women to evaluate the costs and benefits of the connections they have or are thinking of making, with the goal of decreasing conflict and increasing their sense of belonging, emotional support, social interaction, and practical aid. This conceptual focus goes well beyond making referrals. Thus, the illustrative script for *cautious connecting* and the tools developed needed to elaborate and detail this conceptual focus. An information sheet of lessons...
learned from other women about connecting with others after leaving was developed for exploring intrusion related to cautious connecting. Large print showing various reasons women want to connect to others after leaving and a colored table of “costs” of seeking help provide a useful tool to facilitate women exploring the range of possible intrusions from connecting with others. A second tool, a Relationship Map, which is similar to an ecomap, was developed to help women look at the strength and quality of their relationships with people and/or resources that they identify as important to them, first in their “inner circle” and then in the larger community. The illustrative script directs the interventionist to support women to discuss the quality and nature of each relationship and identify which connections are most helpful and which are more intrusive. This sets the stage for a discussion regarding what women might like to change with respect to their connections. A third tool called Options, Tradeoffs and Choices facilitates women’s consideration of their options for taking actions to change connections that are most intrusive. Once women determine the action to take, the interventionist then focuses on helping them build capacity. Seven strategies for supporting women to build capacity regardless of the component are: pacing, informing/educating, acknowledging strengths, coaching/guiding, monitoring change or progress, connecting with services or resources, and advocating (Ford-Gilboe et al., 2011). The modules that we developed for each component became the core materials for a training manual for interventionists.

Putting the intervention into practice

We currently are conducting two studies to gain information regarding the feasibility of implementing the iHEAL in diverse community contexts. A key step in moving forward with the feasibility studies was training the interventionists to practice from the theoretical base, and use its language and conceptual rendering in a meaningful way. The grab of grounded theory is helpful here, but it is also easy to frame parts of the intervention in usual practice. During the initial training, we oriented interventionists to the SCLI theory and to the assumptions, principles, structures, and activities of the intervention. Mindful discussions about our mutual understandings of abuse and trauma, resources and services, and practice philosophies and strengths set the stage for more specific iHEAL preparation sessions. Differences between the iHEAL and usual practice, as well as potential gaps, were identified and salient clinician expertise was useful for further refinement of the therapeutic approach to fit particular contexts. We found that clinical coaching in regular, scheduled meetings was essential for safe case management and to review, highlight, and ensure consistent application of the theory. Interventionist perspectives are particularly useful for helping us to attend to pragmatic obligation (Thorne, 2011), the interrogation of theoretical findings for their potential to cause harm in practice, by bringing potential problem areas to the surface. Periodic ongoing interventionist development sessions were necessary to uncover problem areas, reflect particular challenges with various components, provide further training, identify issues with services and resources that called for advocacy with decision-makers, and gather data to inform further theory development. The strength of a grounded theory-based intervention is the openness to modification using constant comparative analysis with new data to improve fit.

Within the feasibility studies, we have formally collected data not just through pre- and post-test measures of quality of life, health, capacity, and intrusion, but also through qualitative indicators of the intervention process. The latter include interviews with interventionists early in the intervention process and after the intervention study is completed, interviews with participants about their experiences, and notes reflecting salient points from regular administrative and process-focused meetings with interventionists and/or the research team. Further, clinical
file reviews and constant comparative analysis considering the quantitative and qualitative data collected on the corresponding participant are a rich source of insights on the client trajectory, and how the theory was operationalized in the intervention. Together these analyses will lead to further modification of both the intervention and the theory.

**Final thoughts**

The process of translating the SCLI theory to the iHEAL intervention and conducting two feasibility studies focusing on implementation is complex and demanding. Although our feasibility studies are ongoing, preliminary qualitative and quantitative findings are promising. In particular, the *grab* of the SCLI theory, particularly the concept of *intrusion*, for both the interventionists and the women taking part is convincing evidence that grounded theories are an important starting point for clinical interventions that are useful. The complexity of ensuring conceptual correspondence among the original theory, the iHEAL as written, and the iHEAL as implemented requires detailed knowledge of theory and of the practice field. We have come to understand that intervention development, like grounded theory itself, is an ongoing process open to constant modification. The process of developing and implementing an intervention based on a grounded theory does not result in a fixed intervention. Rather continuing constant comparison, refinement of fit, and emergent fit lead to modification not only of the intervention but also the theory itself which in turn has implications for the intervention. Feedback from interventionists and from women combined with outcomes and chart review all contribute to identify aspects of the intervention and theory that need to be rethought or further refined and confirm the usefulness of others. As we move forward, we are challenged to understand how and why this theory-based intervention works or does not work for women with particular health, abuse, or demographic characteristics in order to sharpen its therapeutic focus for diverse groups of women. Thus, our work, it appears, has barely begun!

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**Notes**

1. For a full discussion of grounded theory as a research method, see Wuest (2012).
2. For a full description of the Intervention for Health Enhancement After Leaving (iHEAL), see Ford-Gilboe, Merritt-Gray, Varcoe, and Wuest (2011).

**References**


