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‘They aren't really black fellas but they are easy to talk to’: Factors which influence Australian Aboriginal women's decision to disclose intimate partner violence during pregnancy

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ABSTRACT

Objectives: intimate partner violence is a significant global health problem but remains largely hidden. Understanding decisions about whether or not to disclose violence in response to routine enquiry in health settings can inform safe and responsive systems. Elevated rates of violence and systematic disadvantage found among Indigenous women globally, can impact on their decisions to disclose violence. This study aimed to test, among Indigenous women, a model for decisions on whether to disclose intimate partner violence in the context of antenatal routine screening.
Design: we employed Qualitative Configurative Analysis, a method developed for the social sciences to study complex phenomena with intermediate sample sizes. Data were drawn from single semi- structured interviews with Indigenous women 28+ weeks pregnant attending antenatal care. Interviews addressed decisions to disclose recent intimate partner violence in the context of routine enquiry during the antenatal care. Interview transcripts were binary coded for conditions identified *a priori* from the model being tested and also from themes identified within the current study and analysed using Qualitative Configurative Analysis to determine causal conditions for the outcome of disclosure or non-disclosure of violence experienced.
Settings: five Aboriginal and Maternal Infant Health Services (two urban and three regional), and one mainstream hospital, in New South Wales, Australia.
Participants: indigenous women who had experienced partner violence in the previous year and who had been asked about this as part of an antenatal booking-in visit. Of the 12 participants six had elected to disclose their experience of violence to the midwife, and six had chosen not to do so.
Findings: pathways to disclosure and non-disclosure were mapped using Qualitative Configurative Analysis. Conditions relevant to decisions to disclose were similar to the conditions for non-Aboriginal women found in our earlier study. Unique to Aboriginal women's decisions to disclose abuse was cultural safety. Cultural safety included elements we titled: *Borrowed trust, Build the relationship first, Come at it slowly* and *People like me are here*. The absence of cultural safety Its absence was also a factor in decisions *not* to disclose experiences of violence by this group of women.
Key conclusions: cultural safety was central to Indigenous women's decision to disclose violence and processes for creating safety are identified. Other forms of safety which influenced disclosure included: safety from detection by the abuser; safety from shame; and safety from institutional control. Disclosure was promoted by direct asking by the midwife and a perception of care. Non-disclosure was associated

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with a lack of care and a lack of all four types of safety. Experiences of institutional racism were associated with Indigenous women's perceived risk of control by others, particularly child protection services. *Implications for practice:* policies to ask abuse questions at first visits and models where continuity of care is not maintained, are problematic for Aboriginal women, among whom relationship building is important as is ample warning about questions to be asked. Strategies are needed to build cultural safety to counter widespread racism and promote safe opportunities for Indigenous women to disclose intimate partner violence and receive support. Elements of cultural safety are necessary for vulnerable or marginalised populations to fully utilise available health services.

Introduction

Physical and sexual abuse by an intimate partner affects 30% of ever partnered women (García-Moreno et al., 2013). Taking the World Health Organization's definition(2013), intimate partner violence (IPV) can be understood as comprising a pattern of behaviour by a current or former partner, that may include physical aggression, sexual coercion, psychological abuse and/or controlling behaviours. In Australia, many Aboriginal people prefer the term 'family violence' as it encompasses intimate, family and other relationships of mutual obligation, and recognises the extended nature of harms done (Laing, 2000). Appreciating the diversity of views, in this paper we use the term 'intimate partner violence' to match the language of the partner abuse screening tool used in the antenatal health care context. We also use the terms 'abuse' and 'violence' inter-changeably throughout this paper recognising that for many women, no physical violence occurs, though is no less debilitating. IPV has well documented acute and chronic health effects for women and their children (Krug et al., 2002). perinatal effects include inadequate antenatal weight gain, post-natal depression, preterm and low birth weight infants and maternal and neonatal deaths (Alhusen et al., 2015).

Indigenous people worldwide experience higher rates of IPV (Perry, 2004; Trocmé et al., 2010) with Australian Aboriginal women two to five times more likely to experience IPV than Australian non-Aboriginal women (Willis, 2011). Intimate partner violence related morbidity and mortality are both higher for Aboriginal women than for other Australian women (Olsen and Lovett, 2016). Compared to non-Aboriginal mothers and after adjustment for parity, socio-economic status and remoteness, Aboriginal mothers are seventeen times more likely to die from homicide than non-Aboriginal mothers (Fairthorne et al.,2016). Complex inter-related factors which contribute to the higher rates of violence experienced by Aboriginal women include colonisation, dispossession of culture and dislocation of families through persistent government policies of child removal (Olsen and Lovett, 2016); Atkinson (2003) explains the heightened IPV as a response to the intergenerational transmission of the trauma of invasion and ongoing racism, manifest as despair and rage being re-enacted by Aboriginal people on themselves. Other elements in this complex landscape include higher rates of systematic disadvantage and exposure to stressful life events experienced by Aboriginal people (Gracey and King, 2009).

In response to the high prevalence of IPV and its associated negative impacts, many countries have introduced policies that include routinely asking about experiences of IPV in health settings. The World Health Organization proposes screening for IPV in selected at-risk groups, including pregnant women. Screening during pregnancy increases identification of abuse (O'Reilly et al., 2010) although disclosure rates are low relative to prevalence of partner violence (García-Moreno et al., 2015). Most women do not disclose the abuse they experience (Evans and Feder, 2014), so understanding decisions to disclose and circumstances in which they choose not to, is critical. This is particularly important for Aboriginal women, who face additional barriers to disclosing abuse (Willis, 2011).

Background

Key social indicators demonstrate the gap between Aboriginal and non-Aboriginal people in Australia includes: a 10-13 year life expectancy gap (Rosenstock et al., 2013); half the school completion rate (Australian Bureau of Statistics, 2014); twofold suicide rate (Steering Committee for the Review of Government Service Provision, 2014); and nine-fold rate of child removal (AIHW, 2015). Disparities appear to be growing rather than abating, with a 57% increase in adult Aboriginal imprisonment (2000 – 2013) (Steering Committee for the Review of Government Service Provision, 2014) and an increase from 40 to 53 per 1000 Aboriginal children on child protection orders (2010 – 2014) (AIHW, 2015). Yet evidence is also lacking for what works in responding to IPV among Aboriginal people (McCalman et al., 2014). A comprehensive review on responses to Aboriginal women's experiences of IPV, revealed that there is limited evidence for programmes targeting Aboriginal family violence (Olsen and Lovett, 2016). We found no studies which specifically explored Aboriginal women's experiences of routine IPV screening in health care settings. A study on perceptions of screening which oversampled Māori (Indigenous people of New Zealand) women, found that they welcomed the opportunity to be asked about violence (Koziol-McLain et al., 2008).

In our previous work, we developed a working model for women's decisions to disclose IPV in response to routine screening. The model was based on interviews with 20 women recruited from health services six months after they had disclosed abuse (Spangaro et al., 2011). The model suggested that Direct asking, Choice, A trustworthy asker, Safety from the abuser detecting their disclosure, Safety from shame and safety from others or agencies taking over (Safe from institutional control) were the conditions associated with disclosure. Participant narratives and the resulting model were consistent with trauma theory as articulated by Judith Herman (1992). Among the 20 women who informed the working theory, only two were Aboriginal. There was a critical need to test the IPV disclosure working model in a more heterogeneous group of women. We therefore conducted a follow-up study to test the working IPV disclosure theory among women seeking antenatal care, and over-sampled Aboriginal women. We previously reported analysis of interviews with 32 non-Aboriginal women (Spangaro et al., 2016). While key elements of the a priori model were retained, additional elements included a condition for disclosing: Telling for the baby; and conditions for not disclosing: judging telling as Irrelevant to the situation and Avoiding revisiting trauma. In this paper we present our analysis of interviews with Aboriginal women.