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Deciding to tell: Qualitative configurational analysis of decisions to disclose experience of intimate partner violence in antenatal care

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ABSTRACT

Rationale: Intimate partner violence (IPV) is a significant global public health risk causing premature death and morbidity that largely remains hidden. Understanding decisions about whether or not to disclose abuse when asked about it in health settings is important to ensuring that those experiencing violence are provided with access to services to support their safety and wellbeing.
Objective: This study tested a model for women's decisions to disclose IPV in response to routine inquiry as part of antenatal assessment.
Methods: Qualitative configurational analysis, suited to the study of causal pathways in complex social phenomena, was used to analyse interviews with 32 women who had experienced IPV in the past 12 months and who elected, when asked, to either disclose this to the midwife ($n = 24$) or not to do so ($n = 8$).
Findings: Multiple pathways to disclosure were identified. While no single factor was necessary or sufficient for a decision to disclose, direct asking and care, defined as showing interest and a non-judgemental attitude, were found to be key conditions. The *absence* of care was also central to decisions not to disclose, as were perceptions of relevance of the abuse at the time of assessment.
Conclusion: Confirming key elements of the original model, these findings highlight the importance of being asked about abuse in women's decisions to disclose, as well as the relational nature of this process. Trauma-informed practices for identifying and responding to intimate partner violence are needed.

1. Introduction

Intimate partner violence (IPV) is a significant worldwide public health risk (Krug et al., 2002) and a major cause of premature death, with well-documented effects on women, including significantly higher rates of injury, abortion, HIV, depression and suicide, compared to women without a history of IPV (Garcia-Moreno et al., 2013). We define IPV as behaviour by a current or former intimate partner causing physical, sexual or psychological harm which may include physical aggression, sexual coercion, psychological abuse and/or controlling behaviours (World Health Organization, 2013). Pregnancy brings additional adverse outcomes for women who experience IPV, including higher rates of post-natal depression, perinatal death, low birth-weight and pre-term births (Alhusen et al., 2015). Identifying women who are experiencing IPV is the first step to intervening to support their safety and wellbeing. Lifetime physical IPV prevalence among women in health settings is higher than in population-based studies, with the highest rates in fracture, psychiatric and obstetrics/gynaecology departments (30–50%) (Alhabib et al., 2010; Praise Investigators, 2013). The potential benefits of early identification have led to the introduction of policies for routine IPV screening and intervention in many health systems. The evidence base remains contested, however, with those in favour of screening highlighting the significantly higher rates of identification of DV which result (e.g. Ghandour et al., 2015; United States Preventive Services Task Force, 2013). Others conclude an insufficiency of evidence exists that screening reduces abuse or improves health outcomes, though use in high-

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risk groups, including pregnant women, is warranted (e.g. World Health Organization, 2013).

Regardless of the debates, it is important to understand how women decide to disclose abuse, particularly given that at least 20 per cent of those who experience IPV tell no one else about it (Garcia-Moreno et al., 2005; Mouzos and Makkai, 2004). From early responses to IPV which stressed the importance of providing services, a large body of research has identified barriers to disclosure, including fear, loss of financial security, shame and self-blame (Bullock et al., 2006; Othman et al., 2013; Petersen et al., 2004). Enablers of disclosure, including clinician knowledge of IPV, privacy and non-judgemental attitudes, have also been documented (Feder et al., 2006). Much of the research has addressed the context of spontaneous disclosures or disclosures made during presentations with injury, which is different to the context of routine screening. Further, the *process* of disclosure remains insufficiently studied in IPV research (Alaggia et al., 2012).

The psychological literature provides useful insights into motivations for disclosing sensitive information (e.g. Omarzu, 2000; Jonzon and Lindblad, 2004). Disclosing can yield psychological benefits when it is met with positive responses (Chaudoir and Quinn, 2010). Information concerning experiences that are stigmatised in society, such as past abortion or mental illness, are particularly risky to disclose, potentially leading to rejection and discrimination. Chaudoir and Fisher (2010) model of disclosure describes antecedent goals (pre-existing risk/benefit decisions that people make about the consequences of disclosure), components of the disclosure event itself and outcomes of disclosure that may affect future disclosures. Antecedent goals can be 'approach-focused', anticipating positive outcomes (such as increased psychosocial support), or 'avoidance-focused', aiming to prevent negative outcomes (for example, feeling ashamed). The disclosure event itself may vary in the amount of information shared, the expression of emotion associated with disclosure and the reaction of the confidante, which may shape the way the disclosure event unfolds (Chaudoir and Fisher, 2010).

This model could be extrapolated to disclosure of IPV to predict that prior knowledge about the questions likely to be asked and past experiences of disclosure may influence antecedent goals, that is, what women are likely to gain or lose by disclosure. The reaction of a midwife is a key element which may influence how much information is shared. Alaggia et al. (2012) use a broader, ecological framework to characterise disclosure of IPV as a carefully measured process that is influenced by intrapersonal, interpersonal, community and policy-level considerations. Individuals will carefully assess their situational context and only disclose in varied degrees and amounts, depending on their reading of anticipated risks and benefits.

No overarching theoretical model ties together the psychological literature on individual-level behaviour with an ecological framework that might explain how decisions to disclose IPV are made within a health setting. One model based on interviews with 20 women who had all disclosed recent IPV in the context of being asked at health service entry shows promise (Fig. 1) (Spangaro et al., 2011). Part of a mixed-methods study, it aimed to understand women's decisions to disclose abuse in response to screening. The current study aimed to test and refine this theory-of-change model explaining women's decisions to disclose or not to disclose IPV in the context of antenatal care.

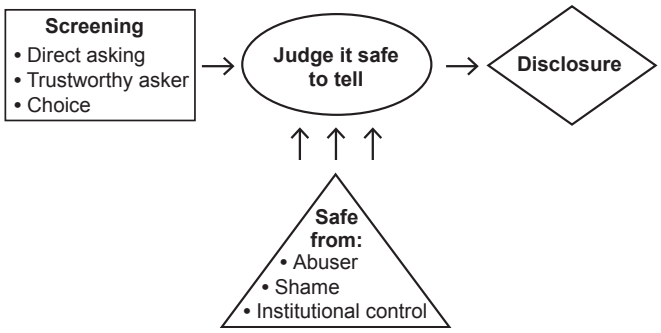

Fig. 1. Model for disclosure of intimate partner violence (Spangaro et al., 2011).

2. Methods

2.1. Methodological approach

This study drew on a realist approach, which aims to identify underlying processes and mechanisms that explain social interactions (Sayer, 2000). Critical realism seeks causal explanations, recognising that these are not understood as regular successions of events, but brought about under particular structures and conditions (Sayer, 2000). This contextually sensitive approach is well suited to understanding the complexity of the decision to disclose IPV and is consistent with the working model (Fig. 1) and emerging disclosure models (Alaggia et al., 2012; Chaudoir and Fisher, 2010).

To test and refine Spangaro et al.'s working theory-of-change model we used qualitative configurational analysis (QCA), a method devised for 'testing a theory or hypothesis by defining a series of conditions that should yield a particular outcome' (Berg-Schlosser et al., 2009, p. 16). Developed for the social sciences to study complex phenomena, the method recognises that outcomes commonly result from multiple conditions, and that different combinations of such conditions can produce the same outcome, allowing for both cross-case comparisons and recognition of within-case complexity (Berg-Schlosser et al., 2009). The analysis results in identification of one or more 'pathways' or combinations of conditions leading to the outcome of interest.

Analysis involves reduction of apparently relevant conditions to binary measures where 0 = low/weak/absent and 1 = present/high. Coded for each case, the impact of a condition's presence or absence in combination with other factors is systematically examined by means of a two-dimensional matrix, referred to as a 'truth table' (Rihoux and Ragin, 2009). While seemingly reductionist, QCA is an iterative process that relies on a holistic understanding of cases and the relationship between cases and theory. Previous QCA applications include exploration of conditions of community engagement in interventions for disadvantaged mothers (Brunton et al., 2014); features of neighbourhoods important to recovery following Hurricane Katrina (Jordan et al., 2014); and organisational conditions explaining sickness absence (Baltzer et al., 2011).

The current study employed QCA to understand the conditions that explain women's disclosure of abuse in the context of an antenatal health visit, defining the outcome of *disclosure* as the woman's perception that at the time of being asked she told the midwife she had experienced abuse or fear of her partner or ex-partner in the prior 12 months. Designed in collaboration with health practitioners, policy advisers and key training providers, the study was approved by the South Eastern Sydney Human Research Ethics Committee (Ref 12/191).

2.2. Study locations

The findings reported here derive from three antenatal clinics in Sydney, Australia, where under state health policy all women are screened for IPV on entry to antenatal, early childhood, mental