CHAPTER 2

LITERATURE REVIEW

This study aimed to understand how Thai women disclose their abuse experience and how women's personal and socio-cultural context influence the disclosure process. This chapter proceeds with a review of selected theoretical and empirical literature that is relevant to the current study. The literature is organized into two sections: an overview of wife abuse and the concept of disclosure of wife abuse.

An Overview of Wife Abuse

A definition and classification of wife abuse is presented first. The causal theories of wife abuse and the impact of wife abuse on women's health are then presented.

Definition and Classification

Abuse can be defined as a pattern of assaultive and coercive behaviors, including physical, sexual, and psychological attacks used against current or former intimate partners potentially or actually result in harm to another person (Kramer, 2002; Wiehe, 1998). In the vast majority of cases, wives are injured and husbands perpetrate the assault. This study, therefore, focuses on the form of violence that occurs in the context of intimate relationships, namely wife abuse. The use of the term wife abuse is informed by feminist principles and is intended to acknowledge the gender-specific

nature of the violence and the power disparities between perpetrators and victims (Bograd, 1990 cited in Boonzaier & De La Rey, 2003). Wife abuse is generally divided into three primary forms: physical, emotional or psychological, and sexual abuse. Physical abuse involves any physical attack, including hitting, slapping, kicking, throwing object, or use of a weapon that results in physical harm such as pain, cuts, bruises, swelling, or fractures. Emotional or psychological abuse may include the use of ridicule, insults, accusations, infidelity, and ignoring the partner, all of which result in an erosion of one's self-esteem and self-worth. A perpetrator who isolates a partner from friends, family, and neighbors inflicts another form of emotional abuse. Emotional abuse can also involve the withholding of economic support. Sexual abuse occurs in the marital relationship when the perpetrator forces sex regardless of wife's feelings. Although the three primary forms of domestic violence are identified and defined individually, all three types may occur sequentially or concurrently and emotional or psychological abuse may underlie physical and sexual abuse (Wiehe, 1998).

Prevalence of Wife Abuse in Thailand

Wife abuse is a prevalent problem in Thailand although specific prevalence estimates vary depending on settings, research methods, and sampling techniques. In central Thailand, a number of studies found a high rate of wife abuse. In a multi- stage sampling survey of 811 wives who resided with their husbands in Bangkok, Sirisunyaluck (2004) found that 62.3% of women in this study reported emotional and 33.43% reported physical abuse in the past year. This prevalence is similar to an earlier large sample survey of women aged 15-49 years old (Archavanitkul, Kanchanachitra, Im-em, & Lertsrisuntas, 2003) which reported that 41% of women in Bangkok and

47 % of women in Nakorn Sawan province had been physically and/or sexually abused by their partners at least once in their lifetime.

Studies in other populations indicate the problem of wife abuse in other regions of Thailand. For example, Sawangchareon and colleagues (2003) reported the lifetime prevalence of wife abuse in three provinces in Northeast Thailand as 63.4 %; of these cases, 55.8 % are in need of help from others. Sripichyakan, Phianmongkhol, Chaiyos, and Krisnuluk (2002) conducted a survey research to explore the prevalence of spouse abuse in Chiang Mai, northern Thailand and reported the prevalence of physical, mental, and both physical and mental abuse committed in the previous year as 13.1%, 38.4%, and 6.6%, respectively. However, this study is a small scale research (98 couples and 1 widow) focused on one community in Chiang Mai. Thus, there is limit in generalizability of results.

In addition, there is an evidence of wife abuse during pregnancy. Thana-udom (1996) found that the prevalence of physical and psychological abuse among pregnant women in Bangkok were 12% and 22.5%, respectively. However, in this study, participants were recruited from only one setting, which limits the generalizability of results. Moreover, only the prevalence of physical and emotional abuse were shown. In a descriptive survey of 475 pregnant aged eighteen and older from five hospitals in Bangkok, Thananowan (2004) reported that 10% of the participants reported abuse in the past year, 4.8% reported abuse during pregnancy, and 10.7, 4.8%, and 4.8% of those who had been abused during pregnancy reported physical, sexual, and emotional abuse, respectively. A recent descriptive study by Sricamsuk (2006) among 421 pregnant women in Khon Kaen province reported the prevalence of physical,

psychological, and sexual abuse during current pregnancy as 26.6%, 53.7%, and 19.2%, respectively.

Although there are a number of studies regarding wife abuse in Thailand, the prevalence varies in each population and data from these studies are not comparable. There is considerable variation in the study populations used for research. Some studies on wife abuse include all women with a specific age range, while other studies interview only women who are currently married or who have been married. Both age and marital status are associated with a women's risk of being abuse. Moreover, some studies examine only violence acts from the previous 12 months, while others measure lifetime experiences. Considering the data from the large scale studies, the prevalence of wife abuse during the life time is approximately from one third to more than haft of respondents (Archavanitkul et al., 2003; Sawangchareon et al., 2003; Sirisunyaluck, 2004).

Causal Theories of Wife Abuse

There are contemporary theories of causation explaining and predicting the motivations, circumstances, and other factors that characterize individuals who perpetrate abuse and violence within intimate partner relationships. There are three major widely accepted theoretical perspectives explaining male violence against women that are well established in various disciplines (Sui-Fun Fong, 2000).

Psychological perspectives focus more on the individual, dyadic and/or triadic levels when explaining why the assault occurs. The psychological theories give little attention to the influence of external factors but concentrate on rectifying or modifying the behavior disorder of the person who is considered responsible for the abusive

situation (Fishwick, Campbell, & Taylor, 2004). On the other hand, sociological perspectives focus on the characteristics of the family unit and/or the social environment in which the individual is raised, socialized and influenced. Two predominant theories informed by the sociological perspective are social learning theory and systems theory. Social learning theory maintains that violence is a learned response. The perpetrator may have learned this dysfunctional response from witnessing violence in his family of origin or from the attitude in society expressed often in the media that males have a right to dominate females. In systems theory, the family or marital couple is seen as a social system. All persons in the system are viewed as in some way influencing or contributing to the abuse that occurs and are affected by the abuse. Factors influencing the family system may include substance abuse, ineffective communication, or stress. However, factors outside the family also may affect the family system and contribute to the abuse, such as economic changes from loss of employment or socially established gender roles (Sui-Fun Fong, 2000; Wiehe, 1998). Thus, the system's perspective for understanding partner abuse suggests that the wife and husband should come together at some stage of treatment therapy (Wiehe).

A more recent theoretical perspective to explaining wife abuse is the feminist perspective. Feminist theories not only integrate the principles of several theories in both psychological and sociological perspectives but also provide the historical and institutional context in which sex role learning and male status acquisition occur (Sui-Fun Fong, 2000). The feminist theories assert that wife abuse is the result of male domination and exploitation of women, often seen in patriarchal society. The central issue is that of power, which rests in the hands of men, and the function of this power is

to control women. The theory also uses aspects of social learning theory, with the premise that perpetrating abusive behaviors is a choice to use a set of learned behaviors (Fishwick et al., 2004; Wiehe, 1998).

In fact, wife abuse is the result of the complex interplay of individual, relationship, social, cultural, and environmental factors. More currently, therefore, integrated framework called ecological framework is proposed to clearly understand wife abused phenomenon (Dahlberg & Krug, 2002; Heise, 1998). An ecological model explores the relationship between individual and contextual factors and considers wife abuse as the product of multiple levels of influence on behavior.

The first level in the ecological model is individual. This level seeks to identify the biological and personal history factors that increase likelihood of being a victim or a perpetrator. Factors such as impulsivity, low education performance, alcohol or substance abuse, and prior history of abuse are considered (Dahlberg & Krug, 2002).

The second level is relationship in family and with peers that represents the immediate context in which abuse takes place. In the case of wife abuse or intimate partner abuse, male dominance or male control of male and marital conflict, for instance, are detected link to violence in the family. In addition, living together and interacting on an almost daily basis may increase or evoke the opportunity for abuse encounters. In addition, peers, intimate partners, or family members all have potential to shape an individual's behavior and range of experience. That is, the abuser may have learned the abusive behaviors from witnessing violence in his/her family or peers.

The third level of the ecological model encompasses the community contexts that embed the family such as school, workplace, neighborhoods, and social networks, and seeks to identify the characteristic of these settings that are associated with being

victims or perpetrators of abuse. Highly diverse population with less relationship among people, high level of unemployment, drug and substance abuse in community are all examples of such characteristics and each has been associated with violence.

The fourth and final level of the ecological model examines the larger societal factors that influence the prevalence of violence. That is, this level represents the general views and attitudes that found in the culture at large.

In summary, the ecological framework highlights the multiple causes of abuse and the interaction of risk factors intertwining within the family and the broader social contexts. As in most society, the problem of wife abuse occurs in Thai society because of social norms that support male dominance over women. Social inequality between genders leads Thai women to feel subordinate to men both in the family and the society (Foundation for Women, 1993). Historically and even today, Thai society is a society for men. It is believed that women's oppressed status in Thailand is influenced by gender-biased interpretations of Buddhism, which favor men and devalue women, deeming women inferior (Kabilsingh, 1998). Through women's oppression, 'legitimized' by religious beliefs, men have power over women and men assume the highest position within the family. This oppression is clearly expressed in the common traditional Thai saying that "Men represent the front legs of elephants and women the hind legs" which strongly values men as leaders in families, whereas women are considered followers. Therefore, men are socialized to be heads of families, while women are socialized to be good housewives, care-giving, submissive and less ambitious (Suriyasarn, 1993). Research in Thailand has also shown that wife abuse is associated with individual, family, and community risk factors as mentioned earlier. Approaching to wife abuse as a multifaceted phenomenon grounded in an interplay

among individual, family, social, and cultural factors will helps to insight in the problem of wife abuse in Thailand.

Impact of Wife Abuse on Women

Wife abuse has many impacts on women, including women's health, economic impact, and their children.

Impact on Health

Abuse has impact on women's health, including physical health, reproductive health, and psychological and behavioral consequences.

Physical health. Living with an abusive partner can have a profound impact on a woman's health. Wife abuse has been linked to adverse health outcomes, both immediate and long-term. Obviously, violence can lead to injuries, ranging from cuts, bruises, and fractures to chronic disabilities and death. A high percentage of these injuries require medical treatment (Heise & Garcia-Moreno, 2002; WHO, 1997). However, injury is not the most common physical problem that brings abused women to seek hospital treatment. More common are psychosomatic disorders that frequently have no identifiable medical cause, such as headaches, abdominal pains, muscle aches, and sleeping and eating disorders (Heise & Garcia-Moreno, 2002; UNFPA, 1998). As with the consequences of tobacco and alcohol use, being a victim of violence can be regarded as increasing vulnerability to illness that may be due partly to lower immunity because of stress resulting from the abuse (Kross, Kross, and Woodruff, 1991). Data from the qualitative studies of Thai women revealed that abused women usually come to emergency room because of psychosomatic symptoms and physical injuries (Sripichyakan, 1999; Suwannarong, 2002; Voraseetakarnkul, 2001). Furthermore,

abused women were more likely to increase use of tranquilizer and analgesic drugs and increase the number of admissions to hospital (Archavanitkul et al., 2003).

Reproductive health. Violence against women also increases risk of poor reproductive health. Forced sex is associated with a range of gynecological and reproductive health problems, including HIV and other sexually transmitted infections (STIs), unwanted pregnancy, vaginal bleeding or infection, because women are unable to negotiate safe-sex practices and contraceptive use. Studies have linked abuse to unwanted pregnancy, especially for adolescent females (Watts & Mayhew, 2004). In Thailand, the descriptive cross-sectional survey on 475 Thai pregnant women from five hospitals in Bangkok found that pregnant abused women in the study were more likely to report that their pregnancy was unplanned and/or unwanted (Thananowan, 2004). Violence also occurs during pregnancy, with consequences not only for the women but also for the fetus. In some studies, many pregnant women reported being hit, kicked, or having things thrown at the abdomen and torso (McFarlane, 1993). These abusive acts toward pregnant women, especially in the last trimester, can lead to premature birth or low birth weight babies (Covington, Hage, Hall, & Mathis, 2001).

Psychological and behavioral consequences. Research suggests that abused women endure enormous psychological suffering because of violence. Abused women suffer more depression, anxiety and phobias than non-abused women (Heise & Garcia-Moreno, 2002; WHO, 1997). According to qualitative studies in Thailand, the effects of violence on women's mental health include feelings of shame, guilt, fear, anger, self-worthlessness, helplessness, and suicide (Sripichyakan, 1999; Suwannarong, 2002; Voraseetakarnkul, 2001). Some women in these studies had been admitted to the hospital because of suicide attempts. In addition, as seen in newspapers, some women

finally ended their abusive relationship by suicide attempts, murder attempts, or even penile amputation. (www.friendsofwomen.or.th)

Economic Impact of Violence

Given a long-term of wife abuse on women's health, women who have suffered abuse are more likely to be long-term users of health services, thereby increasing health care costs. A proportion of health care costs is spent for treating serious physical injury and is also spent on psychological problems including managing anxieties and symptoms related to psychological suffering because of violence (Kross, Kross, and Woodruff, 1991; Heise & Garcia-Moreno, 2002). One study in Thailand showed that abused women usually come to emergency room not only because of injuries, but also psychosomatic symptoms related to abuse that result in increasing healthcare costs (Archavanitkul et al., 2003).

In addition to health care costs, violence places a tremendous economic burden on societies in terms of lost productivity and increased use of social services. The economic impact of abuse may extend to losses in women's earning potential; wife abuse does appear to influence women's job performance and their ability to keep their jobs. (Lloyd, 1999 cited in Heise & Garcia-Moreno, 2002).

Impact on Children

Although women are directly suffered from wife abuse, children exposed to violence within the family have been shown to suffer from psychological and social adjustment problems during childhood and adulthood as well (Arias, 1999). Children who witness marital violence are at higher risk for a whole range of emotional and behavioral problems such as anxiety, depression, low school performance, low self-

esteem, and physical health complaints. Additionally, children who witness violence within their family frequently developed many of behaviors and emotional disturbances as children who are actually abused (Edleson, 1999).

Given the impacts of wife abuse on women, the needs of abused women are tremendous; they are in need of both non-professional and professional help in terms of psychosocial support and/or medical treatment. Certainly, disclosing the abuse to others is critical to their survival because it is the first opportunity for abused women to obtain primary help. In Thailand, many women who have suffered from abuse are less likely to go to hospital and to receive medical treatment, except in the cases of severe injury, because they do not regard wife abuse as a medical problem (Sripichyakan & Parisunyakul, 2005; Voraseetakarnkul, 2001). More importantly, abused women are less likely to receive counseling or psychotherapy, probably because of the stigma of mental problems and psychiatric treatment in Thai society (Sripichyakarn, 1999; The Office of the National Commission of Women's Affair, 2000).

The Concept of Disclosure of Wife Abuse

Disclosure is defined as uncovering, making known, or revealing the private, secret, or unknown information to others, while self-disclosure implies that the information is personal and about the self (Rosenfeld, 2000 cited in Zea et al., 2004). Historically, disclosure has been studied as the psychotherapeutic concept of catharsis, the release of tension or emotion that can be achieved through verbal disclosure of that emotion. Throughout the 20th century, disclosure has been widely studied as a therapeutic device, an individual difference characteristic, and as social behavior (Omarzu, 2000).

Recently, the concept of disclosure has been examined in individuals with stigmatized conditions, such as HIV or AIDS infection, or mental illness, as well as among gay men, individuals who were sexually abused as children and abused women (Black & Miles, 2002; Cain, 1991; Fiene, 1995; Limandri, 1989; Moneyham et al., 1996). Under these conditions, disclosure of their information seems to be a dichotomous variable composed of concealment and disclosure. It may range on a continuum from concealing the abuse to fully telling one's life story to others (Fiene, 1995; Limandri, 1989). There is a timing aspect to the disclosure in that some would conceal for a while and then disclose. Individuals with a high degree of felt stigma were more likely to avoid disclosure of the condition.

Typically, wife abuse is not a single incident but rather it is deliberate and repeated physical aggression or sexual assault inflicted on a woman. Also, abuse is not a static condition. Walker (1979, 1994, cited in Wiehe, 1998) proposed that wife abuse can be understood as occurring in a cycle consisting of three phases or stages: the tension-building phase, the acute battering incident, and the calm or honeymoon period. Each stage in the abuse cycle may influence the disclosing behavior. For instance, women are more likely to disclose the abuse during the second stage that wife is assaulted. However, when the husband realizes the results of his assault, he engages in kindness and contrite behaviors such as begging for forgiveness and promising that the abuse will never again happen. The wife thus continuously keeps the abuse to be secret.

Disclosure as a Process

The literature regarding disclosure in any situation reveals that disclosure of secretive information is best described as a process, not an event (Sorensen &

Snowman, 1991). There is a decision-making process individuals follow before disclosing. The decision to disclose is based on an evaluation of the possible benefits versus the possible risks of disclosure in any specific social situation (Omarzu, 2000). However, once disclosure was implemented, the consequences of disclosure will be observed. Research about disclosure revealed that disclosure may result in both positive and negative responses, which had a direct effect on further disclosure (Goodkind, Gillum, Bybee, & Sullivan, 2003; Hanley, 2004; Merritt-Gray & Wuest, 1995). Smith's (2005) study in 20 sexually abused women using a grounded theory approach reported that disclosure was viewed as a circular process, not a linear one, which included the factors in decisions of disclosure, the disclosure behaviors, and the aftereffects of disclosure. Given that the effects of disclosing might influence the likelihood and character of future disclosure.

In a study of disclosure in 48 African American women who were HIV-positive, Black and Miles (2002) provided evidence of the disclosure as an evaluative process. The women determined "a calculus of disclosure" (p. 688) in making decision to whom and when to reveal their HIV diagnosis. This calculus involved a careful evaluation of the risks and benefits involved in disclosing their secretive information. The results of this study also indicated that the calculus of disclosure was a recursive process, with decisions made and remade over time. Similarly, Kimbery & Serovich (1995) have developed a framework to describe the decision-making process for disclosure among HIV-positive women. The framework outlines a six-step process: adjustment to the diagnosis, an evaluation of personal disclosure skills, evaluating the appropriateness of disclosing to a potential recipient, evaluating the circumstances for disclosure, anticipating the reactions of the potential recipients, and identifying the

motivation for disclosure to each recipient. This framework contributed the understanding disclosure as process in which individuals needs to weight the anticipated reactions against the anticipated benefits of disclosure to others.

Another study that attempted to describe the disclosure process is Limandri's (1989) grounded theory of individuals with various stigmatizing conditions, including abused women in Boston, U.S.A. Twenty-nine individual interviews were conducted. In addition, one group of 25 people with herpes and one group of 8 people who had abuse experiences were interviewed. Analysis of the data resulted in the identification of the stigmatization and disclosure process with five phases: beginning realization, self discovery, lost identity, disclosure, and stabilization of identity. At first, people initially diagnosed themselves and sought confirmation with others about their condition. People then discovered a stigmatized view of self through learning from the family and society and learning to keep their condition a secret when they sensed societal disapproval for certain conditions. After self- discovering being stigmatized, people then rapidly lost their self-identity and were confronted with the need to tell or to conceal their conditions. The process simulated a swinging gate that can be completely open, completely closed, or partially open. While disclosure continued as long as the people had the conditions, eventually they stabilized in their acceptance and integration of the condition into their self-concept. Limandri did not identify differences in the process among different stigmatizing conditions. However, she noted that individuals with greater stigma would be less likely to disclose their conditions. Thus, developing a trusting relationship between nurses and clients and listening carefully to cues that may be veiled disclosure are critical elements for facilitating disclosure of stigmatizing conditions.

Among abused women, the process of how women decide to reveal their abuse was described in Fiene's (1995) grounded theory analysis of unstructured interview data from 8 battered Appalachian women in a rural shelter in the United States. The findings revealed the women's strategies for both hiding and revealing their intensely personal information. Initially, women kept the abuse in their family. Then, when women began to reveal their secret, they always tested others by revealing only partial information. They made fuller revelations if they wanted to get advice or help. The aspects of the revelation process were described by the women, including who women tell, why they reveal the abuse, how they reveal their abuse, and what and how much they reveal. In this study, Fiene also developed a social dynamics model of women's decision making in abusive relationships that integrated factors of social isolation, privacy and secrecy in abusive relationships, women's familial roles, and the myth of the happy family. Therefore, her study model moves beyond individual explanations of the process of disclosure. Fiene's work contributes to further understanding in terms of the description of the abuse disclosure concept and a brief discussion of the process of disclosure.

A recent qualitative study in the United States described interventions, communications, or activities that helped abused women in health care encounters to improve their situation and then improve their health (Gerbert, Abercrombie, Caspers, Love, & Bronstone, 1999). A sample of 25 physically abused women was interviewed. Data were analyzed by using grounded theory techniques. The "dance of disclosure" was used to describe disclosure behaviors between the women and a health care provider at a given encounter. The findings indicated that the dance of disclosure was complicated by multiple factors. During any given health care interaction, abused

women may directly disclose, or drop hints, reveal bits and pieces, minimize, change their stories, or even lie. They were frequently ambivalent, hopeful of being identified or afraid of full disclosure. Providers participate in the "dance," sometimes ignoring obvious signs, failing to recognize abuse, probing around, while sometimes directly asking about abuse. In this study, the women found validation by health care providers to be empowering. Although the process of disclosure was not clearly delineated in this study, the "dance of disclosure" identified in this study provided a range of disclosure and identification behaviors in abused women that seems similar to Limandri's (1989) findings.

Research reveals that abused women often have difficulty telling others, even family and/or friends about their experiences (Landenburger, 1989). Women are less likely to reveal their secretive information because they perceive risks of disclosure such as being stigmatized, rejected, or discriminated. Nonetheless, disclosure of the abuse is still essential because it is a prerequisite for proper care and support, or protection from others. Under circumstances where disclosure is necessary, disclosure cannot always be avoided (Limandri, 1989). When a decision to disclose is made, however, the individual then has to decide again about targets (whom to tell), timing (when to tell), strategies (how to tell), and contents of disclosure (how much to tell), as well as reasons for disclosure to each recipient (why to tell) (Fiene, 1995; Gerbert et al., 1999; Hathaway, Willis, & Zimmer, 2002; Omarzu, 2000).

Whom to tell. Abused women are obliged to determine to whom they will disclose their experiences among family members, friends, and less acquaintances. Many studies show that abused women first tend to approach someone with whom they feel close, comfortable, and safe (Bui, 2003; Chatzifotiou & Dobash, 2001; Dunham &

Senn, 2000; Fiene, 1995; Yoshioka, Gilbert, El-Bassel, & Baig-Amin, 2003). Therefore, women usually first disclose their abuse experiences to family members and/or friends for assistance. However, there are some differences in terms of which family members women turned to based on cultural context. For example, in the study of abused women residing in the northeastern United States, Yoshiko and colleagues'(2003) found that South Asian women were more likely to disclose the abuse to their father or brothers and to the siblings of the abuser. On the other hand, African American and Hispanic women revealed their abuse to members of the abuser's family, especially his mother or sisters, in addition to their own family. Greek women in Chatzifotiou and Dobash's (2001) qualitative study using a feminist perspective described that they first disclosed their abuse with a sister or female friends to receive emotional support. Women tried to conceal the abuse from their parents in the initial stages because they thought their parents would be judgmental and disbelieving rather than supportive, as well as being very disappointed in them for the marriage problems. However, after having suffered a great deal of violence and having lost all hope for a better life, women tried to inform their parents and get them involved in confronting the problems.

Women are less likely to disclose their abuse to professionals than to family and friends. A number of studies have shown the low rate of abuse disclosure to professionals. For example, in a survey study of American women who attended medical care clinics in California, Rodriguez, Sheldon, Bauer, and Perez-Stable (2001) reported that only 42 % of the women had disclosed abuse to a medical clinician. Similarly, findings obtained from a survey study of 364 American women who disclosed a history of recent abuse experience indicated a strongly held desire to keep

the experience of abuse to themselves, in that approximately two out of three of the women reported they would not disclose abuse to a service provider. Interestingly, the most common reason that discouraged the women from disclosing abuse was the feeling that they could manage the abuse by themselves (Briggance et al., 2002). Because of the use of closed-ended questions in this study, however, women were limited in identifying their reasons for disclosing abuse.

When to tell. Timing and the ideal circumstance in which to disclose are other concerns for abused women. Women have to select the most opportune moment (timing) to tell and have to determine the right circumstances for disclosure, which is different for each woman. Qualitative studies of abused women in the US reveal that the time it took women to speak up about the abuse and to seek help varied, from immediately after the first abuse incident to more than 20 years after being abused (Chatzifotiou & Dobash, 2001; Washington, 2001). There is further evidence that women avoid disclosing the abuse by delaying seeking help (Petersen, Moracco, Goldstein, & Clark, 2004). Furthermore, women who waited any amount of time after the abusive incident(s) occurred, tended to minimize their experiences (Dunham & Senn, 2000).Women eventually chose to turn to others for help and support once they could no longer tolerate the abusive relationship, or had no more hope for changing things for the better (Peckover, 2003).

How much to tell. Disclosure can also vary depending upon what and how much information will be given to others. When they disclose, abused women may omit certain details or entirely leave out particular incidents. For example, Dunham and Senn's (2000) research on Canadian female undergraduate students in Ontario demonstrated that although some women told their friends or relatives about the abuse,

they had omitted or minimized certain details of the incidents. Other evidence also described abuse disclosure patterns to health care professionals. In a study undertaken in California, for example, Gerbert and colleagues (1999) described disclosure patterns in abused women, ranging from explicit to tacit, including fully telling about the abuse, dropping hints, revealing bits or pieces, minimizing and/or changing the story, or lying.

How to tell. Disclosure can occur intentionally or unintentionally. According to Sorensen and Snowman's (1991), two types of disclosure are found: accidental disclosure -revealed by chance rather than a deliberate of a discloser; and purposeful disclosure-when a discloser consciously decides to tell others. In this study, however, a majority of disclosure in a sample of 630 sexually abused children were accidental disclosure. The decision to disclosure may be based on visible or invisible conditions individuals held. When visible, even though individuals want to hide there conditions, there is automatic disclosure because the condition is revealed itself. This could be the case of physical abuse when signs or injuries of abuse become more pronounced. On the other hand, in an invisible condition as in people with HIV seropositive, disclosure may be deliberately by using selective disclosure, which disclosing is planed and aimed to control and select how, what, when, and who will be told (Black & Miles, 2002; Joarchim & Acorn, 2000).

Disclosure can be directly and indirectly. Limandri (1989) described the disclosure pattern among people with stigmatizing conditions, including woman abuse, in Oregon. The most common form of disclosure in this study was the open or complete disclosure described as fully telling all information. That is, people reveal their information directly to others. Under this circumstance, however, disclosing can be an explosive or compulsive telling. Another form of disclosure was the invitation

disclosure, where the discloser provided sufficient cues that “something is wrong” to invite the respondent to notice (p. 74). One study focused on disclosure of wife abuse experience to healthcare provider revealed that some women only disclosed the abuse experience if being asked by a provider. On the other hand, some women voluntarily disclosed even without being asked (Gerbert et al., 1999).

Why or why not to tell. Empirical data suggest that there are many factors that influence women’s decisions to disclose their abuse experiences. Reasons women are discouraged from disclosing and/or encouraged to disclose abuse to others may vary from situation to situation and from person to person, so that women may disclose to all, some, or none, depending on factors involved in their decision-making process (Moneyham et al., 1996). These factors are discussed below.

Individual women’s factors. Previous studies have attempted to describe factors that influence the abuse disclosure from the perspective of women (McCauley, Yurk, Jenckes, & Ford, 1998; Rodriguez, Quiroga, & Bauer, 1996; Yam, 2000). Women’s feeling about wife abuse is one of the most common reasons influencing their disclosure. In a focus group study on the abused women’s perspective of physicians and the health care system in California, for example, abused women talked about the silence surrounding abuse (Rodriguez et al., 1996). The silence was described as “the unspoken agreement” (p. 155) between the abused women and other members of society to not disclose or address the abuse. Women reported fearing physical retaliation by the abuser, feeling deeply ashamed and embarrassed, feeling guilty for staying in an abusive relationship, and having an obligation to keep their families together as factors that inhibit disclosing abuse. Other studies conducted in the US also indicated women’s feelings and attitudes which impacted their willingness to disclose,

including feeling of shame, denial of abuse or seriousness of abuse, belief that abuse was not a medical problem, and fear (Rodriguez et al., 1996; Rodriguez et al., 2001; Yam, 2000). Their fear included concern about how others would respond to their disclosure (Gerbert et al., 1999), consequences to the children, and the reaction of the abuser (Yam, 2000). The women also identified their own lack of readiness to change the relationship with the abuser as a barrier. They described that public disclosing of abuse might result in being pushed into leaving the relationship before they are ready (Gerbert et al.).

Another personal factor that prevents women from disclosing their abuse is economic dependency, especially among unemployed women. For example, in a study of Vietnamese American women in the United States, the decision not to report to and seek help from the criminal justice system stems from their fear that police interventions would lead to the arrest, prosecution, and imprisonment of their husbands or partners and would negatively affect their family income (Bui, 2003).

Another factor deterring delayed disclosure or non-disclosure relates to women's recognition of abuse. Hathaway, Willis, and Zimmer (2002) conducted semi-structured interviews with 49 abused women in Boston, U.S.A. In their study, abused women reported that they did not recognize that what was happening to them was abuse and that this abuse was wrong until they got information about abuse. The lack of recognition, minimization, or denial of the abuse was especially valid when women were not hit, as could be the case of verbal abuse or emotional abuse. Petersen and colleagues' (2004) focus group study in American women confirmed the lack of recognition and denial of abuse as barriers to abuse disclosure. Women in their study further suggested that they might not disclose or seek help because they believed that

abuse was a usual (or normal) part of intimate relationships and/or the way men showed their love.

Reactions of others to disclosure. Researchers have identified the professional providers' responses to abuse disclosure as another factor that plays a role in disclosure. Qualitative studies of abused women's experiences in health care settings (Gerbert et al., 1996), in community-based mental health centers and women's shelters (McCauley et al., 1998) and in a hospital-based domestic violence program (Hathaway et al., 2002) found that women's feelings of a judgmental attitude and victim blaming from helpers or potentials helpers were issues which prevent women from disclosing their abuse and seeking and obtaining adequate health care or social services. Women were hesitant to disclose when the provider was perceived as uncaring, disinterested and not actively listening (Bacchus, 2003; Lutenbacher, Cohen, & Mitzel, 2003), or appeared to be rushed or too busy (Hathaway et al., ; Rodriguez et al., 2001). Women also reported that although their talking of abuse was listened to, the service providers such as health professionals, police, or judges refused to believe their stories, or refused to do anything about them (Lutenbacher et al.). Confidentiality was of concern, fearing that the provider might share the information with other family members or might report the abuse to police (McCauley et al.). Abused women reported that provider behaviors can encourage or support disclosure, including being perceived as caring and interested in helping, sympathetic, easy to talk to, and attention to confidentiality. Provider's gender also was of concern for some women. They believed that it would be easier for them to disclose their abuse to female providers rather than male providers whom women did not trust (McCauley et al.; Bacchus).

Severity and frequency of abuse. Severity and frequency of abuse is another factor that influences women to disclose their experience. When outward signs of abuse become obvious, women cannot deny and hide the abuse from others (Hathaway et al., 2002). In a qualitative study of 16 abused women's experience of help-seeking in the UK, Peckover (2003) found that all women reported a reluctance to talk to health visitors about abuse. Some women delayed seeking help to keep their abuse secret until their abuse became extremely serious. The finding is consistence with Hathaway and colleagues' study, which reported that women might not talk about their abuse to others until they experienced escalating or severe abuse.

Socio-cultural and gender influence. The literature on disclosure identifies several individual factors that influence a women's decision to tell someone about their experiences. In fact, wife abuse disclosure is influenced not only by personal factors, but also by socio-cultural and gender factors. Strong socio-cultural beliefs developed under the patriarchal society which forms rigid gender socialization and hierarchy put women in a subordinate position to men (Dobash& Dobash, 1979 cited in Chatzifotiou and Dobash, 2001). Many women feel pressured to fulfill their traditional gender role. Women's belief in the importance of being a good wife and mother, and their sense of family responsibility such as protecting the children or keeping the family together, influenced their willingness to reveal the abuse and seek assistance from outside sources including healthcare services (Chatzifotiou & Dobash, 2001; Rodriguez et al., 1996).

Recently, in a Black feminist grounded theory study on disclosure patterns of 12 Black sexual abused women in the United States, Washington (2001) examined how survivors' awareness of their social location as Black women influences

their willingness to disclose their sexual victimization to others. Analysis of data revealed that only 5 of the 12 survivors participating in this study disclosed their victimization immediately after experiencing sexual abuse. All 5 were very selective about whom to tell because of a fear of being revictimized; thus they chose to disclose only to family members or close friends. The remaining 7 survivors either never told anyone or delayed to disclose for long periods of time after being victimized. The various disclosure patterns of the black women in this study have been associated with a number of socio-cultural factors. For example, receiving inadequate or incomplete information about sex from the family resulted in not recognizing sexual abuse among survivors. The belief that Black women are responsible for coping with problems on their own also influenced the decision to disclose their experiences. More importantly, Black women believed that there was the combination of sexist and racist attitudes and practices found within social institutions such as the criminal justice system. In this study, although the researcher used a small sample size for grounded theory analysis, particularly considering that each woman had a different disclosure pattern, her study contributes to the knowledge base regarding the factors influencing women's decision to disclose their victimization. More importantly, this study of abuse disclosure considers the socio-cultural contexts and moves beyond the individual factors to the broader interplay between individuals and their social context that is important for studying woman abuse.

In conclusion, a review of disclosure in abused women reveals the complex nature of disclosure. There are multiple factors influencing wife abuse disclosure, including individual, interpersonal, and socio-cultural influences. Therefore,

understanding the ways in which abused women come to disclose their abusive situations requires the need to recognize the overlapping influences of multiple factors.

Disclosure of Wife Abuse in Thailand

While wife abuse in Thailand is as prevalent as it is in Western countries, the existing theoretical explanations are inadequate. The research that has been conducted in Thailand is predominantly demographic and descriptive in nature. More specifically, no study has focused directly on abuse disclosure in Thailand. Therefore, there is only partial understanding of the disclosure process in the research literature in Thailand. This lack of empirical evidence regarding abuse disclosure is largely due to the fact that talking about wife abuse in public is embarrassing in Thailand.

Sripichyakan (1999) conducted a qualitative study using an integration of feminist perspective and grounded theory methodology to understand coping with wife abuse among women in northern Thailand. Thirty-four abused women who remained in or left their abusive relationship were interviewed. The women were asked open-ended questions about their formal help seeking experiences, either health care services or social services. The findings indicated that none of the women had contacted social workers because they did not believe that they would be offered any assistance. While some women knew that the women's organizations could provide help, they did not know how to contact them. Some women did not go to the hospital even though they had been severely physically abused. For women who went to the hospital because of injuries, some did not disclose the actual causes of their injury. Among the few women who disclosed the abuse to health care providers, none of them received any helpful information. In the same study, the women described the experience of being unjustly

treated by others, including revictimization and inadequate help. This pioneer research provided a basic understanding of the abuse experience from women's perspectives in the Thai broader social context including factors that may influence their decision not to reveal their abuse. However, the findings of this study focused only on the disclosure of wife abuse to professionals. Moreover, there is a limited understanding of how women disclose their abuse experiences.

Another study that revealed the issue of abuse disclosure is Chaisetsampun's (2000) study. In a qualitative study that focused on women's experience of abuse and the need for help with 10 abused women visiting emergency units in Chiang Mai province, Northern Thailand, the researcher found that most of the participants used various strategies to deal with abuse. Initially, women tried to manage the abuse by themselves. If this failed, they then turned to seek help from others, including family members, neighbors, respected persons (e.g. abuser's boss, community leader), and the police. Some women decided to disclose their abuse because of the need for assistance, while some women disclosed because of fear of escalation of abuse or getting severe injuries. The most common reason for contacting the police was the intent to press charges for physical assault and to have some record of the abuse for getting a divorce. However, when women turned to family members or helping professionals, they heard relatively more often that they should compromise the situation for keeping the family intact. Subsequently, when the abuse was recurrent, women chose turning to solve the problem by themselves again. This study was conducted for the purpose of gaining information to understand coping with wife abuse of Thai women in northern Thailand; therefore, although there is a wife abuse disclosure theme elucidated from the data, the

understanding of how women disclose their abuse experiences remains unclear in this study.

Another study that also documents the disclosure of abuse as a means to deal with wife abuse is Voraseetakarnkul's (2001) qualitative study of health impacts and coping among abused women. Eight women who had been abused in Chiang Mai province, Northern Thailand, were interviewed. All of the women experienced psycho-emotional and physical abuse. They reported the negative impacts of abuse on physical, psychological, and spiritual health, as well as the family relationship. Similar to Chaisetsampun's (2000) study, the findings in this study indicated that all women initially attempted to deal with the problem by themselves and tried to keep the abuse within the family. The reasons for concealing the abuse were the women's attitude that wife abuse was a private matter, feelings of shame, fear that nobody would believe their story or could help them, distrust in helping professionals, and lack of information about resources. However, the women eventually disclosed the abuse when they realized that they could not deal with the problem by themselves. The women first disclosed their abuse to their family network to obtain assistance and emotional support. They were more likely to contact the police when they needed protection from abuse. All women sought help from health care providers only for medical treatment. The limitation of this study is that most of the participants (6 out of 8 women) are low socioeconomic status. These women might face different factors, such as economic dependence on abusers or limited access to resources that may influence their decision to disclose the abuse. Therefore, further study may be needed to validate the findings of this study.

Recently, as part of the World Health Organization's multi-country study on women's health and domestic violence, Archavanitkul and colleagues (2003) surveyed 2078 women aged 14 to 49 residing in Bangkok and one province in central Thailand. Of the 586 women reporting a history of wife abuse, forty- one percent of those survivors had never disclosed abuse prior to the survey interview, while forty- three percent had never sought help. Most women disclosed abuse to friends and family network for assistance and this often included the family of the abuser. Data from individual interviews revealed that women were more likely to endure and conceal the abuse because wife abuse was perceived as a private and embarrassing issue in the family. If women were not able to bear the abuse on their own any longer, then they were relatively more likely to disclose the abuse to their friends or persons who had similar experiences in order to receive emotional support. Some women confided in persons in the formal helping professions such as the police or health care providers, whereas some spoke with the Buddhist monks. The most common reasons for seeking help were the inability to bear the abuse and getting severe injury. The perception that abuse was a normal part of marriage was the most common reason for women not seeking help. The strength of this study is the large sample size and the use of both quantitative and qualitative methods to gather data. The qualitative interview data show the influence of cultural beliefs on wife abuse disclosure. However, the study provides only the reasons that encourage or discourage women in disclosing abuse. In fact, abuse disclosure is a complex phenomenon influencing by socio-cultural factors. Thus, the study did not provide an understanding of how women disclose their abusive experiences and how socio-cultural factors influence abuse disclosure.

In addition, as part of the descriptive study on domestic violence against Thai pregnant women, Sricamsuk (2006) surveyed 421 pregnant women from two tertiary hospital antenatal clinics in Khon Kaen province Thailand. Of 251 pregnant women who experienced at least one type of intimate partner violence (IPV), twenty-eight percent (n=71) of those survivor did not disclose the violence to others. The most common barrier to violence disclosing and help seeking was the perception of IPV as a private issue or a family issue. Other barriers reported by abused women included the perception of the problem as not serious enough, feelings of shame, feeling that no-one could help, and lack of support person.

In summary, in the reviewed literature relevant to the disclosure of wife abuse in Thailand, both qualitative and quantitative, researchers have identified patterns of abuse disclosure and some of the common individual factors influencing the willingness to disclose the abuse among Thai women. The results of these studies provide partial understanding of disclosure of Thai abused women in aspects of why, when, and with whom women will disclose wife abuse. At the same time, little information is available about the impact of such disclosure on women and whether disclosure of abuse experiences is beneficial, benign or detrimental to a women's well-being. Furthermore, little attention has been given to uncovering the socio-cultural context that influences abuse disclosure. There is, therefore, a need for research to explore more fully the phenomenon of disclosure in the context of wife abuse in Thailand.

Summary

Wife abuse is a social and health problem around the world. It has a large impact on women's health and well being, both in the short and in the long term, regardless of forms of abuse. Many survivors continue to suffer in silence from wife abuse every day. Because of the socio-cultural factors surrounding wife abuse, abused women often do not disclose or delay talking about abuse for extended periods of time. However, disclosure is, most often, the opportunity for nurses and other professionals to help women with abuse experiences. Therefore, understanding the disclosure process may facilitate a more positive outcome for abused women. There have been no studies and explanations about wife abuse disclosure in Thailand; the existing literature related to this phenomenon is based on Western cultures that might not be applicable to Thai culture.

Under the traditional strong socio-cultural beliefs related to wife abuse in Thai society, disclosing abuse is critical and complicated for Thai women. Within a patriarchal society, Thai women are subordinate to their male partners who are considered leaders of the family. Moreover, through socialization, Thai women place value on family harmony and feel compelled to fulfill their roles as 'good' wives and mothers. To understand the disclosure process, this study will begin to examine the process of abuse disclosure and how the broader socio-cultural context influences women's decisions to disclose.