CHAPTER 5

CONCLUSIONS AND RECOMMENDATIONS

This chapter is presented in three parts. The first part contains the conclusions of the study. The second part provides implications which focus on the nursing profession and recommendations for further research. The final part conveys the strengths and limitations of the study.

Part 1: Conclusions of this Study

The purpose of this study was to understand the experiences of Northeastern Thai women in disclosing wife abuse. The participants of this study were 16 women who were physically, psycho-emotionally, or sexually abused by their husbands or ex-husbands, and disclosed their abusive experience to members of informal networks (friends, family members, neighbors, co-workers) and/or formal service providers (health care providers, social workers, policemen). Age of the participants ranged from 28 to 56 years old (mean=40.5, SD=6.7). The majority were Thais and Buddhists. Five participants completed primary school and six completed high school education. Most of the participants were employed with sufficient income for their living expenses. Ten participants had already left their husbands and the other six remained living with husbands. Eleven participants had 2 or more children. All participants in this study experienced psycho-emotional abuse. Physical abuse and sexual abuse were reported by 12 and 3 participants, respectively. Two-thirds of the participants experienced

physical abuse concurrently with psycho-emotional abuse, whereas the other two participants experienced all types of abuse.

This qualitative study employed the integration of a feminist perspective and grounded theory methodology. In-depth interviews with reflexive discussions and a balanced power relationship and theoretical sampling were conducted to obtain authentic understanding of the women's experience. Ten women were interviewed twice and another four women were interviewed once. Only two women were interviewed three times. There were a total of 30 interview sessions; each interview ranged in length from one to two hours with an average time of 84 minutes. The total time spent in interviewing was 42 hours. The length of each participant interview ranged from 60 to 270 minutes (1-3 times) with an average duration of 157 minutes. Coding, constant comparison, theoretical sensitivity, and theoretical memoing were used as data analysis procedures. Data were inspected through a feminist lens. Trustworthiness of the study was established mainly through member checking and peer debriefing.

Grounded in the interview data, the basic social process that conceptually explained how the women disclosed or concealed their abuse experience to others was entitled as "Moving to Disclosure for Survival". There were two causal conditions or goals determining whether the women disclosed the abuse or not. Firstly, desiring to survive revictimization directed the women to engage in concealing to protect their sense of self and physical safety, to preserve their husbands' image, or to prevent a family burden. Secondly, desiring to survive critical circumstances encouraged the women to reveal their stories to deal with critical events resulting from the abuse. To survive critical circumstances, disclosing was implemented to release tension, to seek

support, to get through the unbearable point, or to be free from abuse. The moving to disclosure was also influenced by three conditioning factors: (a) wife abuse myths, (b) confidant's attributes and responses, and (c) characteristics of abuse. These conditioning factors potentially interacted with one another and collectively influenced the women's decisions about disclosure.

The strategies employed in concealing and disclosing apparently started with concealing and moved to disclosing. While the strategies are presented in a linear fashion, the process of moving to disclosure for survival is not linear. That is, the women may not progress sequentially from concealing to disclosing. Each strategy could be employed, and varied across situations and time depending on which aspects of survival were the priority and the influence of three conditioning factors. In this study, there was a range of detail given in disclosures, from concealing to disclosing. Concealing included covering, isolating, silencing, and revising. Disclosing included yielding, hinting, telling, and sharing the story with other abused women. Suffering with a secret was identified as the consequence of concealment including the feelings of repression and fear that interfered with their physical well-being. Following disclosure, some women experienced negative feelings, including shame, guilt, as well as being blamed and revictimized, or gossiped about. Positively, some women felt relieved, improved self-worth, and obtained support. The consequences of abuse disclosure determined whether the women disclosed the abuse in the future.

Part 2: Recommendations

These findings suggest some recommendations for nursing professionals and further research as follows.

Implications for Nursing Professionals

The major contribution of this study to nursing professionals is that it offers nurses a new understanding and insight into the phenomena of abuse disclosure among Northeastern Thai women. The findings from this study have important implications for nursing practice in order to assist women who have been abused and help make social changes in Thailand.

Nurses' understanding and attitude about disclosure

The findings in this study reflected the influence of women's personal beliefs on wife abuse myths and the abuse disclosure. Adherence to the beliefs of wife abuse as a private or family matter also shapes the way nurses respond to abuse disclosure. Therefore, nurses who work with abused women should self-assess their personal beliefs about wife abuse. Nurses should be encouraged to view wife abuse as a significant health problem rather than a private matter. To inform their views, special training or education programs about the nature of wife abuse, the influence of gender-role beliefs on wife abuse disclosure and nursing practice is needed. Furthermore, nurses should assess women's beliefs and attitudes about wife abuse that discourage women from disclosing the abuse. This would substantially help nurses gain a better understanding and develop positive attitudes in which the women should not be seen as passive victims. Instead, they are active and capable in dealing with the abuse and social responses to this issue.

Nurses' strategies in encouraging abuse disclosure

In addition to wife abuse myths, confidants' attributes and responses were also identified in this study as influences on abuse disclosure. In screening and detecting

wife abuse, nurses should approach women with attentive listening and compassion. Confidentiality should be ensured because this is a great concern for women when they decide whether to disclose the abuse. Discussion with a woman should be done in a private room without anybody else present, not even her child. Many women believe that disclosing is useless. Therefore, initial assistance and information about service availability should be initially provided. Moreover, nurses should demonstrate an understanding and non-judgmental stance, and not blame an abused woman, even one who conceals the abuse. Concealing behaviors that the abused women engaged in should be recognized as strategies of survival in the Thai social context where issues of blame and responsibility of the abuse are placed on women after disclosure. An understanding and supportive environment will encourage women to disclose the abuse and to seek help. The findings of this study revealed that sexual abuse is the most difficult issue to discuss in public. Therefore, during health care encounters nurses should be aware of and sensitive to types of abuse experienced by women.

Nurses' responses following abuse disclosure

To encourage disclosure and prevent a sense of being revictimized, when a woman starts disclosing, nurses should not blame either the women or their abusive husbands. Such questions as "Why did your husband beat up you?", "Why did you allow your husband to abuse you for so long?", or "Why don't you leave your husband?" should be avoided. Nurses should let the woman know that the abuse is not her fault, and should emphasize that her safety and decision-making are important. Confidentiality should be reassured by telling her that her story will be kept confidential. Nurses should acknowledge women's courage in disclosing the abuse, and assistance should be promptly offered and provided. Options and information about

resources and services available both in a hospital and community should then be provided. Doing so will help women understand that nurses are willing to listen, understand, and help them get through the circumstances.

Nurses' sensitivity to various disclosure strategies

Nurses should be sensitive to various disclosure strategies that a woman might employ and should acknowledge individual differences in abuse disclosure. Nurses should understand that disclosing the abuse is not a one-time occurrence. Rather, it is dynamic according to the nature of the violence cycle and women's current situations. If a woman denies the presence of wife abuse, nurses should respect her voice rather than compel, blame, or show any suspicion in her answer. Nurses should provide descriptions that she is always welcomed talk and have help any time she wants to. When concealing is the women's option, nurses should be concern with and assess potential physical and psychological problems resulting from keeping the abuse secret. Nurses should provide other disclosing strategies for releasing emotional burdens without jeopardizing confidentiality, for example, encouraging women to disclose to other trusted persons, to engage in self-talk, or to write a diary or poem.

Disclosing is sometimes not fully done in detail. The methods used in telling may be indirect, and it may be difficult to identify the occurrence of the abuse. Nurses need to thoroughly listen to what a woman has said and to observe her appearance. Assessing consistency of women's stories and outward signs of abuse will help nurses be aware of abuse occurrence. If nurses recognize signs, or for any reason suspect the woman is in an abusive relationship, nurses should not ignore or overlook these observations or suspicions. Rather, nurses should continue to assess the woman's safety while offering ongoing validation, support, and referrals.

The findings in the present study reveal the benefits of sharing the abuse experience with individuals who had similar experience. Self-help groups or support groups among abused women should be established. Attending these groups can offer women opportunities to give voice to their experiences and release emotional tension in a supportive environment. Such groups also provide various options shared among women about coping with a similar situation. Tangible support and help are often mutually exchanged. These activities can help women enhance self-esteem as well as strengthen their social networks and support.

Public education

The findings in this study reveal that the women were more likely to disclose the abuse to informal support groups such as friends or family members. To avoid "revictimizing" women, public education to informal networks by community nurses should be implemented to increase public understanding and awareness about this issue. Public education should focus on de-stigmatizing abused women by re-defining wife abuse as a health problem that needs medical treatment and lay people's assistance. Through public education, traditional beliefs and attitudes about wife abuse as a private matter could be eliminated from Thai society. Moreover, the attitude that outsiders should not get involved in abuse problems needs to be changed. This study confirmed that members of informal networks were important helpers whom women were likely to disclose to. These informal helpers should be informed and encouraged to interact with abused women in a supportive and caring manner similar to the aforementioned nurses' manner. Changing views of wife abuse would encourage abused women to disclose their experience without revictimization.

Implications for Further Research

In the present study, the women's experience of disclosing abuse to professionals was quite limited. To expand knowledge about abuse disclosure, further research should be conducted with abused women who disclose and seek medical services. Reasons for disclosure, strategies used in concealing and disclosing, and consequences of disclosure within the context of health care settings needs further explanation. In addition, further research should be extended to be conducted with other groups of violence against women (e.g., rape, dating violence). This will help in strengthening a substantive theory of abuse disclosure among Thai women.

According to the findings of this study, women's decision to disclose the abuse and their felt consequences of disclosure were influenced by their expectations of how others would, and did, respond to their disclosure. The women's accounts reflected the presence of traditional gender-role bias that shaped the responses of the confidants. Therefore, further research should explore how gender-role expectations influence the confidants' attitudes of wife abuse and their responses toward abuse disclosure.

As the findings of this study confirmed that disclosure of abuse is the first opportunity for women to obtain primary help and survive critical circumstances, all women who access health services should be routinely screened about violence. Further research on women's experiences and opinions of being asked about violence and abuse will contribute to the body of knowledge addressing the issue of routine inquiry. As well, this issue should be explored from health care providers' perspectives. The knowledge obtained from such study will help to inform practice guidelines for health care professionals.

Part 3: Strengths and Limitations of the Study

One of the strengths of this study was the use of methodology which generated rich detailed data about abused women's disclosure experiences. Moreover, the use of a feminist grounded theory methodology provided knowledge and a rich understanding of the abuse disclosure process which is a very complicated process influenced by personal and socio-cultural contexts. This methodology has not been used in previous research regarding women's abuse disclosure in the Thai context. The results address some gaps in the research.

Another strength of this study was that this study provided the opportunity for abused women to give voice to their traumatic experiences. Some participants felt strongly that more information about disclosure was needed, and they were motivated to contribute to the limited knowledge base by participating in the study. Participants in this research, moreover, experienced their involvement as a meaningful opportunity for sharing their story and making a contribution.

There are limitations of the study which are associated with participant recruitment. There was no participant recruited from a one stop crisis center (OSCC) because abused women usually came to an emergency unit with physical injury and emotional crisis, and were unwilling to participate in this study. The participants' experiences regarding formal service encounters (health care services, social agencies) were quite limited. More variation and saturation of the categories such as the confidants' attributes and consequences of abuse disclosure might be added into the theory if women who encountered health care services are included.