

Women's experiences of domestic abuse in rural and remote Australia

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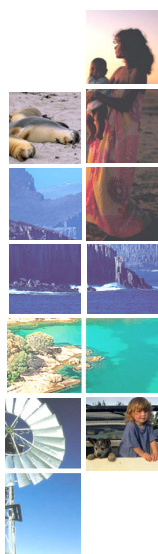
INTRODUCTION

In The Women's Safety Australia Survey (Australian Bureau of Statistics, 1996), and across all three age cohorts (young aged 18–23; mid aged 45–50; older aged 70–75) in the first surveys of WHA (1997) the lifetime prevalence of domestic violence was higher for women from rural and remote regions, than for women living in urban areas. The Partnerships Against Domestic Violence (PADV) initiative identified women from rural and remote regions as constituting a group that required special attention, due to the unique circumstances that surround non-urban living (PADV, 1999).

Social and physical isolation have been identified as being a major problem for women who experience abuse while living in non-urban areas, due to geographical location, transport difficulties, and unreliable or unavailable telephone services (Bagshaw, Chung, Couch, Lilburn, & Wadham, 2000). Limited financial resources due to the complex nature of running a property, and the prevalence of firearms in the country have also been identified as problems that are specific to rural and remote experiences of living with domestic abuse (Alston, 1997).

Isolation, the limited availability of legal services, such as police, legal aid, and advocacy support, and specialist domestic violence services, such as long-term counselling and refuge accommodation, mean that reaching out for help is problematic (The Women's Services Network [Wesnet], 2000). Furthermore, when services are available they are often not used because of a variety of reasons, such as the stigma attached to having relationship problems, and concerns over confidentiality including: social relationships with the people providing the service (eg. their partner being friends with the local police officer), a lack of awareness of the available services, and a perception that domestic abuse must involve physical violence (Alston, 1997; Bagshaw et al., 2000).

Women from rural and remote areas have been found to be reluctant to change their domestic situation because they feared damaging their place in the local community. Current evidence suggests that these fears may be justified. In interviews with women who had lived in an abusive relationship in rural areas, researchers found that trying to talk to friends and family often resulted in ostracism, or with people siding with one partner or the other (Bagshaw et al., 2000). In another study that interviewed women aged over 45, women who talked about the abuse with doctors, family, friends, or clergy were most commonly met by disbelief, embarrassment, or entreaties to "try harder" (Morgan, Disney & Assoc., Leigh Cupitt & Assoc., & Council on the Ageing, 2000).



Women from rural and remote regions who consider leaving an abusive relationship face further obstacles. The social and geographical isolation, and difficulties with obtaining help, outlined above, contribute to women tending to face leaving an abusive relationship without support. Women in rural areas were more likely to be financially dependent on their partners, and leaving a family property is fraught with legal and financial complexities (Bagshaw et al., 2000; Wesnet, 2000). Furthermore, women were found to believe that they would feel safe only if they moved away from their local communities (Bagshaw et al., 2000; Morgan Disney et al., 2000). This entails leaving what social support networks they do have (Morgan Disney et al., 2000). Lack of transport and fears about future employment prospects were issues for some women (Bagshaw et al., 2000; Morgan Disney et al., 2000). In assessing what actually happened for older women (aged over 45) when they left abusive relationships Morgan Disney et al. found that women from all areas experienced a lower standard of living (as indicated by income and housing) and difficulty in gaining employment after leaving. Furthermore, rural women did have to leave the areas in which they had been living when the abuse occurred, often leaving family assets to do so.

The above research indicates that the fears women from rural and remote regions hold about seeking help, disclosing domestic abuse, and about leaving abusive relationships may be well founded. The following investigation considers the experiences of women who lived in rural and remote regions while living in an abusive relationship, their experiences of help seeking, their fears around confidentiality, and their experiences of leaving an abusive relationship.

METHOD

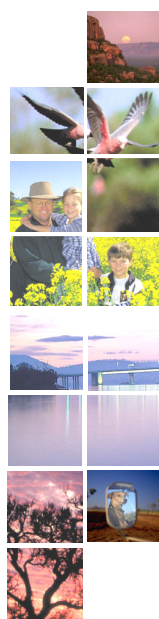
The qualitative interview study was conducted with the primary aim of elaborating on the impact of domestic abuse on health, and the psychosocial factors that had acted to improve or further damage health. For the purposes of this paper, issues that were raised by women that related to their place of residence were examined, and major themes that pertained to living in rural and remote regions were identified.

Informants

A pool of 120 potential informants was drawn from the WHA mid-aged sample. Potential informants had indicated on previous WHA surveys that they had left a violent relationship, and that they were willing to participate in a telephone interview. Informants were then randomly selected from the pool and invited to participate. Of the 38 women contacted, 26 completed interviews that were transcribed, and 17 of these women had lived in a rural or remote region for at least a proportion of the time that they were living in an abusive relationship. Of these women, one had lived in a same-sex relationship. Ages ranged from 50 to 55 years at the time the interviews took place (August to November, 2001).

Interview

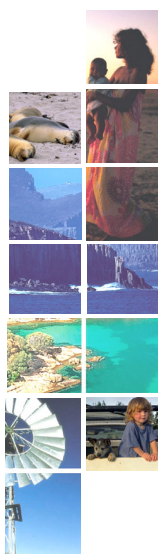
The interviews were semi-structured and aimed at eliciting the stories of women who had experienced domestic abuse. Five broad questions were asked that concerned the relationship, the context of the relationship, leaving the relationship, the impact of abuse, and the informant's health over her lifetime. In keeping with the recursive



method of interviewing, areas of interest were followed up with prompts (eg. Can you tell me more about...?). Any questions that were considered relevant to the research that had not been covered during the interview were specifically asked at the end (eg. How old were you when you entered the relationship?). Interviews took from between 35 minutes and 3 hours, with an average time of 67 minutes. The time taken for each interview was guided by the informant.

Analysis

Interviews were audiotaped and transcribed verbatim, with identifying characteristics removed. The interviews were analysed by coding passages that addressed the research questions. These included: onset of abuse, abusive events, coping strategies, circumstances surrounding leaving the abusive relationship, the informant's experience of stress, social support, income, and area of residence. Each interview was then summarised into a case report format.



RESULTS AND DISCUSSION

Informant characteristics

Of the 17 women who had lived in rural and remote areas while in abusive relationships, 13 had been married and 2 had lived in defacto relationships with the abuser, while 2 had lived in a defacto relationship prior to marrying the abuser. Women began to live with the abusive partner at an average age of 20, with ages ranging from 14 to 39 at the start of cohabitation. Average age at leaving the relationship was 32. The length of the abusive relationships ranged from 2 to 37 years, with an average length of 11 years. The majority of women began living with the abusive partner in the late 1960s and early 1970s, however, the range was large (1966–1988). Dates for the end of the abusive relationship ranged from 1969 to 1997.

Types of abuse experienced

The types of abuse experienced included verbal abuse (being called names, put-downs, being shouted at), physical abuse (being hit, shoved, threatened with a weapon, stabbed, shot at, denied medical care), sexual abuse (experiencing forced, coerced, or unwanted sexual acts), financial abuse (being denied access to money), isolative abuse (being denied access to transport, telephones, other people), and emotional abuse (humiliation, criticism, constant questioning).

The higher prevalence of domestic abuse in rural and remote areas

Explanations for the higher prevalence of domestic abuse in rural and remote areas have included the increased stress of rural living in a harsh economic climate (Johnson & Elliot, 1997). However, one informant in this study pointed out that moving to an isolated area may have suited her partner's wishes by disrupting her social support networks.

We moved, yeah we moved around to so many different places out of the way places and it was like he was trying to keep me out of the way of every body...[I3]



Isolation

Isolative abuse was experienced by women from both urban and rural and remote locations. However, women living in remote locations were easier to isolate than women living in urban areas, because they were already geographically isolated.

Transport

For many women living in remote locations, public transport is not an available option. As one woman who had lived on a property commented:

I come home one err Sunday and he'd sold my car. And I said thanks very much cause that means I was stuck at home then and couldn't go when I wanted to only when he let me have the car. [I2]

Women in rural towns were similarly restricted in their ability to be mobile, but more restrictions were necessary in order to keep the women "housebound".

Yeah umm, I was I was sort of isolated, umm, my husband wouldn't umm mix with other people... By umm not allowing me to get a driver's licence, and then finally when I did get one he wouldn't let me have the car. Umm. There wasn't any money, he wouldn't give me any money. Things like that so I really couldn't go out anywhere, catch a bus or anything like that...[I1]

Farm and family business responsibilities

The responsibilities of working on a family property, and in some cases working in the family business as well, in addition to the normal responsibilities of running a household and raising children kept many women "on the farm" and away from social gatherings and family get togethers. One woman who was asked about her ability to visit friends replied:

...I mean I couldn't I had I had to be there for the phone and you know that sort of thing because it was it was a business, so and I was part of it so I had to do my share, of course, do yeh... I really yearned to go down and see the kids and I didn't see them as much as I should have when they were at (boarding) school. [I18]

Telephone access

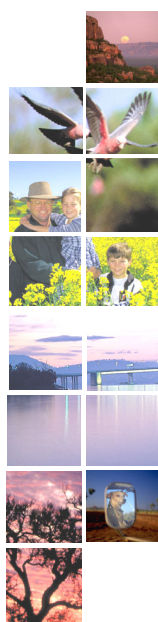
Many women were denied access to a telephone, or were not permitted to have a telephone connected. This resulted in increased isolation. As one woman recalled after years of not having a telephone, when her husband connected the telephone there was "...no body to phone" [I3].

Financial resources

As was expected from past research, women who lived in rural and remote areas often experienced limited access to money, which contributed to a loss of independence, a limited ability to seek help, increased isolation, and difficulty in leaving the relationship.

Access to firearms

While 35% (n = 6) of women from rural and remote areas reported that they had been threatened with a gun, shot at, or had their partner threaten suicide with a gun, only one woman from an urban area indicated that her partner had a gun. This is in



keeping with Alston (1997) who found that firearms were more readily available in rural areas.

Help seeking

The ability to seek help was restricted by the lack of transport, farm and business responsibilities, telephone, and financial restrictions that were experienced. In addition, at the time most of the interviewed women were experiencing domestic abuse, refuges were yet to become common in urban, let alone rural areas, and counselling services were limited or unavailable.

Of the five women who left abusive relationships in the 1990s, one felt unable to discuss the abuse with anybody, one found talking with her family doctor to be helpful, and three sought professional counselling. Two felt that counselling had not been useful, one commenting that the five and a half hour drive was too difficult, and the other saying, "...she said I was easy...and that made me feel weak." [I20] One woman had a very positive experience with a counsellor, and her story is discussed below. Even though counselling was not successful for the majority of these women, fears that confidentiality would be breached were not substantiated. None of the four women reported that talking about the abuse with a professional resulted in their situation becoming known in their communities.

Women were more likely to disclose abuse when they had a good rapport with their doctors. However, high staff turnover made it difficult for some women to form a trusting relationship with their doctors, and the lack of time available for consultations in rural practices was also noted. Informants also mentioned that in rural towns limited services meant that **choosing** a doctor was not always possible.

Generally women were reluctant to call the police due to fears about town gossip, and of being disbelieved.

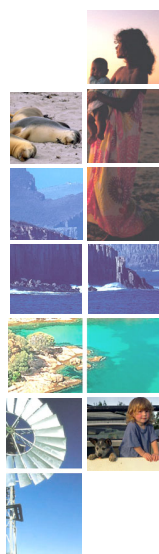
And you didn't bring the police into it because that would be seen to be err the scourge of the neighbourhood, everybody would talk about you if you had the police out. [I28]

In some cases this reluctance was exacerbated because their partners knew the police socially, and in one case the woman's partner **was** the local police officer.

Overall, the results of this study echoed those of previous research. Most women mentioned that the distance they needed to travel in order to attain services was problematic, and many had been unaware that domestic abuse services were available. Factors which influenced women to disclose abuse included assurances of confidentiality, that the person they were disclosing to was unknown to their partners and/or unknown in their community, trust that they would be believed, and desperation (i.e. They were in a situation that had become intolerable or life threatening and felt they had to tell someone). Factors that influenced women not to disclose abuse included previous adverse responses, a belief that they would be judged as being in the wrong, shame, not knowing who to talk to, and a fear that they would not be believed.

Responses of health workers

Many of the women who sought help did so by talking with their family doctors. Many women waited years before attempting to discuss the abuse with a professional



of any sort, and the responses of workers to this initial disclosure had profound effects.

The story of the woman who had a positive experience with her counsellor, makes several salient points. After 25 years of living in an abusive relationship she found herself feeling constantly ill and suicidal. She approached her doctor with these problems, and he asked her if she had problems at home, and although she did not disclose the abuse, she did feel comfortable enough to say that she was having “problems”. He recommended a counsellor, to whom the informant disclosed her experiences of abuse. With his assistance she was able to leave the relationship. When asked what it was that enabled her to disclose the abuse, the informant said that knowing the session was confidential had been important and that:

...I mean (the counsellor) was a stranger, he didn't know me, he actually came into this town about once or twice a week from another town and I think that in itself...didn't live in the town.[11]

Two women had been hospitalised in psychiatric wards after attempting to commit suicide. One of these women was given shock treatment, and reported that she learned to recognise the signs of an impending breakdown and to work through her feelings alone, not because the intervention had been useful but because the experiences had been so aversive. The other woman indicated that her stay in hospital was interrupted by her husband, who insisted she come home. This woman signed herself out of hospital, but found the experience to be validating because the doctor's told her that her mental state was her husband's fault.

A lack of awareness (keeping in mind the timeframe in which many of these relationships occurred) about domestic abuse and its consequences led to inappropriate responses to disclosures of abuse. For example:

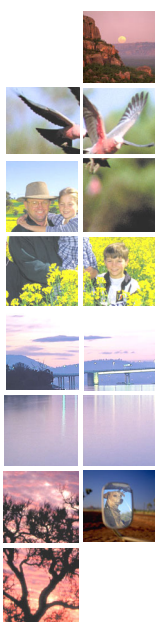
...he suggested that I have a good break away you know like we're talking quite a few years ago so you know it was probably like have a Bex and a good lie down kind of thing you know...[16]

In addition, many women mentioned that talking with their doctors about feeling nervous and having difficulties at home led to them being prescribed Valium, antidepressants and sleeping tablets. In some cases doctors spoke to their partners. For some women this was a validating experience whereby their partners were told that their behaviour was unacceptable. However, other women found that their partners were able to persuade the doctor that there was nothing going on, thus effectively cutting off an avenue for further assistance.

Negative responses from health workers generally led to the use of psychoactive medication for a long period of time, and increased feelings of depression and hopelessness. Positive responses from health workers included referrals to counsellors, supportive listening, and validation of the woman's experience. Positive responses generally led women to feel emotionally supported, and in some cases were directly responsible for further help seeking, and eventual leaving.

Responses of police

The responses women encountered when contacting the police were as varied as the responses they received from doctors. Specific problems encountered by rural and remote women included being disbelieved, being told that there was nothing that could be done, and a general unwillingness of police to become involved in “domestic



disturbances". Again, the historical context of the abuse must be taken into account, and it is hoped that responses have improved with the increasing awareness about domestic abuse. However, one informant mentioned that the police were equally unhelpful when her daughter called them because of her husband's violent behaviour in 1996. Two women found police to be particularly supportive. In both cases contact with the police occurred after a severe acts of abuse (a beating that required hospitalisation, and being shot at).

Privacy and confidentiality

An overwhelming desire to keep the extent of the abuse they were experiencing quiet was common for most women. One woman who entered into the relationship in 1988, and worked in the health area commented:

I felt very ashamed as well. And, and, I was concerned about the facial disfiguration, I mean it wasn't a great but I was concerned that (my work colleagues) believed me (that it had been an accident and not the result of abuse)...[I20]

Feeling shame that they were being abused and taking steps to cover-up the visible results of abuse were common responses made by women from all areas. Problems that were mentioned by women from rural and remote regions related mainly to fears of being labelled and ridiculed. A woman who had been shot at after leaving her husband commented:

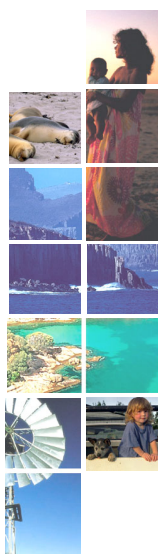
And when um, when my husband went crazy with the gun of course that got out and umm, oh look it was terrible. I suffered at work you know, it went on and on and on. I thought when is this going to end I wasn't. I thought, I felt because I was the female that I was being umm I was being told that I was the bad person you know because and uh, and uh, in a lot of ways it's true in society, I mean things are changing slowly but it's always the woman you know? The man seems to be always **right**? [I1]

Fears about being found out by seeking help were generally found to be unwarranted when health care workers were consulted. However, contacting the police, and having dealings with court were found to publicise the informant's domestic abuse.

The issue of privacy involves contradictory elements. Overall, women felt that they did not want to, or were not able to, discuss the abuse with anybody. Yet when asked what might have helped them during the relationship, most women, regardless of where they lived, responded that having someone to talk to would have been the most helpful resource.

Leaving an abusive relationship

Many women spent years planning or wanting to leave their relationships. Barriers to leaving included fear of the abuser, not wanting to leave their surroundings, a lack of financial and social support, transport difficulties, and fears over housing and future employment prospects. Gaining support, usually from family members, allowed many women to overcome these obstacles. Asking for support in order to leave was usually prompted by a particularly severe incident of physical abuse, and/or a realisation that things were never going to get better, and/or the negative impact of the abusive relationship on their children.



Only one woman in this study remained in the home she had shared with her abusive partner¹. Most women immediately left the general area that they had been living in, with only two women remaining in the same area 12 months after the separation. One of these women reported that she felt as though everyone was still talking about her, and was planning to move in the near future (10 years after the relationship ended). The other woman who remained in her home town achieved this by talking her husband into moving interstate. Once they were settled in, she and her children moved back to her hometown, leaving her husband behind.

In the short term leaving an abusive relationship was found to involve moving house, leaving the local community, finding work, replacing possessions that were left behind, financial hardship, and loss of friendships.

In the longer term, the outcomes of leaving an abusive relationship were more positive.

Most of the women were employed in the workforce. Three women were on disability pensions, one because of a recently contracted illness, one because of a stroke, and the other due to the effects of abuse she experienced as a child and as an adult. With one exception, the informants felt settled in their new housing. Some women were still experiencing financial difficulties, but most were not. All of the women felt that they had built successful social support networks, although this had taken some of them a considerable length of time (up to five years). All of the women in this study said that they did not regret leaving their abusive partner.

CONCLUSIONS

This study found that women from rural and remote areas who experience domestic abuse tend to be isolated, and face an increased risk of being threatened with a firearm. Help seeking was inhibited by isolation, lack of knowledge of local services, distance to help providers, fears about confidentiality, social relationships between the perpetrator and the help providers, poor rapport with doctors who were not known, previous adverse responses, and a fear of not being believed. Help seeking was enhanced when help providers could engender trust, which included assurances of confidentiality, a non-judgemental attitude, and being a “stranger” to the area.

No women in this study reported that their confidentiality was breached to the local community by a health worker. Where contact with the police and court system occurred, the community became aware of the abusive situation leaving women to contend with community gossip which they found distressing.

Although the short-term consequences of leaving an abusive relationship were stressful, the long-term outcomes were more positive.

¹ It should be noted that the study inclusion criteria may have excluded women who did not physically leave the home in which the abuse occurred.

RECOMMENDATION

It is the recommendation of this paper that the feasibility of providing domestic abuse counselling services by people who do not live in the towns that they service be investigated.

ACKNOWLEDGMENT

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PRESENTER

Deborah Loxton is a PhD candidate in the School of Health, The University of New England. She is currently completing her PhD thesis on domestic violence and the health of mid-aged Australian women using data from Women's Health Australia (WHA) study.

