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ORIGINAL PAPER

Factors influencing rural women's disclosure of intimate partner violence: a qualitative study

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Abstract

Many women who experience intimate partner violence (IPV) choose not to disclose their abuse to health care professionals (HCPs), yet less is known about the reasoning behind this decision. This paper presents a sub-analysis of a larger study and describes the personal meaning attributed to disclosure of IPV by women living in rural Ontario, Canada. A qualitative case study approach grounded in a feminist framework was used. Women were recruited using a snowball sampling strategy. Data collected via one-on-one semi-structured interviews and an interpretative phenomenological analysis (IPA) using a reflexive-relational approach were used to analyse the data. Seven women who met inclusion criteria and responded to interview questions regarding disclosure were included in the sub-analysis. The majority of the women were born in Canada, divorced/separated, and mothers of dependent children. Thematic analysis revealed four key themes: (1) privacy and trust concerns; (2) discomfort acknowledging IPV; (3) exerting control over information; and (4) violence as unimportant to health concerns. The rural environment poses unique barriers for women who have experienced IPV, making it challenging for women to disclose abuse. While women's decisions to disclose are personal and context dependent, efforts should be made to create a non-judgemental, comfortable environment for women to disclose at their own discretion.

Keywords Intimate partner violence · Rural · Women's health · Disclosure

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Introduction

Intimate partner violence (IPV) is a pattern of physical, sexual, and/or emotional abuse by an intimate partner within the context of coercive control (Tjaden and Thoennes 2000). Globally, IPV affects 30% of women in relationships; however, in some regions this number is as high as 38% (World Health Organization 2013). In Canada, it is estimated that one in every four women is impacted by IPV (Clark and Du Mont 2003). Abuse is overwhelmingly perpetrated by men, with estimates indicating a 4:1 ratio of male-perpetrated violence to female-perpetrated violence (Kimmel 2002). Moreover, violence that is conducted to maintain control over a partner is perpetrated by men in over 90% of cases (Kimmel 2002). In Canada, men are responsible for 83% of police-reported violence committed against women (Canadian Centre for Justice Statistics 2015). As such, it is necessary to closely examine the experiences of violence against women to develop targeted public health interventions.

IPV is a complex and pervasive problem that transcends health, social, and economic spheres, and is shaped by women's feelings and perceptions of violence (Feder et al. 2006; Spangaro et al. 2009). Women who experience IPV face physical and mental health issues that are both acute and chronic in nature, ranging from stomach ulcers, angina, and chronic pain, to depression, anxiety, and traumatic stress (Annan 2008; Bohn and Holz 1996; Coker et al. 2000; Ford-Gilboe et al. 2009; Krishnan et al. 2001; Logan et al. 2003; Wuest et al. 2008). Such health conditions can negatively impact women's quality of life by interfering with their daily functioning and participation in society (Breivik et al. 2006), which, in turn, imposes financial constraints and limits economic mobility (Breivik et al. 2006; Coker et al. 2005). While the health consequences of abuse can result in medical bills and forced time off work, the economic toll of IPV for women can also include restricted access to financial resources and unstable employment due to an abuser's control (Institute for Women's Policy Research 2017).

Ultimately, the widespread impact of IPV interferes with all aspects of women's lives and consequently health care providers (HCPs) are frequently involved in women's care (Feder et al. 2006; García-Moreno et al. 2015). The HCPs most frequently caring for women who have experienced IPV are nurses and physicians, often working in emergency departments, although other relevant HCPs include public health practitioners, community health practitioners, and midwives (Catallo et al. 2013; Feder et al. 2006; García-Moreno et al. 2015). HCPs may be able to provide resources or support if they are aware of the abuse; however, women are often reluctant to disclose (Catallo et al. 2013). In cases of disclosure, HCPs can offer empathy, compassion, coping mechanisms, ongoing psychosocial support, clinical care, and referrals to additional support services and community resources; these activities are critical to supporting women on their journey to safety (Catallo et al. 2013; García-Moreno et al. 2015).

In a sub-analysis of a large-scale study, Catallo et al. (2013) examined women's exposure to and disclosure of IPV to HCPs across three emergency departments

(MacMillan et al. 2009). In a sample of 1182 women, 174 (14.7%) women reported abuse through screening instruments, yet only 22 (1.9%) disclosed the abuse to an HCP (Catallo et al. 2013; MacMillan et al. 2009). Primary reasons that contributed to women's reluctance to disclose abuse included the level of trust between the women and HCPs, the need for privacy and confidentiality, long wait times, and intrusion from nurses and HCPs (Catallo et al. 2013). The small number of women who choose to disclose abuse to HCPs is alarming, yet understandable due to the environmental and relational challenges present for women.

The health care system itself may perpetuate the silence and secrecy surrounding abuse, as the transient and institutional nature of modern clinical settings is often not conducive to communication regarding such highly sensitive subject matter (Gerbert et al. 2008). This can be attributed to environmental considerations, including rushed consultations (Feder et al. 2006; Kramer et al. 2004), a lack of trauma- and violence-informed care practices, and a dearth of 'safe spaces'—all of which impede disclosure (Eastman and Bunch 2007). Additionally, some women fear that their HCP(s) will involve health and social service professionals in the post-disclosure period who may inadvertently disrupt their lives and jeopardize their safety and/or access to their children (Catallo et al. 2013). Furthermore, previous negative experiences with HCPs can contribute to distrust and may prevent future disclosure (Catallo et al. 2013). Such structural barriers may contribute to a general distrust in the health care system, which exacerbates the complexity of women's lives touched by IPV.

HCPs may also prevent disclosure by women who have experienced IPV (Kramer et al. 2004). Ignorance and underestimation of the prevalence and severity of IPV by HCPs can contribute to women's reluctance to openly discuss their experiences of violence (Wathen and MacMillan 2003). Kramer et al. (2004) surveyed 1268 women aged 18 and older to determine the prevalence of abuse reported by those seeking health care in urban, rural, and suburban locations, respectively. Researchers investigated the barriers and facilitators to women disclosing abuse, the health problems associated with such abuse, and women's perceptions of available support services (Kramer et al. 2004). Specifically, women reported that it was easier to disclose abuse when they were confident that the HCP would keep their records confidential; when they felt ready to address the issue of abuse; and when their HCPs were female, did not ignore the concerns of their patients, showed genuine concern about abuse, and did not rush consultations (Kramer et al. 2004). In contrast, women had difficulty disclosing when they did not feel as though HCPs were listening, and when they felt embarrassed and/or were not yet ready to address the abuse (Kramer et al. 2004).

Women typically choose to disclose abuse in order to receive assistance such as emotional support, medical care, social support, and/or services to secure their safety (Boethius and Åkerström 2020). The choice to disclose abuse is often associated with readiness to address the issue, which is deeply personal and context dependent, although emergency situations can provoke unplanned disclosure (Boethius and Åkerström 2020; Catallo et al. 2013; Wathen and MacMillan 2012). Wathen and MacMillan (2012) found that mothers may be more willing to seek support services than women without children, despite a common fear of their abusive partner. The circumstances in which women decide to disclose abuse not only differ between individuals, but also between urban and rural communities—an area of research that remains understudied (DeKeseredy 2011; Kramer et al. 2004; Wathen and MacMillan 2012).

In urban settings, many women have concealed abuse from HCPs due to shame and fear of retaliation from their partners (Gerbert et al. 2008). Additionally, some urban women have described their experiences with the health care system as negative, feeling as though their HCPs were disinterested in their needs, and unsympathetic (Gerbert et al. 2008). These perceptions create additional barriers that prevent women from disclosing IPV to their HCPs (Gerbert et al. 2008). To ameliorate these challenges, urban women have voiced a desire for HCPs to be non-judgemental, compassionate, and to demonstrate a genuine understanding of the complexity of IPV and its associated health implications (Feder et al. 2006). Furthermore, many urban women have indicated a preference for HCPs who validate their concerns by reinforcing the unacceptable and undeserved nature of violence, rather than those whose ignorance and/or implicit biases result in further stigmatization (Feder et al. 2006). Finally, women desired HCPs who respected their personal decisions regarding disclosure and did not pressure their patients to discuss experiences of violence (Feder et al. 2006).

The issues concerning lack of disclosure of IPV are further problematized for women in rural contexts; women who have experienced IPV in rural settings are far less likely to disclose abuse than their urban counterparts (Van Dis et al. 2002; Websdale and Johnson 1998). In a study of 42 women, participants expressed that they often experience social control, which perpetuates feelings of self-blame and interferes with help-seeking behaviour (Riddell et al. 2009). This can restrict women's access to informal social support and limit interactions through which women might share their experiences of violence (Riddell et al. 2009). DeKeseredy (2011) and DeKeseredy et al. (2020) provide further support for the lack of social support available in rural communities, noting social isolation is a significant barrier to accessing supports. Consequently, many rural women are forced to rely upon HCPs as their primary source of social support (Riddell et al. 2009). This is highly problematic, and rural women are often reluctant to disclose IPV to an HCP due to concerns regarding privacy and confidentiality, stemming from close-knit communities and personal relationships with HCPs that extend beyond the practitioner–patient dyad (Annan 2008; Merritt-Gray and Wuest 1995; Zorn et al. 2017). Additionally, the traditional patriarchal views, commonly held by rural families regarding gender roles and relationship dynamics, can inhibit disclosure (Cohn 2008; DeKeseredy et al. 2020; Gagne 1992; Websdale 1998). Such shared values among rural community members reinforce the belief that intimate relationships are a private matter and should not be subjected to public discussion and/or intervention (Gagne 1992; Wendt et al. 2002). Prevailing social norms in rural contexts may result in less communal tolerance of social deviance and diversity—further exacerbating pre-existing barriers to the disclosure of IPV (Gagne 1992; Hornosty and Doherty 2003; Wendt et al. 2002).

Purpose

To examine the personal meaning attributed to disclosure of IPV by seven women living in rural Ontario, Canada.

Methods

This paper represents a sub-analysis of a larger study ($n=8$) exploring how women who have experienced IPV navigate health and social services within rural Ontario. Emerging from that study was an in-depth exploration of the decision-making processes surrounding disclosure of IPV to frontline HCPs in rural settings. A qualitative case study approach was used to enhance understanding of what influenced each woman's decisions around whether or not to disclose IPV, and how those decisions were made (Baxter and Jack 2008). A feminist framework of structural intersectionality grounded the findings of this qualitative sub-analysis within the lived experiences of participants (Cho et al. 2013). The interplay of various social dynamics and power relations was considered to account for the unique experiences of IPV for women of different socioeconomic status, race/ethnicity, geographical location, and level of education. These considerations are fundamental to contextualizing experiences of IPV, as while abuse does not discriminate, it is known to disproportionately impact specific populations (Ard and Makadon 2011; Coker et al. 2005; Kimmel, 2002; Zorn et al. 2017).

Participants

Ethics approval was obtained from the Health Science Research Ethics Board (#111175) prior to initiating communication with participants. Key considerations included that discussing personal experiences of violence may be distressing and that participating in an interview may put a participant at risk if the abusers heard her discussing her experiences of abuse. To combat this, all participants were provided with phone number for women's helpline that specializes in IPV. In addition, at the beginning of the interview, all women were asked what they would like the researcher to do in the event that the call was abruptly terminated (i.e. call back immediately, call 911, or call a friend/neighbour to check on them).

Using a snowball sampling strategy, participants were recruited via social media advertisements posted electronically by rural shelters in Ontario. Interested parties were invited to contact the principal investigator by email. Women who spoke English were at least 18 years of age and had accessed both a women's shelter and health care services within the past six months were deemed eligible to participate. Ten women responded to the social media advertisements, one of which did not meet the inclusion criteria, and one did not respond following their initial request for more information about the study, leaving a total of seven women enrolled in the study. While the original study enrolled eight participants, seven were included in this sub-analysis, as one woman did not respond to questions regarding disclosure. This participant did not want to discuss disclosure during the interview.

Each participant completed a semi-structured interview averaging 60 min in length. Prior to data collection, informed consent to participate was obtained, and each participant received a small honorarium ($25) in recognition of their time. During the interview, efforts to maintain trustworthiness and authenticity were undertaken—including member-checking, paraphrasing, and synopses—to maximize the likelihood that data were accurate reflection of participants' experiences (Guba and Lincoln 2000). The principal investigator also created and retained field notes throughout the interview process to contextually situate the study's findings and enhance the richness of participants' descriptions. The field notes provided the researchers with a deeper understanding of the interviews and provided context and enhanced the meaning of the transcripts for those involved in the analysis who were not the interviewer. Interviews were audio-recorded and subsequently transcribed verbatim by a third-party transcription service.

Due to the sensitive nature of this research, several actions were taken to protect the anonymity and confidentiality of participants. As recommended by the Canadian Institutes of Health Research (2005), the collection of direct identifiers was minimized, and participants were assigned a pseudonym to maintain anonymity during data collection and dissemination. In addition, all participants were advised to limit the sharing of potentially identifiable information during the interviews. As an added precaution, any potentially identifiable information was redacted from interview transcripts prior to analysis. Only members of the research team were granted access to the data on a need-to-know basis to safeguard information and maintain the integrity of the project, as recommended by the Canadian Institutes of Health Research (2005) and Panel on Research Ethics (2018). Any information that could be used to identify a participant has also been omitted from publication.

Measures

A short questionnaire captured demographic data, including participants' highest level of education achieved, family structure (marital/parental status), place of residence, employment status, personal income, and race/ethnicity. These data were necessary to facilitate the use of a feminist structural intersectionality framework, which makes a point of acknowledging power dynamics and social identities. Participants were also asked open-ended questions regarding IPV disclosure. Questions included: "Were you able to disclose violence to your HCP?"; "Do you think there's anything that [your HCP] could have done or could do that would make you choose to disclose, or that would help you choose to disclose?"; and "Are there any ways that health care has been really supportive?" These questions aimed to elucidate constructive criticism of a HCPs promotion and management of disclosure. A primary objective of these questions was to identify solutions to encourage feelings of safety and support in health care settings for women who have experienced abuse. The use of a semi-structured interview guide offered great flexibility—affording participants the opportunity to speak about issues that were most relevant and important to them, while also allowing the researcher to explore certain topics in further detail.

Analysis

Once the interviews were transcribed, a team of five researchers from three diverse disciplines (i.e. nursing, health studies, and health information science) independently conducted an interpretative phenomenological analysis (IPA) using a reflexive-relational approach (Smith 2007). Given its close alignment with this study's primary aim, IPA was selected as an appropriate analytic method to explore the meaning that participants ascribed to their experiences of IPV disclosure (Flowers et al. 2009). In particular, IPA was favoured for its commitment to detailed analysis, ultimately providing rich and nuanced insights of lived experiences (Smith 2007). Moreover, IPA was conducive to understanding how women make sense of their experiences of IPV and disclosure, and also to interpreting their perspectives to further enhance understanding. A reflexive-relational approach was selected to complement IPA because it views data as co-constructed by both researcher and participant through dialogical encounter (Smith 2007). As such, a reflexive-relational approach was ideally suited to complement the semi-structured interview technique, which supports flexible dialogue to direct the conversation and produce new information as either interviewer or interviewee desires. In combination, these approaches involved multiple readings of each transcript, open coding to annotate the dialogue, identification of themes, and subsequent clustering of themes into categories (Smith and Osborn 2004). Once each researcher had completed their preliminary analysis independently, the group reconvened to discuss emergent themes and categories, with each researcher's subjective interpretation of the meaning of disclosure given due consideration. Given the diverse disciplines of the researchers, each offered a unique perspective and vantage point from which their analyses were positioned. This discussion was moderated by a researcher who did not complete the analysis and was therefore well positioned to aid in the identification of similarities and patterns across independent analyses. Through continued deliberation, consensus was reached, and thematic categories were agreed upon.

Results

In accordance with the feminist structural intersectionality framework applied to this study, demographic variables were computed to identify unique social identities (Cho et al. 2013). This analysis identified that participants ranged from 21 to 58 years of age, with a mean age of 30. All were born in Canada, and two participants identified as Indigenous. Five women were divorced or separated, and two women remained with their abusive partner. While participants spent an average of 6 years with their abusive partner, the length of this relationship varied significantly, ranging from 6 months to over 30 years. Five women were mothers of dependent children who currently lived with them on a full- or part-time basis.

Four women had completed either a community college or university degree program, two had graduated from high school, while one had not completed her high school education. Three participants were employed full-time, two part-time, and two were receiving social assistance benefits. Four participants made between \$50,000 and \$99,999 per year after taxes, and three made less than \$50,000. All participants resided in rural areas with populations of less than 30,000, with six of the participants living in communities of less than 10,000 residents. A universally agreed upon population size for “rural” does not yet exist, hence the population size was identified. It should be noted that an area of 30,000 people has been labelled as rural in previous IPV research (Logan et al. 2003). Given the small sample size, the researchers decided not to further delineate demographic findings using subgroups to respect the anonymity and privacy of the participants; however, this would be a direction of future interest. Furthermore, the results gleaned from a sub-group analysis of this size may be too narrow to be indicative of the broader population whom this research hopes to serve.

Use of health care services

Access to health services was predominantly influenced by a lack of local primary HCPs ($n=4$), a shortage of mental health professionals in the area ($n=5$), and limited transportation to health care services ($n=4$). Rurality is a well-evidenced barrier to service provision for women who have experienced IPV due to a paucity of providers and inaccessibility thus preventing disclosure and/or treatment (Eastman and Bunch 2007; Lanier and O’Maume 2009; Logan et al. 2003; Websdale and Johnson 1998; Zorn et al. 2017). Due to the scarcity and inaccessibility of these important resources, four participants described having visited a walk-in clinic in the past 6 months, while two resorted to visiting a hospital emergency department to address their non-emergent health needs.

Thematic analysis

Through in-depth interviews with women who have experienced IPV, a number of reasons for electing not to disclose such abuse to primary HCPs were uncovered, and assigned to one of four thematic categories: (1) privacy and trust concerns; (2) discomfort in acknowledging IPV; (3) exerting control over information; and (4) violence as unimportant to health concerns (see Fig. 1). All seven participants’ voices were included in the thematic analysis. Quotations are scarce due to the small sample size; however, this is in accordance with IPA as the focus is on finding meaning in the data, rather than the frequency of responses (Smith and Osborn 2007). All quotations regarding disclosure are presented and each category is discussed in detail below.

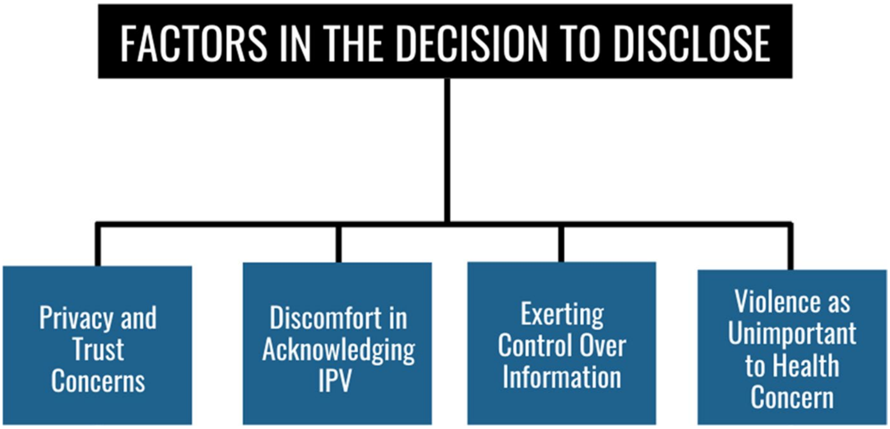

Fig. 1 Factors that contribute to women's decision to disclose IPV

Privacy and trust

Privacy and trust concerns were of paramount importance. One woman (W4) stated, "No [I didn't tell my physician I was in the shelter] because I didn't trust him...". Similarly, another participant (W6) provided the following statement regarding her HCP:

> She wasn't aware of the situation. My family doctor had no idea what was going on. I didn't feel comfortable discussing it with her because we also — my daughter's mom — also share the same family doctor. I know there's the whole entire privacy thing, but I was scared that maybe she would have mentioned something to her just forgetting. So, I was very quiet when it came to that.

There is substantial evidence that privacy is a valid concern for women in rural areas, as service providers are more likely to have a personal relationship (ex: relative) with patients and services such as safe houses/shelters may be widely known instead of secretive (Zorn et al. 2017). Furthermore, service providers may know the abuser personally, causing women to distrust the provider (Websdale and Johnson 1998). As such, disclosure can compromise personal relationships and even endanger women if they are unable to safely access services to leave their abuser. Given the highly sensitive nature of IPV and dangers associated with disclosure**,** it is understandable that women who question their HCP's ability to maintain privacy and confidentiality may choose not to disclose their experiences of abuse.

Discomfort in acknowledging IPV

The second category that emerged from transcribed dialogue was women's discomfort in acknowledging IPV. One participant (N01) stated, "I think I just felt maybe a little embarrassed about it", while another women (W6) wanted to avoid the topic—recounting, "I didn't tell her. She asked how everything was going, and I just said, 'fine', and I nodded so the conversation would just end". Similarly, another respondent (W3) stated, "I think originally it's something you're not really... you don't really feel comfortable talking about". These sentiments of embarrassment and discomfort are also noted by the literature, with Merritt-Gray and Wuest (1995) acknowledging that abuse is stigmatized as a private and shameful issue. In addition, women my fear that nurses judge their relationship choices, especially if they choose to stay with an abusive partner, making them feel ashamed and embarrassed (Catallo et al. 2013). Moreover, disclosure can result in feelings of heightened vulnerability, resulting in a sense of discomfort (Catallo et al. 2013). Although each of these women spoke of different feeling or emotions, whether discomfort or a desire to avoid the topic, each response represents challenges associated with acknowledging experiences of IPV.

Exerting control over information

For those who chose not to disclose experiences of IPV to HCPs, this decision appeared to be representative of participants exerting control over their personal information. This was highlighted by one women (W1) when she stated that "I think it was just a choice that I made to keep that private. I love my physician and I feel like I can be open with her, but it was just something I chose not to disclose". IPV is motivated by the desire to control (Kimmel 2002); women who have experienced IPV may consequently feel a lack of personal agency and search for avenues to exert control over their lives. Disclosure can be viewed as an opportunity to regain control. Equally, women may resist disclosure by exercising agency over how and when they will share their experiences of abuse (Catallo et al. 2013). Additionally, Merritt-Gray and Wuest (1995) advocate that women who have been abused are survivors and may actively resist the label of "victim" by HCPs because of the connotations of being helpless and passive. In fact, women actively resist violence in their survivorship, which may contradict an HCPs perspective. This conscious decision to not disclose exemplifies an exercise of personal autonomy, whereby this particular woman (W1) retained power and control within the patient–provider dyad.

Violence as unimportant to health concerns

Some women opted not to disclose IPV to their HCP when they did not see the violence as important or related to their health concern. This may be attributed to a general societal ignorance of what constitutes violence that affects the perspectives of both women who have been abused and the HCPs caring for them. Merritt-Gray and Wuest (1995) have noted that many women do not self-identify as having experienced abuse if the abuse is not physical, while Catallo et al. (2013) and Krishnan et al. (2001) acknowledge a focus on physical abuse by HCPs and a lack of assessment/treatment for emotional concerns. As such, some women may not disclose non-physical forms of violence and HCPs may not prompt conversation of non-physical abuse concerns. For example, one participant (W2) stated:

> No. I didn't have to. I wasn't getting bruised. I wasn't … there was one incident where I had a bunch of really pretty heavy serious scratches, but nothing ever required medical attention to that degree. There was [sic] no broken bones or anything like that. I got to be honest; I took it all with a grain of salt.

Similarly, another respondent (W6) stated:

> I've used emergency if needed, or just my family doctor, or I called Telehealth … I focused on the concern that I had [rather than providing background information about being in an abusive relationship] … That was the only thing that was important at that time.

One woman (W5) reported frustration related to disclosure, stating "I found that very frustrating because you're telling your story, you have no solution, and then you're going to a whole other place. It's just like – it's almost more PTSD. It's reliving it again". Negative experiences such as these may contribute to a general distrust in the health care system and prevent a woman from disclosing to an HCP in the future (Catallo et al. 2013). This woman (W5) further disclosed the following regarding self-identification as a woman who experienced IPV:

> When I finally came to terms with the fact… At first, I was like, "I'm not an abused woman, what are you talking about?" When I came to terms with things and people started talking like, "Oh, have you thought about this, or that?" I looked them up. I actually had a friend who was working [at the shelter] at the time which is the only reason I even thought to even try there. That was a little bit frustrating, especially when you're trying to deal with all the ins and outs of the rest of your life that are breaking down. You're just trying to take care of yourself.

The four aforementioned themes—privacy and trust concerns; uncomfortable with acknowledging IPV; exerting control over information; and violence as unimportant to health concerns—likely represent only a portion of the many reasons why a woman may choose not to disclose. For example, fear of retaliation by the abuser is noted in the literature to be a significant barrier to disclosure, although this did not surface during the interviews. Catallo et al. (2013) note that some women do not disclose for fear of the HCP engaging other services, such as the police, which may lead to retaliatory abuse by their partner. However, the powerful insights gathered from these women serve to illuminate the transformative process of identifying as a woman who has experienced IPV, coupled with the frustration that ensues when disclosure is not appropriately validated and addressed by HCPs.

Discussion

Due to the small sample size, sub-group analysis was not conducted to protect the anonymity of the participants. As such, the applied feminist framework is limited in scope to explore how rurality informed the women's experiences and excludes discussions of additional social identities and variables. Furthermore, the small sample size coupled with IPA allowed for the sacrifice of “breadth for depth” (Smith and Osborn 2007, p. 56). Thus, IPA can include single case studies, such as the one presented in the section *Exerting Control Over Information* (Smith and Osborn 2007).

In this study, it seemed clear that participants did not trust their HCPs, preventing them from disclosing their experiences of abuse. This is similarly reflected in the literature about rural women who were concerned with breaches of privacy (Annan 2008; Merritt-Gray and Wuest 1995). Women in this study likely had a limited selection of HCPs, given their rural geographic location (Lanier and O’Maume 2009). This is particularly problematic as women are already in a challenging position given the patriarchy often embedded within rural environments (Cohn 2008; DeKeseredy et al. 2020; Gagne 1992; Websdale 1998). Furthermore, HCPs practicing in these settings are often familiar with many members of the community (Zorn et al. 2017), and—as described by one woman in this study (W6)—may have known the abuser directly. Fear of breach of confidentiality may increase vulnerable women’s reluctance to disclose IPV, irrespective of the HCPs’ intentions.

Women also discussed their discomfort with disclosing the abuse to an HCP. One woman said that she liked her doctor and felt comfortable with her but did not disclose because she felt embarrassed. Several others described not wanting to broach the subject with their physician due to feelings of shame. Such feelings of shame in admitting IPV support established findings in violence literature (Baker 2013). In a study conducted by Kramer et al. (2004), researchers found that 60% of English-speaking women surveyed felt that embarrassment was a barrier to disclosing abuse to a physician or nurse. Almost a third of the women stated they were “not ready to address the problem”, which might suggest a discomfort in acknowledging IPV (Kramer et al. 2004, p. 25). Discomfort due to shame and embarrassment is further supported by Wendt et al. (2002) who acknowledge that rural women likely share the cultural, religious, and societal beliefs and values of their communities. Often, rural communities support a norm of tolerance and silence regarding “disruptive” family dynamics, which if adopted by the women themselves may result in non-disclosure and internalized shame (DeKeseredy and Schwartz 2009; DeKeseredy 2011). For example, women may be conflicted between the social and religious value of maintaining a nuclear family and belief in being subservient to one’s husband, which can complicate women from acting in their best interests. This does not necessarily identify feeling prevented from disclosing; rather, that the women simply were not ready at the time to discuss their experiences of abuse. Wathen and MacMillan (2012) also discussed “readiness to address” abuse, which is dependent upon each woman’s experiences and circumstances (p. 713). This may further explain the woman in our study who simply said that she chose not to disclose abuse without providing a specific rationale. The concept of ‘readiness’ may further explain the decision of this woman to keep her experiences of IPV private, despite liking and trusting her physician. This suggests that even without feelings of embarrassment and shame, women may still choose not to talk about IPV, and that disclosure is a case-specific decision-making process.

Two participants did not perceive their experiences of IPV as relevant to disclose to an HCP. One of the women noted the absence of any physical injuries that required medical attention as the reason for not disclosing. While the second woman sought medical attention for her injuries, she considered the abuse to be irrelevant background information. These findings reflect those of previous studies, including Kramer et al. (2004) who stated that “women may only relate abuse directly with injuries and not associate their stress and ongoing abuse with other health problems, nor identify the health care system as a place where they could go for help” (p. 27). This may be reflective of a general societal ignorance surrounding IPV and its various forms, with physical abuse being the dominant, and often solely acknowledged type of abuse. This can cause women to not recognize experiences of non-physical abuse as IPV, thus resulting in non-disclosure (Merritt-Gray and Wuest 1995). Thus, despite the incidence of physical injuries, ongoing health ramifications, and above-average health care service utilization (Ford-Gilboe et al. 2009, 2015; Graham-Bermann et al. 2011), women who have experienced IPV may still not consider their abuse as relevant in a health care setting. Even more troubling is the fact that HCPs may not recognize, assess, or treat non-physical abuse, which can invalidate a woman’s non-physical experiences of IPV (Catallo et al. 2013; Krishnan et al. 2001). Experiencing IPV of any form can result in mental health issues, including stress, depression, anxiety, addiction, suicidal ideation/attempt(s), and PTSD (Bohn and Holz 1996; Coker et al. 2000; Kramer et al. 2004; Krishnan et al. 2001; Logan et al. 2003). Rural women may experience worse mental health than their urban counterparts as suggested by a self-report measure by Logan et al. (2003), lending further evidence to the need for mental health support for rural women who have experienced IPV. The breadth of mental health sequelae of experiencing violence makes it necessary for HCPs to acknowledge, assess, and treat non-physical manifestations of abuse.

In addition, Kramer et al. (2004) found that 74% of the women they surveyed did *not* seek health care for issues related to IPV. This reiterates that women experiencing IPV do not necessarily see a congruence between IPV and the help that an HCP can offer. In fact, HCPs can provide immediate clinical care, in addition to supportive care including active listening, psychosocial support, and referrals to additional services (i.e. mental health, legal, police, housing, and financial services) (García-Moreno et al. 2015). HCPs with additional relevant training can also provide women with safety planning, counselling, and trauma-informed mental health care (García-Moreno et al. 2015; World Health Organization 2013). Interestingly, despite the clear potential of HCPs to help women who are experiencing/have experienced abuse, findings from a study by Gerbert et al. (2008) revealed that women experiencing IPV did not perceive it as part of the HCP’s job to address the violence they face, with one of the interviewees stating “They are there to fix the injury and that is it” (p. 11). Moreover, Catallo et al. (2013) acknowledge that many women would like their HCP to address violence, although they may think that an HCP will not actually be helpful to them. This again illustrates that women experiencing IPV perceive organizational silos between health and domestic violence services; thereby creating systemic barriers to disclosure. One of the participants in this study supported this notion by stating that her experience of disclosure was negative. She found no therapeutic benefit, citing that HCPs “have no solution”. Instead, through the process of disclosure, she relived her trauma without any respite provided in return. Overall, women did not perceive HCPs as capable of ameliorating any of their negative circumstances related to abuse.

While there are many acknowledged barriers to disclosing experiences of IPV, the concept of screening, or asking blanket systematic questions of women in health care settings, is contentiously debated in the literature. Gerbert et al. (2008) found that even when women are directly asked about the source of their injuries, they may refrain from identifying their abusers as the cause—noting fear of retaliation from their partner and fearing loss of child custody as primary concerns. In addition, a study by Klevens and Saltzman (2009) found that universal screening did not improve overall quality of life for women experiencing IPV or reduce the reoccurrence of abuse. The literature reveals that even when directly asked about their experiences of violence, the overall health outcomes for women do not necessarily change. This reiterates that even if IPV can be identified by HCPs, the overall goal is to improve the lives of the women experiencing violence, which might not happen through blanket screening processes (Klevens and Saltzman 2009; Wathen and MacMillan 2012). Interestingly, Gerbert et al. (2008) found that positive experiences of disclosure did not necessarily include referral to other resources, but rather, validation of women's experiences without placing pressure on women to leave the abusive relationship. This demonstrates that agency and control in the process of disclosure is of tantamount importance to women experiencing IPV and the role of HCPs in the provision of judgement-free and empowering spaces is conducive to such critical conversations.

The importance of agency and control is especially relevant in rural settings, as women who experience violence in a rural environment face unique challenges that predispose them to context-specific stressors (Annan 2008). For example, the obligation to one's community and religious affiliation is typically stressed more in rural than urban settings. This enforces expectations of loyalty, which typically leads rural women to stay with their abuser instead of seeking help and/or safety (Annan 2008; Merritt-Gray and Wuest 1995; Zorn et al. 2017). A lack of control is further exacerbated through inadequate law enforcement, where women can experience victim blaming and police may not come when called, come a long time after the call was made, and/or be reluctant to make arrests once on the scene (Annan 2008). DeKeseredy (2011) and DeKeseredy and Schwartz (2009) elaborate to note that the patriarchy in rural communities can also result in police protecting male abusers, rendering it useless for a woman to involve local law enforcement. In addition, while confidentiality is likely to be preserved during disclosure, anonymity is not, as many rural women encounter their providers in non-professional settings (Annan 2008; Gagne 1992; Wendt et al. 2002). Finally, rural women may find themselves isolated without transportation or phone/virtual access to services, thus limiting their agency (Annan 2008). Evidently, the rural environment is rife with factors that limit a woman's agency and control as it relates to disclosure.

It is thus paramount that HCPs shift their practice to better enable women to disclose IPV and enhance their confidence that issues emanating from IPV may be sensitively addressed. To the researchers' knowledge this has yet to occur in a rural context; however, Mantler et al. (2018) proposed a 'Hub Model', which is a women-centred approach that aims to improve access to safety and health services. The Hub Model views women as resourceful and able leaders who are capable of strengthening service delivery and support women's safety and health in rural shelters when they are provided with community education, networking, and technology (Mantler et al. 2018). A model such as this might also show promise in addressing challenges regarding disclosure of IPV, especially in achieving higher standards for rural HCP services surrounding disclosure, hence it warrants consideration.

Limitations

While this small qualitative study underscores the challenges that rural women face when deciding to disclose IPV, it is not without limitations. First, the sample size was smaller than what was desired due to being pulled from a broader study, however, it is the perspective of the authors that the small number of participants allowed for thorough analysis of information-rich cases. The sample size was ideal for the development of detailed themes due to the ability to cultivate an in-depth perspective of the complexities attached to disclosure of IPV in a rural setting. This is supported by Boddy (2016), who stressed that any sample size can generate value if it offers a rich, descriptive understanding that contributes to the knowledge base of the topic at hand. However, the extent of sampling error associated with a small sample should not be overlooked, meaning that generalizability cannot be assumed (Vasileiou et al. 2018). It is important to note that a broader sample may have permitted for the identification of additional themes and inferences regarding generalizability. Thus, the sample size was insufficient for achieving thematic saturation, but adequate for depth of thematic analysis, as evidenced by the identification of four strong, well-evidenced themes (Vasileiou et al. 2018). To draw the most accurate conclusions, data from additional small, local samples should be combined in a validity generalization study (Rafilson 1990). The detailed collection of characteristics of this sample purposively allows for the use of these results in future research that aims to draw broader conclusions. Second, there was diversity in the approaches of the shelters and health care centres, which might have been attributed to the rural context (Lanier and O'Maume 2009; Websdale 1998). Many rural areas lack funding and as a result often offer few services, thus resulting in geographic variation of availability of specific services (Lanier and O'Maume 2009; Websdale 1998). There was a lack of consistency between the approaches used, as some were more client-centred than others. Again, a larger sample size would account for more variety in service delivery and allow better comparison of whether the results are consistent with other contexts. Lastly, there was the potential for self-selection bias as women might have had difficult experiences and thus self-selected into the study (Lavrakas 2008). Although this is inherent to any research study that involves self-selection, as a result, respondents may not be representative of the entire target population (Lavrakas 2008). However, each of the identified themes were consistent with the literature, which leads the authors to conclude that self-selection bias did not compromise the integrity of this study.

Conclusion

IPV is a complex problem that affects women's health and is shaped by their experiences and understanding of violence (Feder et al. 2006; Spangaro et al. 2009). Despite being high-system users, women who experience IPV tend not to disclose their abuse to HCPs and while this decision is context dependent, it is amplified in rural settings (Kramer et al. 2004; Van Dis et al. 2002; Wathen and MacMillan 2012; Websdale and Johnson 1998). This sub-analysis describes the experience of and personal meaning attributed to disclosure of IPV by seven women living in rural Ontario, Canada. It was found that women's decisions to disclose abuse were dependent on the level of privacy/trust between the women and HCPs, the women's comfort in acknowledging IPV, their efforts to exert control over the situation, and whether or not they viewed experiencing violence as a health concern. The findings of this analysis conform with those of previous literature and underscore the challenges that rural women experience when deciding to disclose IPV. Although the decision to disclose abuse is fixed within the context of the rural environment, it is imperative to create a non-judgmental, comfortable environment for disclosure. Efforts to improve privacy and trust between women and their HCPs are critical and will facilitate the achievement of this goal.

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Data availability The datasets generated during and/or analysed during the current study are not publicly available due to the fact that the authors never asked the participants if their data could be entered into a public repository.

Compliance with ethical standards

Conflicts of interest The authors declare that they have no conflict of interest.

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