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The Voices of Native Hawaiian Women: Perceptions, Responses and Needs Regarding Intimate Partner Violence

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Abstract

Using a community based participatory approach, individual interviews and focus groups were conducted with Native Hawaiian women to understand their cultural perceptions, responses, and needs regarding intimate partner violence (IPV). Semi-structured interview guides were used for both interviews. The overriding theme derived from content analysis is that IPV “starts in the home,” it is learned in the family and in the community. Visible injuries requiring emergency care is commonly perceived as IPV. The response to IPV included a primary theme of “defend the collective.” Intimate partner violence is understood to be a “family matter,” dealt within the family or by oneself. Native Hawaiian women who participated in this study sought to re-connect or establish relationships with self, others, spirit, natural elements, cultural practices, and community. Responding to IPV requires an understanding of cultural perceptions, responses, and needs of Native Hawaiians, with implications for families and communities. The needs expressed by Native Hawaiian participants reflect what they need to access “health.” Implications for health care providers require understanding how best to facilitate an individual’s access to “health” vs. access to “health care.”

Keywords

intimate partner violence; Native Hawaiian women; cultural perceptions; Hawaii

Introduction

The purpose of this paper is to present a community based participatory research (CBPR) exploratory study that investigated the perceptions, responses, and needs of Native Hawaiian women regarding intimate partner violence (IPV). The research was part of a larger study of three cultural groups. Find-ings from the interviews and focus groups with the Native Hawaiian women in Hawaii are presented in this paper.

Intimate Partner Violence

A multi-country study of women’s health and IPV conducted by the World Health Organization (WHO) confirmed that IPV is a complex health and social issue affecting women around the world (Garcia-Moreno, Jansen, Ellsberg, Heise, & Watts, 2006). Intimate partner violence is pervasive in American society and is the most common cause of non-

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fatal injury to women (Kyriacou et al., 1999). In the National Violence Against Women Survey (NVAWS) (Tjaden & Thoennes, 2000), approximately 25% of women reported being assaulted during their lifetime. More than 1.8 million physical assaults occur that cause injuries, 519,031 of which require medical care (Centers for Disease Control and Prevention, 2003).

The population of women who are victims of IPV is not homogenous (Crichton-Hill, 2001), yet intervention strategies are based on Western notions of family life. Services are geared to women in general and do not take into account the unique perspectives of different cultures. In Hawaii, the Strategic Plan for the STOP Violence Against Women Formula Grant (Hawaii State Department of the Attorney General, 2003) identifies outreach to underserved populations that are isolated by culture and language as a priority. Differences between cultural perspectives may lead to barriers that prevent women from receiving effective care (Campbell & Fishwick, 1993). Experts suggest that clinical interventions for abused women should be based on principles, which include cultural competence and empowerment (Campbell & Campbell, 1996).

Hawai`i is a state with a diverse population: Native Hawaiian, 20%; Caucasian, 24 %; Filipino, 14 %; Japanese, 16%; Hispanic, 7%; African American, 1.8%; Pacific Islander, 2.3% (2000 Census). Twenty percent of women age 19–64 have been victims of IPV in their lifetimes (Hawaii State Dept. of the Attorney General, 2003). In 2006, 22,000 adults reported IPV, 2.4% of the adult population, and 10% of high school students reported being physically hurt by partners (SMS Research and Marketing Service, Inc., 2007). Between 2000 and 2009 there were 58 murders of women resulting from IPV and 70% was Filipino or Native Hawaiian (Domestic Violence Coalition, 2009). Findings from previous studies confirm that only a small percentage of abuse is reported to police and by the time an arrest is made, the violence has occurred for a number of years (League of Women Voters of Honolulu & Hawaii State Commission on the Status of Women, 1996). In a 2003 review of records in four community health centers (CHCs) (Magnussen et al., 2004), 19% of the participants were identified as Native Hawaiian; however, 32.3% of documented reports of IPV were made by Native Hawaiian women (self-identified in medical record documentation).

Native Hawaiian Health

Responding to IPV in Hawai`i requires an understanding of cultural perceptions, responses, and needs of *Kanaka maoli*, the indigenous peoples of the State of Hawai`i, referred to in this paper as Native Hawaiians. As defined in Title 45 CFR Part 1336.62, Native Hawaiian means “an individual any of whose ancestors were natives of the area which consists of the Hawaiian Islands prior to 1778.”

Since the late 1960’s, the indigenous peoples of this State have seen a resurgence and revival of their culture. Many have become reacquainted with cultural practices, values, and rituals. Achieving balance or harmony, pono, for Hawaiians, meant maintaining a relationship with akua (god, spirit), the `āina (land), and the`ohana (family). It was through the `ohana that cultural values, history, rituals, and traditions were communicated. However, as a result of Westernization and the resulting environmental influences, there are many that remain alienated from their cultural values and traditions and unable to cope with the stressors produced from the necessary processes of trying to assimilate.

Sociopolitical issues of Western domination over land and individual and collective rights have devastated Native Hawaiians and displaced them from their lands and culture (Kame`eleihiwa, 1992). When dis-aggregated from the general Asian/Pacific Islander category, Native Hawaiians have higher prevalence and mortality rates of diabetes and cancer, one of the shortest life expectancies in the State, striking disparities in cancer mortality rates between part-Hawaiians and pure Hawaiians (Busch, Easa, Grandinetti, Mor, & Harrigan, 2003), a higher percent of individuals overweight and obese (Hawaii State Department of Health, 2007), and as previously mentioned, high rates of IPV. This description is not unfamiliar to many indigenous peoples; it is an all too familiar recounting of historical events which have impacted the health of native peoples. Despite these challenges, Native Hawaiians have been outspoken in taking action to resolve identified problems, have strong ties to their communities, retain strong attachments to their family, including a close relationship with their elders (Kana`iaupuni, Malone, & Ishibashi, 2005), are protective of perceptions of their community, and are very tied to their land. Their pursuit for self-determination has been unrelenting as a means of survival (Oneha, 2001).

The data presented in this paper are from a larger study in which a CBPR team sought to understand how IPV and culture came together for selected cultural groups: Native Hawaiian, Ilocano (Filipino), and Chuukese (Micronesian). The research question was, "What are the cultural perceptions, responses and needs of selected individuals and groups served through a variety of programs that are affiliated with the three participating CHCs regarding IPV?" In this paper we present the findings from Native Hawaiian women from one of the three CHC’s. The unique findings from the Native Hawaiian women can be used to develop culturally appropriate interventions specific to this population.

Methods

Theoretical Framework

The theoretical foundation for this study was Critical Social Theory, a post-modern philosophical perspective that acknowledges some voices are privileged and others are marginalized (Boudreau, 1997). The use of the CBPR approach to this study was consistent with the perspective of Critical Social Theory (Israel, Eng, Schulz, Parker, 2005; Wallerstein & Duran, 2003). An expected outcome of CBPR is the attainment of new knowledge that guides actions.

Community based participatory research works within and recognizes the expertise of community health centers and community members. The CBPR team for this project came together in 2003 with the intent of addressing IPV which challenged each community site and of which the identified cultural groups consumed the most resources.

One or two representatives from each partner site, interested in making a difference, became a member of this CBPR team. Personnel varied at each site, but most had responsibility for management of maternal child programs within the CHCs and were representative of the cultural groups included in the study. There were approximately seven members on the CBPR team, including faculty members from a University school of nursing with clinical and administrative backgrounds that include women’s and community health. Team members recognized that the organizations they represented were not the sole authority on the community each site served. However, the CHCs have had longstanding relationships with the community they serve and have an organizational structure that advocates and supports this outreach. Team members sought input from patients, staff, providers, and preformed women’s groups in the design of this research study.

Recruitment

The CBPR team received training on recruiting and conducting focus groups with a diverse population. Due to the sensitivity of the research topic, a script developed by the research team was used as a guide to recruit eligible women for this study. The WHO guidelines, a confidentiality agreement, a NIH Certificate of Confidentiality were instituted at each site, and plans were developed to ensure safety. Recruitment and data collection was conducted by a member of the CBPR team, an employee of the CHC for 17 years, and a Native Hawaiian nurse.

Inclusion criteria for individual interviews were that women self identified as Native Hawaiian (All participants lived in a predominantly Native Hawaiian community. While blood quantum evidence was not required, it would be unlikely that those who self-identified as Native Hawaiian, in this community, have only a cultural appreciation of things Hawaiian), over the age of 18, and had personally experienced IPV. Inclusion criteria for focus group participation included women who self identified as Native Hawaiian, over the age of 18, and may or may not have personally experienced IPV. Recruitment for the individual interviews consisted of identification of 39 eligible women. Contact was attempted on 16 women, 10 were reached, and 5 consented to be interviewed. Similar challenges were faced with recruitment for the focus group. When approached through a pre-existing group, women were cautious in volunteering to participate, some were vocal at not wanting to participate nor discuss the issue, and a few voiced their perceptions of IPV and the expected role of the woman. Anticipated challenges to participating in a focus group ranged from discomfort with discussing the topic in front of others to a need to keep family and group relationships intact. Eight eligible women were contacted and five participated in the focus group. Women contacted were asked to bring a friend or relative (also meeting the sample criteria) as a way for them to identify additional participants and to feel comfortable in the group with someone they knew. The number of participants in the individual interviews and focus groups, while limited for each cultural group, were appropriate for this exploratory pilot study. Combining the individual perspective with the group perspective provided a more comprehensive description of the cultural group's perception of IPV.

Sample

Ten women, ranging in age from 27–61 years, who self-identified as Native Hawaiian, residing in a predominately Native Hawaiian community, participated; five in the individual interviews, and 5 in the focus group. Fifty percent were married, 60% employed, 70% had some college or were college graduates, all participants had children, and nearly all were lifetime residents of Hawaii. Purposive sampling was used and phased so that women who had experienced IPV and participated in the individual interviews were not recruited to participate in the focus groups.

Data Collection

Two semi-structured interview guides were used: the first, for the individual interviews, asked specific questions regarding IPV; and the second for the focus groups asked general information about the cultural perceptions of IPV in the community. The questions were adapted from a study conducted in Seattle with multiple ethnic groups (Senturia, Sullivan, Ciske, & Shiu-Thornton, 2000). Individuals and groups were interviewed twice to validate responses provided at the initial interview. Examples of individual interview questions included, “How do you understand IPV? How did you and your `ohana (family) respond to IPV? How did your partner’s `ohana respond to IPV? Did you get the support you needed?” Examples of focus group interview questions included: “What do you think is the community’s perception of IPV?” “What would be helpful for women who experience IPV?” “How much do people talk about IPV?” “How do women cope with IPV?” All participants were also asked to illustrate, using an ecomap or “Pohai Ke Aloha” (circle of love illustrated by a lei of kukui leaves) developed specifically for Native Hawaiian women (Wilcox & Armstrong, 1996) with words, pictures, or symbols, “who or what supports you or serves you best?” Informed consent was received from all participants and interviews audio-taped. Validation or member checking was conducted for individuals at the second interview, and for the focus group at a second group interview.

Data Analysis

Tapes were transcribed verbatim and imported into Atlas.ti 5.2 (1993–2009 Atlas.ti Scientific Software Development GmbH, Berlin). Analysis of individual interviews, focus groups, and field notes was accomplished using content analysis (Downe-Wamboldt, 1992). Codes, categories, and themes were identified in response to the research question, and reviewed by the CBPR team and clinical content consultant, Dr. Jacqueline Campbell via email, telephone conference, and site visit.

Results

Several themes emerged in response to the research question.

Perceptions: “Starts in the Home”

The overriding theme was that IPV “starts in the home.” It is learned in the family and in the community. The participants described the home in which they were raised and the community in which they resided. For many women, IPV was a part of their childhood and/or their partner’s childhood. The experiences and understanding of IPV was learned in the home, most commonly through the violent relationship of their parents.

Participants shared that it was a challenge for their families to believe that IPV was occurring because the family understood it as “how it is (sic) suppose to be,” “it was normal.” I thought it was normal. I was with him for 6 years thinking it was normal. Then I had kids. I realized it was getting out of hand. I didn't want my children to think that it was okay, especially my oldest. He was a boy. I didn't want him to think that he can just beat on one girl and expect her to do whatever he wants just because he wants her to do it.

Similarly, participants also expressed how common it was to hear about IPV in the community, for example, at the grocery store. Participants recalled that during their parent’s/grandparent’s generation, it was the woman’s obligation and responsibility to keep the family together. The woman may have had her partner arrested and sent to jail, but still accepted him back because of the need to keep the family together.

> We still feel it's an obligation, this responsibility to hold the family together…. but I might have you arrested…. I might have you go to jail for little while… but you can come home and, because I need to keep my family intact,…… and then we come around to this generation… and I can talk freely about it in the store, in the parking lot…How have we gotten to this place…. and where do we go from here?

There is recognition that verbal and emotional abuse is just as “damaging.” Participants believed that the community perceives this to be something the woman can “handle.” Visible injuries requiring emergency care is more commonly perceived as IPV. Abuse became abuse when there were visible bruises, scratches, cuts, or blood. The frequency could be one instance or multiple instances with “no sign of getting better.”

Individual interview participants who experienced IPV described their partner’s understanding of IPV as being the fault of the person being harmed because of being “bad” or not doing what they were told. Focus group participants described instances in which they felt the person doing the harm was driven to or provoked to harm, particularly related to verbal or emotional abuse – they (the person doing the harm) lose their “sense of self” or identity and discover this is not who I am, another person brought me to this point.

Responses: Defend the Collective

The response to IPV included a primary theme of “defend the collective.” Intimate partner violence is understood to be a “family matter,” dealt with in the family or by oneself. Participants explained that the response from their families ranged from providing a place to stay, someone to talk to who would listen, a shoulder to cry on, advice to obtain a temporary restraining order or calling the police, to beating up their partner or not interfering – keeping it within the participant’s household, behind closed doors. While extended family members offered support, participants did not want to burden or bring problems to their extended family.

The response to IPV also included “self-soothing” behaviors to deal with suffering of: “don’t care,” substance use (drugs and/or alcohol), fighting back, feeling ambivalent, finding another intimate partner, or denial. The IPV experience shared by all participants in the individual interviews, involved substance (drugs and/or alcohol) use. Participants stated, “Physically I would fight back. I couldn't handle it already. I used to hit him with like bats, anything that I could see around me, fly it at him, everything,” and from another participant, “I used to go out with them (friends) just so that I didn't have to go home so early, I could go get drunk and then go home, just to alleviate that situation.”

The participants and their families, both, reached a point of “enough is enough.” This realization, for the woman, was usually associated with having her child(ren) near while the violence occurred or having her child(ren) angry at her. Participants also described their families reaching this point when they stop helping because she continues to go back to the violent relationship or the relationship is interfering with the functioning of the family.

> It was like, drop the kids off, figure your life out, and when you got it together, call us back and you can come get your kids. I made a few bad choices and I ended up in a very violent relationship and it was to the point where I just felt I grew up, family business is family business and don't shame the family. I tried to hold my family together as much as I could until I couldn't and, after years of going through that I finally said, enough already, this is enough.

Disclosure to a health care provider required a trusting relationship. Most women, who experienced IPV, found it difficult to disclose due to shame, provider attitude – making her feel like it was her fault, their partner being present, or not realizing it was abuse, “it was just verbal, I never think (sic) it would get that physical.” Conditions shared by participants under which IPV was disclosed included: comfort with provider; established, trusting relationship; provider recognition of abuse and belief in what the woman was saying; privacy; and provider knowledgeable about IPV.

Needs: Re-Connect with Cultural Base

Native Hawaiian women seek to re-connect or establish relationships with self, others, spirit, natural elements, cultural practices, and place/community. Most of these needs were identified by participants through the completion of their ecomap or Pohai Ke Aloha using words. The relationship with self reflected a need to understand the role of self as female, partner, and mother – being pono (proper) with self and overcoming shame. Women also had a need to believe that they could change their circumstances (self-efficacy), work to recover from their experiences, and persevere.

The relationship with others included a need for support from family and friends in order to be safe, to keep the family together, and to have someone “listen to and understand what I was going through.” One participant described her relationship with her mother:

> I think I had only wanted her to believe me and, and hear me and actually sit down with me and say, "So how you?" At least let me figure out how am I going to work this? But she always sided with him and it was hard. I think until I left him, that's when she realized that I wasn't playing. I told her I wasn't playing.

Women also expressed a need for the Western formal systems of care which they accessed or which were accessed for them (court-ordered) such as support groups which provided an opportunity to share a “common bond” with other women in similar situations, providers of health services (primary care and supportive services, mental health treatment, and substance treatment), shelters, and employment and educational classes. One participant stated, “I'm in college to become a teacher, I think that's how I'll stay safe, it's meaningful, it gives back to the community.”

Re-establishing a spiritual relationship with self through a formal recovery process or engagement with a particular church was also expressed as a need by participants. Similarly, re-connecting with a cultural base through traditional cultural practices of working in the lo`i (irrigated terrace for taro), chanting, and hula helped participants reclaim their identity, “it got me to realize who I am, you know, the way I should be, and the way I'm supposed to be.”

> I'm part Hawaiian, who needs to reconnect with self. I know how to do it, and that is to get back to where I came from, which is to the land, put my energy and my thoughts into what I'm doing with the land, whether it's working in the lo'i, watering the yard, whatever the case may be, dancing. And it helps me to realign myself back to where I should be in my life.

The natural elements of the land, mountain, ocean, rain, wind, and stars provided a source of “serenity,” an avenue to release “pilikia” (troubles), a sense of belonging, and relaxation or calm. Relationship with the natural elements provided a sense of belonging to something that felt natural and served to take away or “lift” their problems, removed from the violent experiences they encountered. Participants described seeing, particularly, the ocean and mountains as landmarks, which signified home, “I feel that's home, that's home.” This sense of feeling “at home” was also conveyed in the need to establish or re-establish relationships with their community or the place they came from. “It starts at home with the family” was a phrase emphasized by participants. While most participants learned about IPV through their family experiences, they also recognized that prevention begins with the family: “… the family would be your prevention whereas community organizations would come in as your intervention.” A need also expressed by participants was to look out for each other within a community or neighborhood. Remembering that this was prominent when growing up, participants identified the need to look out for children and their parents as a valued resource for families within the same neighborhood.

The participants' children are important to them, including teaching them how to respond appropriately to situations without hurting another person, understanding appropriate roles for males and females, and introducing cultural practices or family routines in their lives. Leaving this legacy was important to participants as it reflected how participants raised or would raise their children.

Discussion

Summary of Findings

Concerted efforts to address violence among Native Hawaiians have reinforced a culturally integrated approach to a community’s strategy (Kana`iaupuni et al., 2005; Wilcox & Armstrong, 1996). Research with Native Hawaiians has also suggested that a “strong ethnic affiliation is an important component of resiliency for witnessing, experiencing, and perpetrating violence” (Austin, 2004, p. 742). Innovative programs focused on improving Native Hawaiian well-being have incorporated cultural values, beliefs, and practices (Affonso, Shibuya, & French, 2007; Kana`iaupuni et al., 2005; Mokuau, 2002).

Similarly, needs identified by participants in this study go beyond common organizational responses to IPV and are specific to their cultural group. Perceptions that “it starts at home,” was a common theme identified by participants. This perception serves as an appropriate metaphor to understanding implications for families, communities, and health care providers. `Ohana, of both the earthly and spiritual world, serves as a source of knowledge, strength, security, and unifying force for Native Hawaiians (Kana`iaupuni et al., 2005; Pukui, Haertig, & Lee, 1972). Learning about behavior (how to respond) and gender roles and relationships are derived and affirmed originally from the `ohana. Approaches to influence generational behavior which harm an intimate partner, therefore, begins with the `ohana – past, present, and future. Living within and defending this collective (of the family) is a unique cultural perspective of IPV, expressed by participants, in comparison to the individualized perspective of the American culture.

While the knowledge shared by family members, directly or indirectly, may be considered a risk factor, the traditional functioning of the `ohana can also serve as a protective factor in keeping family members safe, unique and different from the traditional Western response of seeking professional health or human services. Participants recognized that re-connecting to their cultural base helped to reclaim their identity.

Communities, and the resources they provide are vital to addressing IPV. While participants acknowledge the value formal systems of Western care provide (shelters, treatment, support groups), this infrastructure alone is not enough to address the historical trauma of colonization (Oetzel & Duran, 2004). Community resources that go beyond the traditional Western systems of care include, not only those basic to survival as food and water and its traditional system of cultivation and access, but natural elements, landmarks, patterns, neighbors, and communal events that create a sense of belonging that this is “home.” Identifying the importance of belonging to a place and the meaning places and the land have in the healing process is unique and significant for indigenous peoples. Community-based action derived from the strengths and resources within each community ensures cultural appropriateness and community ownership – preventing outsiders from coming in to “fix” the problem (Oetzel & Duran, 2004). These findings are consistent with “hearing the voices of marginalized people”, a goal of Critical Social Theory. Actions recommended by the participants are consistent with the goal of CBPR.

Implications for Practice

Implications for health care providers require understanding of how best to facilitate an individual’s access to “health” vs. access to “health care.” The needs expressed by Native Hawaiian participants (“what gives you life?”) reflect what they need to access “health,” or ola, meaning life, well-being. While there is a common understanding of the components to accessing health care (availability of health provider, geographic proximity, insurance, income, need for care, willingness to utilize services, etc.), there is less understanding about an individual’s need to access “health” from a cultural perspective. Components of accessing “health” from a Native Hawaiian perspective do not all reside with Western health care systems and providers. Characteristics that distinguish access to health vs. health care include the: a) place where the intervention occurs, b) provider of care, c) sense of time (analog vs. natural time), d) type of intervention, and e) the context (historical vs. present focused).

The place where the intervention occurs is differentiated as a health care organization being the place where health care is accessed, and the home, community, or place you come from being the place where health is accessed. Similarly, the provider of care is commonly a health care professional when accessing health care, and family, elders, or self when accessing health. A sense of time is experienced differently when accessing health. Natural time, understood through seasons or generations, is consistent with Native Hawaiian life. On the other hand, health care presents time limitations with the type of interventions prescribed through appointments, treatments, procedures, and provider-patient interactions. Interventions to accessing health are more focused on relating with the natural elements, engaging in exercise (subsistence activities), and building or maintaining relationships (family, spirit, and place or community). Finally, the context of health care represents a person's present issues of self (illness or disease, needs, problems), and their or their family's past medical history, and the treatment necessary to alleviate or reduce symptoms or barriers interfering with activities of daily life. Different from health care is understanding the context of health as a historical accumulation of experiences that are generational. These experiences, in particular, relate to the impact cultural, socio-political, and environmental events have cumulatively had on a distinct population. Therefore, family, community members, natural leaders, community organizations, and health care professionals must advocate for and support access to the natural elements and the natural familial and community infrastructures that serve to cultivate health and safety.

Limitations

Although part of a larger study (with aggregate findings being developed in a separate paper), the limitations of these findings include first, that participation was limited to women from one Native Hawaiian community in Hawaii. The sample size of 10 women was small and a larger sample size encompassing several Native Hawaiian communities, in Hawaii and beyond, would strengthen the findings and determine its transferability. Second, even though all participants were self declared Native Hawaiians and lived in a Native Hawaiian community, the general themes may not necessarily have been shared by all participants. Third, recruitment was limited to purposive sampling. Women who accessed CHC services and were willing to discuss IPV consented to participate in this study. The perspectives of these women may be different than others in the community who were not willing to participate. Finally, this study focused on responses from women and how they perceived they, their family, partner, and partner's family understood and responded to IPV. Interviews with family members of Native Hawaiian women who experienced IPV and additional partner/relationship data from the violent experience may have provided broader understanding of this phenomenon.

Despite these limitations, the findings present consistent evidence to focus the development of effective interventions on cultural concepts, values, and practices that are consistent with each cultural group. The CBPR team continues to work on developing a pilot intervention based on the findings from this study, and has expanded to include a direct service provider of IPV providers.

Community involvement is critical to not only understanding perceptions, responses and needs, but participating in the design and implementation of future interventions. Multiple factors influence perceptions and responses to IPV. Listening and engaging the participants, a part of the CBPR process, revealed that this complex issue which is mediated within families and communities is best addressed with their full participation.

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