CALD Family Violence
Resource for Health Practitioners

Working with Asian, Middle Eastern and African women and families
Disclaimer

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This resource is available in limited paperback edition and also available in PDF version, as well as a HTML online tool accessible via www.eCALD.com. NB: the HTML online version has additional video case scenarios not available in the paperback and the PDF versions.
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Overview

The Culturally and Linguistically Diverse (CALD) Family Violence resource provides a general guide and essential culture-specific knowledge and tools around family violence intervention for health professionals who work with clients from Asian, Middle Eastern and African backgrounds. The term ‘Family Violence’ in this resource refers to partner abuse, child abuse and neglect, as well as other interfamilial violence, such as in–law abuse. The resource contains research material and guidelines to enhance health professionals’ knowledge, attitudes and skills in intervention.

“I think they don’t act upon it until the abuse is really bad. I think they’re happy to go along the [child] protection line because they know what to do. But when it’s [partner abuse] prevention services, I think they don’t know how to intervene because they might feel, “Oh it is cultural? Are we doing the right thing?” Health Professional

The purpose of the CALD Family Violence Resource is to enable health professionals to gain understanding around what is required to provide culturally appropriate partner abuse screening and interventions.

Who this resource is for

This supplementary resource is for health professionals working in primary and secondary care services who have implemented the Violence Intervention Programme (VIP). The CALD Family Violence Resource complements eCALD® Services, CALD Cultural Competency Training Programme and District Health Boards’ VIP Training Programmes.

DHB-Specific Policies

There are DHB-specific policies relating to Family Violence/Partner Abuse Screening as well as Child Abuse and Neglect. Examples of what is available in the DHBs in the Auckland region include the following policies. :

<table>
<thead>
<tr>
<th>DHB</th>
<th>Document Name</th>
<th>How/where to access the document?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waitemata DHB</td>
<td>Family Violence/Partner Abuse Screening Child protection / child abuse &amp; neglect policies</td>
<td>Waitemata DHB Quality Controlled documentation located on WDHB Intranet under Policies</td>
</tr>
<tr>
<td>Auckland DHB</td>
<td>Partner Abuse Intervention - Family violence Starship’s Abuse and Neglect Policy</td>
<td>ADHB Quality Controlled documentation located on ADHB intranet under Policies</td>
</tr>
<tr>
<td>Counties Manukau Health (CMH)</td>
<td>Family Violence Intervention Procedure Child protection / child abuse &amp; neglect policies</td>
<td>CMH Documentation Directory located on Southnet</td>
</tr>
</tbody>
</table>
What this resource aims to do

The purpose of the CALD Family Violence Resource is to enable health professionals to:

- Understand the risk factors for partner and child abuse in Asian, Middle Eastern and African communities.
- Understand cultural perspectives about family violence (which includes partner abuse, child abuse and in-law abuse) in Asian, Middle Eastern and African communities.
- Understand the CALD family violence dynamics which hinder disclosure and access to services for CALD women and children, including immigration and residence issues.
- Be aware and show sensitivity when dealing with shame and stigma, and other cultural issues when screening for partner abuse.
- Become familiar with how to provide culturally appropriate partner abuse screening and interventions, including child abuse and neglect.
- Understand safe screening practice for CALD clients who are the victims of family violence especially when working with interpreters.

What this resource does not include

- Family violence community prevention programmes.
- Interventions with perpetrators.
- Male victims of abuse.
- Elder abuse (this is addressed in the CALD Older People Resource for Health Providers: Working with Asian, Middle Eastern and African older people which can be accessed on www.eCALD.com).

Recommended background learning for this resource

This resource is not a stand-alone document. Viewers are required to:

- have completed CALD 1: Culture and Cultural Competency.
- have completed your own organisation’s Violence Intervention Programme core training.
- be familiar with VIP related policies, procedures and protocols on Family Violence/Partner Abuse Screening and Intervention and Child Protection and Neglect policies.

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1 Note the Crimes Amendment Act (No 3) 2011 which took effect on the 19th March 2012, strengthens provisions in the Crimes Act 1961 particularly in relation to violent and sexual offending. The Act applies to adults living in the same household as the child, or to those so closely connected that it is reasonable to consider them members of the household. This includes staff members at a hospital, institution, or residence where the child lives. [http://www.legislation.govt.nz/act/public/2011/0079/latest/DLM3650006.html](http://www.legislation.govt.nz/act/public/2011/0079/latest/DLM3650006.html).
“Culture plays a significant role in how family violence is perceived, how the issue is dealt with, and further, the options available to victims. Thus it becomes important to explore the cultural barriers CALD women face and how these barriers influence CALD victim’s help-seeking behaviours” (Lay, 2006).

It is highly recommended that users have completed the following CALD courses, which provide learners with information on working in a culturally competent way with CALD migrants, refugees, and interpreters:

- CALD 1 Culture and Cultural Competency (a pre-requisite).
- CALD 2 Working with Migrant Patients.
- CALD 3 Working with Refugee Patients.
- CALD 5 Working with Asian mental health clients.
- CALD 4 Working with Interpreters (highly recommended).
- CALD 7 Working with Religious Diversity.
- CALD 9 Working in a Mental Health Context with CALD clients.

Please enrol for courses through the eCALD® Services, CALD Resources site www.eCALD.com

How this resource is organised

Introduction: Overviews the scope of the resource and what the resource aims to achieve.

Background: This section provides an introduction to the topic, including an overview of who are our CALD populations, definitions of family violence, partner abuse, child abuse and neglect; and the health and social consequences of family violence.

Recapping CALD: For those who have completed CALD training this is an easy reminder of the relevant points regarding migrant groups.

CALD Cultural Perspectives: This section provides an overview of Asian, Middle Eastern and African background community cultural/religious perspectives on family violence.

Asian Communities: Describes Asian community’s cultural and religious perspectives around family violence; and looks at the beliefs and practices specific to Chinese, Korean, Cambodian, Vietnamese, Indian and Sri Lankan communities.

Middle Eastern and African Communities: Describes Middle Eastern and African community’s cultural and religious perspectives around family violence.
**Supporting Partner Abuse Disclosure:** This section looks at the cultural and religious factors which hinder disclosure, offers tips on how to make screening safe for CALD women; as well as providing tips for assessing the need for an interpreter and working with an interpreter.

**Case Studies:** This section provides some family violence case studies to reflect on.

**Resources and references:** This section includes a list of culture and language appropriate services for CALD family violence victims, a glossary of abbreviations; references and power and control wheels.

Guidelines are offered throughout as 'Implications for Practice'.
Background

Introduction

This CALD Family Violence Resource is informed by New Zealand and international literature. The goal is to inform health professionals about cultural differences in the ways that family violence presents and interventions “that work with culture, not against it or without it” (Yick & Oomen-Early, 2009 p. 135).

Violence and abuse cause significant and cumulative health harm. The longer violence and abuse continues, the worse the harm to child and adult victims (Fanslow, Chalmers & Langley, 1991; Feletti & Anda, 2009; Feletti et al., 1998). Victims of violence use services at approximately three times the rate of people who are not victimised (Fanslow & Robinson, 2004; Krug et al., 2002; Koss, Koss & Woodruff, 1991). The Adverse Childhood Experiences (ACE) study suggests that being a victim of child abuse and/or witnessing partner abuse is linked to serious health conditions in adulthood (Felitti et al., 1998). To reduce health and social harm, identification and intervention by health professionals’ of child and adult victims is critical.

Diverse cultural, linguistic and religious groups have their own social norms and values. Specific cultural and religious practices and beliefs will determine the form that family violence takes in each community. How and when migrant and refugee women decide to access formal assistance is embedded in a larger socio-cultural context including collectivist family and religious beliefs, family and extended family structures, community belonging, and access to health, social and legal services.

Pan et al. (2006) have identified six key issues in the literature on addressing family violence in CALD communities. These are (Pan et al., 2006):

1. Cultures’ definitions of family violence.
2. Cultures’ specific definitions of family harmony, gender roles and conflict resolution strategies.
3. Recognition of the client’s cultural identity and spirituality.
4. The cultural competency of health and social service providers.
5. The availability of interpreting services.
6. Cross-cultural support in health and social support services.

These issues will be discussed as we proceed through this resource.

As health professionals we need to understand the cultural context in which family violence takes place and how to intervene successfully to protect women and children.

While general guidelines are offered for family violence interventions for CALD groups in this resource, it must be remembered that Asian, South Asian, South-East Asian, Middle Eastern and African (MEA) groups are extremely diverse, and values and traditions vary across ethnicities, cultures, religions and countries. Cultural groups have their own cultural norms, values and practices, which will determine their response to family violence. Communities have different
definitions of abuse, and conceptualisations of family violence vary across communities and from one country to another (Fernández, 2006; Midlarsky et al., 2006).

Family violence interventions in New Zealand, for example, screening for partner abuse, are based on Western concepts of the nuclear family, which may be dissonant with Asian, Middle Eastern and African women’s collective cultural values and expectations. Additionally, if women do not recognise a situation as abusive, they are less likely to seek help.

Health professionals’ knowledge of their client’s cultural and religious backgrounds, and how this may impact on women’s responses to abuse, is critical to facilitating disclosure of partner abuse and appropriate intervention.

Who are CALD populations

Culturally and Linguistically Diverse (CALD) populations in New Zealand refers to peoples from Asian, South Asian, Middle Eastern, Latin American and African backgrounds.

Asian people

In the 2013 Census, in the Auckland Region, 22% (298,554) of the population was Asian. The biggest Asian groups were Chinese and Indian, each accounted for over a third of Asian ethnicity responses. Koreans were the biggest group in the Other Asian category. Thirteen percent of the Asian population spoke no English. Twenty-one percent of the Asian population in the Auckland Region were born in New Zealand (Walker, 2014).

For this resource we have created broad groupings based on cultural similarities. Our groupings are as follows:

East Asian: People who have migrated from China, Japan, Taiwan, Mongolia, South Korea, North Korea, Macau and the Philippines.

South East Asian: People from Vietnam, Cambodia, Malaysia, Singapore, Indonesia, Thailand, Philippines, Burma, Brunei, East Timor, and Laos.

South Asian: Includes people originating from India, Sri Lanka, Nepal, Pakistan, Bangladesh, Afghanistan, Bhutan, the Maldives and Fijian Indians.
Middle Eastern, Latin American and African people

The Middle Eastern, Latin American and African (MELAA) ethnicity grouping consists of extremely diverse groups with dissimilar cultures, religions and backgrounds. In 2013, in the Auckland Region, two percent (23,682) of the population was Middle Eastern/Latin American/African (MELAA). For the MELAA population about half are Middle Eastern and a quarter each for African and Latin American ethnic groups. Twenty- one percent of the MELAA population in the Auckland Region were born in New Zealand (Walker, 2014). This group is one of the fastest growing population groups in the Auckland region (Perumal, 2011).

Defining family violence, partner abuse and child abuse and neglect

The following terms and definitions will be used through-out this document (Fanslow, J. L. Family Violence Intervention Guidelines. Wellington: Ministry of Health, 2002).

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child</td>
<td>In this document the word child refers to children/tamariki aged 0-14 years inclusive. Note that the Child, Young Persons and their Families Act covers young people up to their 17th birthday.</td>
</tr>
<tr>
<td>Child Protection</td>
<td>Activities carried out to ensure the safety of the child in cases where there is abuse or risk of abuse.</td>
</tr>
<tr>
<td>Child Abuse</td>
<td>The harming (physically, emotionally, or sexually), ill treatment, abuse, neglect or serious deprivation of any child/tamariki, or young person (Section 14b Children, Young Persons and their Families Act, 1989).</td>
</tr>
<tr>
<td>Physical Abuse</td>
<td>Child physical abuse is any act or acts that may result in inflicted injury to a child or young person.</td>
</tr>
<tr>
<td>Child Sexual Abuse</td>
<td>Child sexual abuse is any act or acts that result in the sexual exploitation of a child or young person, whether consensual or not.</td>
</tr>
<tr>
<td>Child Emotional/ Psychological Abuse</td>
<td>Child emotional/psychological abuse is any act or omission that results in impaired psychological, social, intellectual and/or emotional functioning and development of a child or young person.</td>
</tr>
<tr>
<td>Neglect</td>
<td>Child neglect is any act or omission that results in impaired physical functioning, injury, and/or development of a child or a young person. This includes physical and medical neglect, neglectful supervision, abandonment and refusal to assume parental responsibility.</td>
</tr>
<tr>
<td>Family Violence</td>
<td>Violence or abuse of any type, perpetrated by one family member against another family member. It includes child abuse, partner abuse and elder abuse.</td>
</tr>
<tr>
<td>Physical Abuse</td>
<td>Includes acts of violence that may result in pain, injury, impairment or diseases, may include hitting, choking or in any way assaulting another person, and also under/over medication. There is usually visible evidence of physical abuse (bruising, fractures, burns, lacerations etc) though the difference between accidental injury and abuse can be slight and require expert investigation.</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
</tr>
<tr>
<td>------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Psychological/Emotional Abuse</td>
<td>Includes any behaviour that causes anguish or fear. Intimidation, harassment, damage to property, threats of physical or sexual abuse, removal of decision-making powers (in relation to adults) and (in relation to a child) exposing the child to physical, psychological or sexual abuse of another person. Concerted attacks on an individual’s self-esteem and social competence results in increased social isolation.</td>
</tr>
<tr>
<td>Sexual Abuse</td>
<td>Includes any forced, coerced or exploitive sexual behaviour or threats imposed on an individual, including sexual acts imposed on a person unable to give consent, or sexual activity when an adult with mental incapacity is unable to understand.</td>
</tr>
<tr>
<td>Partner Abuse (also called intimate partner violence)</td>
<td>Physical or sexual violence, psychological/emotional abuse, or threat of physical or sexual violence that occurs between intimate partners. Intimate partners include current spouses (including de facto spouses), current non-marital partners (including dating partners, heterosexual or same-sex), former marital partners and former non-marital partners.</td>
</tr>
<tr>
<td>Routine Screening</td>
<td>Routine enquiry, either written or verbal, by health care providers to patients about personal history of partner abuse. Unlike indicator-based questioning, routine questioning means routinely questioning all women aged 16 years and over about abuse. The enquiry is usually made within the social history.</td>
</tr>
<tr>
<td>Young Person</td>
<td>14-17 years old.</td>
</tr>
</tbody>
</table>

**Health and social consequences of family violence**

Family violence impacts on parenting ability (Chetty & Agee, 2009; Feletti & Anda, 2009; Feletti et al., 1998). International and New Zealand studies show that a mother’s exposure to family violence could impair her parenting capacity, including her ability to perceive the psychological trauma being caused to her children, as well as her ability to protect them and to facilitate their development (Card, 2004; Chetty & Agee, 2009; Hester et al., 2000; Ososky, 2004; Zuckerman & Augustyn, 1995). A New Zealand study of young migrants of Indian origin highlights the added vulnerability of migrants who do not have their extended families to turn to (Chetty & Agee, 2009). Learners need to review VIP core training for the health and social consequences of family violence.
Family violence: A summary of ways that abuse can occur

<table>
<thead>
<tr>
<th>Physical violence</th>
<th>Using isolation</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Hitting, punching, kicking.</td>
<td>• Controlling what she does, who she sees, who she talks to and where she goes.</td>
</tr>
<tr>
<td>• Withholding medications.</td>
<td>• Limiting her involvement with others.</td>
</tr>
<tr>
<td>• Attempting to force miscarriage.</td>
<td>• Using jealousy to justify his action.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sexual violence</th>
<th>Using economic abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Forced sexual activities.</td>
<td>• Preventing her from getting or keeping a job.</td>
</tr>
<tr>
<td>• Forced prostitution or exotic dancing.</td>
<td>• Forcing the victim to work “under the table”.</td>
</tr>
<tr>
<td>• Threatening to sexually abuse children.</td>
<td>• Taking the victim’s earned income.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Using coercion or threats</th>
<th>Using children</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Making and/or carrying out threats to hurt her.</td>
<td>• Using children to relay intimidating or threatening messages to her.</td>
</tr>
<tr>
<td>• Threatening to leave her, to commit suicide, to report her to welfare or immigration officials.</td>
<td>• Threatening to take children away from her.</td>
</tr>
<tr>
<td></td>
<td>• Using visitation to harass her.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Using intimidation</th>
<th>Minimising, denying and blaming</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Making her afraid by using looks, actions or gestures.</td>
<td>• Saying the abuse didn’t happen.</td>
</tr>
<tr>
<td>• Smashing things and destroying her property.</td>
<td>• Saying she caused the abuse.</td>
</tr>
<tr>
<td>• Displaying weapons as a threat to harm her.</td>
<td>• Making light of the abuse.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Using emotional abuse</th>
<th>Using assumed male privilege</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Putting her down and making her feel bad about herself.</td>
<td>• Expecting subservience based on her perceived status as a woman.</td>
</tr>
<tr>
<td>• Making her think that she is “crazy”.</td>
<td>• Making relevant decisions unanimously.</td>
</tr>
<tr>
<td>• Humiliating her and calling her names including racial slurs.</td>
<td>• Being the one to define the male and female roles in their relationship.</td>
</tr>
</tbody>
</table>

(From: Weber & Levin, 2003)
Recapping CALD

An overview

Some key points are summarised here for viewers of this resource who have not yet completed CALD modules 1-4 and 7, and for viewers who completed these modules some time previously. It is highly recommended that viewers access this information as understanding cultural values and practices is relevant to how women respond to partner abuse and their willingness to disclose. It is important to remember that:

1. Cultural competency requires awareness, sensitivity and knowledge, and the ability to apply these in practice.

2. Many migrants from CALD backgrounds face settlement challenges establishing a new life in an unfamiliar culture and society, including understanding a significantly different health system. Language and cultural barriers, as well as discrimination, prejudice and stereotyping are experiences common to many CALD migrants.

3. Refugees often face these same challenges overlaid with traumatic experiences. The refugee experience is of civil war, multiple loss of family and community support, dangerous journeys of flight, and often long periods in refugee camps. Many have little or no choice over their destination and no possibility of returning home if families do not settle well. Refugees often have higher mental health needs than migrants.

4. Professional interpreters need to be provided for clients who have little or no English language proficiency. Family or friends should not be used as interpreters for health settings unless in an emergency.

5. Health professionals need to know how and when to work with interpreters, have a clear understanding of their roles, know how to brief the interpreter, and how to structure a session. Translated resources need to be offered to clients where available.

6. Culture and religious backgrounds will influence whether women seek help, how they communicate their experiences, and from whom they are likely to seek assistance.
**Implications for Practice**

When working with CALD migrant groups, health professionals need to understand how migration, the refugee experience, acculturation and systemic barriers, such as failure to use professional interpreters may further jeopardise vulnerable groups.

It is recommended that health professionals:

• Understand the various cultural forms of victimisation of migrant women
• Have broad understandings of migration experiences for CALD women
• Thoroughly understand the woman’s presenting situation and have confidence in working with an interpreter
• Understand the role of family and communities in CALD women’s lives
• Have access to adequate supervision with a cross-cultural framework to ensure ongoing reflective practices.
CALD Cultural Perspectives

Introduction

This section provides an overview of Asian, Middle Eastern and African community cultural perspectives on family violence, while the following two sections will provide cultural perspectives on family violence specific to:

- **Asian communities**
  - South East Asian communities
  - East Asian communities
  - South Asian communities
- **MEA communities**
  - Middle Eastern communities
  - African communities

A woman’s immigration status plays a significant role in her susceptibility to abuse. Included in this section, are differing perceptions of what defines abuse in ethnic communities; triggers for family violence post migration and; issues of vulnerability for migrant, refugee, and non-English speaking women.

Women from culturally diverse backgrounds may face cultural and language barriers to using health services and may be under-served as health populations. Migrant women in situations of family violence are particularly at-risk during pregnancy. There is a linkage between family violence and poor mental health in migrant women.

Asian women and children in New Zealand have the poorest access to women’s refuge services compared to all other ethnic groups (Ministry of Social Development, 2011). New Zealand and international literature suggests that family violence in Asian, refugee and other CALD migrant families is heavily stigmatised and is under-reported (Boutros et al., 2011; Department for Community Development, Government of Western Australia, 2006; Family Violence Prevention Fund, 2009; Mehta, 2012; Rees & Pease, 2007).

**Family violence defined in migrant communities**

Definitions of family violence are not universally understood or accepted by CALD families, for example, when asked to define abuse; over a third of Chinese American women surveyed associated abuse only with physical violence. Most mentioned hitting and striking, beating and fighting but fewer mentioned sexual, emotional, and verbal abuse (Senturia et al., 2000).

The forms of psychological abuse used in cultural contexts have specific meanings and consequences, for example in the Sri Lankan Tamil community being threatened with being a “castoff wife” and sent back to a war-torn country has significant implications (Mason et al., 2008).
Immigration and family violence

Immigration issues play a significant role in the lives of women experiencing partner abuse. Uncertain immigration status can make women particularly susceptible to abuse by men who exploit that uncertainty as a tactic of power and control (Ministry of Women’s Affairs, 2007b). Women in the following situations are particularly at risk:

• Women who establish a relationship in their home country and immigrate to New Zealand with their partner, and the partner is the principal applicant for residency.
• Women who come to New Zealand and get residence independent of the men with whom they form relationships.
• Women whose applications for residence depend on the sponsorship of a partner who is a New Zealand resident or citizen. These women are especially vulnerable as they cannot talk to their own family and cannot return to their home country when abuse happens. There is a myth in Asian cultures that women married to men in a Western country are protected by law, respected by their husband and given all the freedom they want. Therefore, parents back home have difficulty accepting violence against their married daughters.
• Undocumented women, who are women on visitor’s permits; student visas; and those awaiting confirmation of refugee status (ie asylum seekers) etc.

It is important to tell women about their rights according to the Residence Policy for Victims of Family Violence (Immigration New Zealand, 2015).

What triggers family violence

Women from refugee backgrounds report that there are more incidents of domestic violence in their new societies than when they lived in their countries of origin (Bhuyan & Senturia, 2005; Reese & Pease, 2007; Semlak et al., 2008).

The process of settlement can assist the strategies of abusers in many ways because:

• Isolation from family support prevents victims of abuse from speaking out about violence.
• Without the traditional support of family members women have fewer options to talk about violence.
• In new societies, women are also isolated because of unemployment, limited finances and inadequate English language skills.
• Social isolation includes being intentionally kept from social and community contact and from attending English language classes.

A New Zealand study of family violence in Asian communities found that the triggers for family violence related to difficulties in adjusting to living in a new country, in particular, finding suitable employment and experiencing financial hardship (Tse, 2003). Men’s dominance in some Asian families was an issue, especially when men saw control over their wives as a last resort to protect their cultural values and traditions.
Other triggers for family violence in migrant communities include:

- Settlement stress, especially for the first three years post migration
- Alcohol abuse by either partner
- Problem gambling
- Over-involvement of in-laws in the marriage

Ethnic community perceptions that family violence is a private matter and; women’s desire to keep their marriage intact are significant barriers to reporting partner abuse. It is also important to remember that divorced women, even when there is known abuse, lose all their social status in their community and are often ostracised.

**Migrant women are particularly vulnerable**

Women from culturally diverse backgrounds whether from new migrant or long settled communities face many of the same challenges as any other abused women. However, those new to New Zealand have more barriers to accessing resources and support (Ministry of Women’s Affairs, 2007a; 2007b; Tse, 2007). Women’s cultural and religious beliefs and their legal status can increase their vulnerability to abuse. There are a number of factors which contribute to the migrant women’s vulnerability to partner abuse. These include the following issues:

- **Family, face saving, faith, custom and fate**

  In many CALD migrant/refugee groups, the family is regarded as the unit of central importance. There is strong pressure to keep the family together and the strong sense of familialism can hinder women’s willingness to escape from, disclose, or report their partners’ abuse. This also works in reverse in that although it may hinder help-seeking, the strong sense of familialism can provide women with a sense of belonging, and may provide support and care from family members.

  There is also strong pressure to avoid shaming the family, which is likely to hinder women’s efforts to seek outside help for “family” problems. These feelings can prevent them from taking action to protect themselves.

  Strong religious beliefs that marriage is a sacred vow and cannot be broken also contribute to some women refusing to report partner abuse and to leave violent relationships.

  A belief in fate has been identified as playing a significant role in CALD migrant/refugee women’s responses to partner abuse. Women may accept their partners’ violence as fate and believe (or be led to believe) that they have little control over it.

  Religious belonging and faith are central to the lives of many migrant and refugee families and communities.

  Strong social pressures in faith-based communities to not separate or divorce may mean that women endure abuse that is prolonged and severe before leaving (Khawaja, Linos et al. 2008).
A number of studies have found that faith provides survivors of family violence the strength for healing and allows many to accept themselves, let go, and move on with their lives (Hassouneh-Phillips, 2003).

It is essential that health professionals understand the significant influence that belief systems have on women, abusers, and their communities. Importantly, women’s religious beliefs can provide healing and reduce the occurrence of secondary victimisation.

**Social Isolation and lack of family networks**

Abusers, frequently use isolation to keep women from understanding their situation, from seeking help, and from leaving a violent relationship. Women’s self-sufficiency challenges abusers’ dominance and control (Midlarsky et al., 2006).

New migrant women are particularly vulnerable when socially isolated in a new society because they leave their networks of family and friends behind when they migrate. Prior to migration, many Asian, Middle Eastern and African women have lived in extended families who provide social support, including emotional comfort, material support, and the constant presence of a family network (Kasturirangan et al., 2004). As a result of migration, most women lack the support of kin and non-kin social networks that would be available in their country of origin. This isolation can enhance feelings of helplessness and despair, leaving migrant women with little access to the outer world (Midlarsky, 2006).

Raj and Silverman (2003) showed that women reporting no family in the United States were three times more likely than those with family to have been physically injured by their current partner.

**Family values**

Cultural attitudes towards violence, and towards separation and divorce, and the desire to ‘keep the family together’ may pressure a woman to remain with her violent partner.

In Asian, Middle Eastern and African cultures, when marital conflicts occur, older family members frequently serve as mediators or inhibitors of violence (Kasturirangan et al., 2004; Yoshioka et al., 2001). Extended families may serve as a buffer to partner violence, providing social support, financial resources, child care, and protection for women (Lee & Hadeed, 2009).

However, *conflict with in-laws or in-law abuse* (eg from a mother-in-law) has been found to be an additional risk factor relating to family violence in Asian communities (Bhuyan et al., 2005; Dasgupta, 2000; Fernandez, 1997; Lee & Hadeed, 2009; Ryu, 2010).

**Dependency through low or no English language and literacy skills**

Women who are new migrants may experience heightened dependency economically and emotionally on their spouses (Kasturirangan et al., 2004). Tactics such as hindering women from learning English, curtailing their social activities, and providing inadequate financial support are
used as a means of control. In extreme cases, women may be forbidden from leaving the home (Abraham, 2000; Dasgupta, 2000).

• **Uncertainty around accessing help**

Social isolation combined with the lack of awareness of family violence services prevents abused migrant women from seeking help (Yoshioka et al., 2003). A lack of knowledge around how to access alternative housing, income, legal and support services make it difficult for women to leave their partners (Lay, 2006). Additionally, women may be unaware of the New Zealand laws prohibiting family violence and therefore unaware of their rights under New Zealand law.

• **Forced Marriage**

Forced marriage has been identified as an emerging issue in New Zealand in some migrant communities. Forced marriage is defined by Police, Child Youth and Family, Work and Income and Family and Community Services (Ministry of Social Development) and the Ministry of Education in a letter of Agreement (2012) as:

> ... when a marriage is conducted without the valid consent of both parties where duress is a factor. Duress may include physical, psychological, financial, sexual and emotional pressure. Duress may occur prior to and during the arrangement of a forced marriage and continue once it has taken place.


**In-law conflict and family violence**

In-law conflict in this resource refers to the abuser of daughters-in-law by parents-in-law. Elder abuse is not discussed in this topic but is discussed in the CALD Older People Resource which can be found at [www.ecald.com](http://www.ecald.com).

As many Asian households are extended patrilineal households, comprising of parents residing with adult married sons, their wives and children, in-law conflict is of greater relevance than in Western households. Living within extended families may appear supportive, but it can also create increased levels of conflict with family members with high demands placed on women to fulfil a “tripartite role” of mother, wife, and daughter-in-law (Baldwin & Griffiths, 2009). Chan et al.’s (2008) study examines the correlation between in-law conflict and partner abuse against women in a cohort of
Chinese women in Hong Kong. The study shows that in-law conflict was the characteristic most significantly associated with women’s reports of violent victimisation in the family.

Women in a New Zealand study of family violence in Asian communities shared their experiences of in-law abuse (Tse, 2008). In these cases, husbands were often passive observers of violence against their wives by in-laws. The in-laws’ abuse towards or control over women included financial, emotional and physical violence. Abusive in-laws also allowed sons to act violently against the wife. A number of studies have illustrate the role of mothers-in-law as perpetrators of violence against their daughters-in-law (Ramanathan, 1996; Rianon & Shelton, 2003; Counts, Brown, & Campbell, 1999), including pregnant women (Dasgupta, 2000; Leung et al., 1999). In Tse’s (2008) New Zealand study a South Asian woman stated:

“My mother-in-law gave me a hard time … She knew that I was pregnant, but she made me carry heavy things, do all the housework then go to work without having a break first. My miscarriage happened because of stress.” (Tse, 2008).

Conflict with a mother-in-law has also been associated with wives’ postnatal depression (Lee et al., 2004).

In-law conflict is the characteristic most significantly associated with preceding-year abuse against pregnant women in Chinese and Korean studies (Chan et al., 2009; Ryu, 2010).

“My husband threatened me when I was pregnant saying that if I can’t bear him a son, he would not leave me alone. It was huge stress as a pregnant woman”. (Ryu, 2010).

**Migrant women who are abused are under-served as patients**

A Canadian study of migrant women who had experienced partner abuse found that health professionals’ responses were influenced by stereotypes about violence within migrant groups (Jiwani, 2001). Family doctors frequently missed the linkage between the effects of violence and women’s somatic complaints. Mental health issues were often not dealt with trivialised or were undiagnosed. A failure to examine mental health symptoms in the context of women’s lives was a major limitation on the disclosure of partner abuse (Jiwani, 2001).

**Link between family violence and poor mental health**

- Many abused migrant women report experiencing symptoms of depression, feelings of isolation, lack of social support, low sense of self-efficacy, and hopelessness (Lee & Hadeed, 2009). These are all factors that have been associated with an increased risk of attempted suicide among victims of abuse. Suicide has been associated with family violence, and has been a response to victimisation in migrant cultures, both as an escape mechanism and as a way of retaliation by bringing shame to the abuser and his family (Ting, 2010).

- In migrant women, psychological problems may be somatically expressed as physical symptoms including: fatigue; poor or disturbed sleep; headaches; chest and back pain; and menstrual...
Overview of challenges that prevent migrant women from disclosing family violence

“Culture influences how people view abuse: whether they seek help: how they communicate their experience and from whom they are likely to seek assistance.” (Weber & Levin, 2003).

The following chart shows the range of factors which may serve as barriers to CALD migrant women disclosing family violence including child abuse. Some CALD victims of family violence do not perceive themselves as victims of crime and therefore do not believe that they have rights as victims, nor do they consider themselves eligible for support services (Lay, 2006). While it is difficult for any women to disclose family violence, there are often additional barriers to disclosure for women from diverse cultural backgrounds.

Personal challenges
How to reduce fear of authorities

(Adapted from Weber and Levine, 2003)

<table>
<thead>
<tr>
<th>Fear of the Police</th>
<th>Fear of Immigration Authorities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Factors to consider</strong></td>
<td><strong>Factors to consider</strong></td>
</tr>
<tr>
<td>The victim may believe that her immigration status prevents her from seeking police protection and assistance.</td>
<td>If a woman is not a New Zealand resident, her abusive partner may threaten to contact immigration officials to have her deported. Women should be informed that as a victim of partner abuse, they can seek protection from such deportation (Immigration New Zealand, 2009).</td>
</tr>
<tr>
<td>A refugee or migrant woman’s negative experience with police in her country of origin or asylum may affect her expectations of police in New Zealand.</td>
<td>Women need to be reassured that it is safe to report family violence to police in New Zealand. Further, as above women need to be informed that they can seek protection from deportation, as a victim of family violence.</td>
</tr>
<tr>
<td><strong>Critical information for the patient</strong></td>
<td><strong>Critical information for the patient</strong></td>
</tr>
<tr>
<td>Disclosing abuse to a health professional does not imply that the police will be contacted (refer to DHB Partner Abuse Intervention policy on disclosure).</td>
<td>The victim does not jeopardise her immigration status by seeking medical treatment for her injuries.</td>
</tr>
<tr>
<td>Protection orders are available.</td>
<td>Family violence victims who rely on their abusers for immigration status should consult with lawyers who have expertise in family violence and immigration matters.</td>
</tr>
<tr>
<td>Health professionals can help establish a plan of safety for the victim and her children, as well as provide referrals for them (refer to DHB Partner Abuse Intervention policy).</td>
<td>The abuser does not have the power to have immigration officials deport the victim. Inform the victim of the Residence Policy for Victims of Family violence (Immigration New Zealand, 2015). Refer to S4.5 Residence Category for victims of domestic violence on the Immigration NZ website: <a href="http://onlineservices.immigration.govt.nz/opsmanual/42635.htm">http://onlineservices.immigration.govt.nz/opsmanual/42635.htm</a>.</td>
</tr>
</tbody>
</table>
Fear of the Police | Fear of Immigration Authorities
---|---
If necessary allow the patient to call the family violence hotline or the police from a safe and private place. | Counselling and other social services may be available in the victim’s language and may be offered by health professionals/services who understand her culture/religious background.

Means of support | The victim may be eligible for welfare assistance.

What you can do

- Emphasise that the health professional and the interpreter are bound by patient confidentiality—unless there is threat of serious harm to the patient, children or others.
- Confidentiality of disclosures – advise and reassure the patient/client that any details will be kept secure and not given out without authority – unless people are in danger. In the case of serious harm to the patient or others the Police and/or Child, Youth and Family will be informed. Consult with experienced staff first if possible.
- Where relevant, inform the victim of the *Residence Policy for Victims of Family violence* in New Zealand.
- Inform the patient that there is expert legal assistance available to her.
- Refer the victim to trustworthy and confidential cultural support (if available).

If there are any concerns for the safety of patients, contact hospital security and/or the Police as per DHB policy. NB If the healthcare provider believes a patient/client’s life is in danger, or has good reason to believe that the patient/client is unable to extricate themselves from a high level of ongoing, life-threatening danger; the, Police or Child Youth and Family Service may be notified without patient/client permission.
Asian communities

Summary of cultural differences between Asian communities

When we talk about Asian communities, for simplicity’s sake we attempt to generalise. However, we need to bear in mind that Asia is a very large and culturally diverse continent and additionally that not all Asian people are Asian born. There are a number of groups to acknowledge, including New Zealand born generations of Asian people, Asian communities who are born elsewhere, e.g., Indians born in South Africa, Zimbabwe and Fiji. Be aware that the following generalisations will not apply to all families and groups.

In general, Asian communities are not responsive to incidents of family violence. There is a strong sense of shame associated with family violence and Asian families and communities are more likely to support the notion that family violence is a private matter and to be less receptive to outside intervention (Fanslow et al., 2010). Disclosure damages the whole community’s reputation, and is seen to bring shame to the ethnic community concerned, and to children and families. If women start to disclose violence, it becomes a “community affair”.

“Women represent the ambassadors of their country. Women feel that they have to take the violence rather than speaking up.” (Tse, 2007).

Health professional’s knowledge of their client’s cultural/religious needs and of the impact of family dynamics is critical to gaining disclosure, and to their client’s acceptance of support from health service providers.

The following table summarises the cultural differences in family structures between East Asian, South East Asian and South Asian groups, and the impact on family violence disclosure. Please note that the statements are generalisations and will not represent all views or practices in families from all Asian backgrounds. The statements are intended to provide perspectives on cultural practices, which may influence a woman’s willingness to disclose and to accept health professional intervention. However, to avoid stereotyping, it is essential that all families and clients are assessed individually.
### Attitudes in general towards partner abuse

<table>
<thead>
<tr>
<th>East Asian communities (from China, Japan, Taiwan, Mongolia, South Korea, North Korea, Macau, Philippines)</th>
<th>South East Asian communities (from Vietnam, Cambodia, Malaysia, Singapore, Indonesia, Thailand, Philippines, Burma, Brunei, East Timor, Laos)</th>
<th>South Asian communities (from India, Sri Lanka, Nepal, Pakistan, Bangladesh, Afghanistan, Bhutan, the Maldives and Fijian Indians)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• The husband/wife relationship is an important relationship that is marked by a distinctive authority structure where husbands are the head of the household, and wives are to be obedient and subservient with the sole purpose of keeping the family intact.</td>
<td>• Men are respected, as they are the head of families, and are trustworthy and loyal.</td>
<td>• As with other Asian cultures the patriarchal family head is important.</td>
</tr>
<tr>
<td>• 'Saving face' is an important value and if breached there can be harsh consequences for women.</td>
<td>• There is a strong value on keeping the family together, and divorce is thought to be detrimental to the family and the children.</td>
<td>• Women are taught that the public image of the family is more important than individual safety.</td>
</tr>
<tr>
<td></td>
<td>• Partner abuse is often viewed as the woman’s fault, such that divorced women are viewed with disapproval in the community.</td>
<td>• Psychological abuse may include threats to ruin a woman’s reputation among relatives, accusing women of being a traitor to her culture and community.</td>
</tr>
</tbody>
</table>

### Relationships and Expectations

<table>
<thead>
<tr>
<th>East Asian communities (from China, Japan, Taiwan, Mongolia, South Korea, North Korea, Macau, Philippines)</th>
<th>South East Asian communities (from Vietnam, Cambodia, Malaysia, Singapore, Indonesia, Thailand, Philippines, Burma, Brunei, East Timor, Laos)</th>
<th>South Asian communities (from India, Sri Lanka, Nepal, Pakistan, Bangladesh, Afghanistan, Bhutan, the Maldives and Fijian Indians)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Underlying “moral code” that exists about what situations justify the use of violence.</td>
<td>• Women are seen as the guardians of familial relationships with their primary duty being to maintain harmony within the family.</td>
<td>• In traditional Indian cultures women face a range of expectations associated with the principle of “sewa” (selfless service).</td>
</tr>
<tr>
<td>• Adherence to traditional cultural or religious norms may hinder a Chinese woman from leaving an abusive relationship for fear of being labelled a bad mother or wife.</td>
<td>• An intact family is integral to a woman’s life achievements and to her self-worth.</td>
<td>• A dowry is given by the bride’s family to the groom and his family. If the dowry a woman brings to the family is not regarded as adequate, it can become a cause of abuse for a woman following marriage.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Honour and respectability are dependent on a successful marriage, and women fear the dishonour and rejection from their community if their marriage should fail.</td>
</tr>
</tbody>
</table>

### Role of family

<table>
<thead>
<tr>
<th>East Asian communities (from China, Japan, Taiwan, Mongolia, South Korea, North Korea, Macau, Philippines)</th>
<th>South East Asian communities (from Vietnam, Cambodia, Malaysia, Singapore, Indonesia, Thailand, Philippines, Burma, Brunei, East Timor, Laos)</th>
<th>South Asian communities (from India, Sri Lanka, Nepal, Pakistan, Bangladesh, Afghanistan, Bhutan, the Maldives and Fijian Indians)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• The family is the most fundamental social unit.</td>
<td>• The family is the most fundamental social unit.</td>
<td>• South Asian women tend to approach their family for</td>
</tr>
</tbody>
</table>
### East Asian communities (from China, Japan, Taiwan, Mongolia, South Korea, North Korea, Macau, Philippines)

- Within the household, informal power resides with the husband’s mother, and wives are expected to be obedient to their husbands and their in-laws.
- In-law conflict has particular relevance for Chinese women.
- In-law conflict is a significant characteristic associated with women’s reports of violent victimisation in the family.

### South East Asian communities (from Vietnam, Cambodia, Malaysia, Singapore, Indonesia, Thailand, Philippines, Burma, Brunei, East Timor, Laos)

- Within the household, informal power resides with the husband’s mother, and wives are expected to be obedient to their husbands and their in-laws.
- If there are problems in the marriage relationship, community members or the couple’s parents advise the couple, and a woman would be encouraged to stay with her husband.
- Although sympathetic, friends and relatives may not want to intervene because they see partner abuse as “a private matter”. Some family and friends may advise the abused women to “accept the abuse or try not to make the husband angry”.

### South Asian communities (from India, Sri Lanka, Nepal, Pakistan, Bangladesh, Afghanistan, Bhutan, the Maldives and Fijian Indians)

assistance. When family condemn the actions of the perpetrator and sympathise with the women, they are a great source of help. However, this is the exception rather than the norm.

<table>
<thead>
<tr>
<th>Challenges that prevent migrant women from disclosing family violence</th>
<th>East Asian communities (from China, Japan, Taiwan, Mongolia, South Korea, North Korea, Macau, Philippines)</th>
<th>South East Asian communities (from Vietnam, Cambodia, Malaysia, Singapore, Indonesia, Thailand, Philippines, Burma, Brunei, East Timor, Laos)</th>
<th>South Asian communities (from India, Sri Lanka, Nepal, Pakistan, Bangladesh, Afghanistan, Bhutan, the Maldives and Fijian Indians)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Fear for personal safety.</td>
<td>• Fear for personal safety.</td>
<td>• Fear for personal safety.</td>
<td></td>
</tr>
<tr>
<td>• Pressure from support systems not to talk.</td>
<td>• Pressure from support systems not to talk.</td>
<td>• Pressure from support systems not to talk.</td>
<td></td>
</tr>
<tr>
<td>• Fear of legal authorities.</td>
<td>• Fear of legal authorities.</td>
<td>• Fear of legal authorities.</td>
<td></td>
</tr>
<tr>
<td>• Concern about bringing shame to her family.</td>
<td>• Concern about bringing shame to her family.</td>
<td>• Concern about bringing shame to her family.</td>
<td></td>
</tr>
<tr>
<td>• Concern about being ostracised by her community.</td>
<td>• Concern about being ostracised by her community.</td>
<td>• Concern about being ostracised by her community.</td>
<td></td>
</tr>
<tr>
<td>• Fear of immigration authorities and police.</td>
<td>• Fear of immigration authorities and police.</td>
<td>• Fear of immigration authorities and police.</td>
<td></td>
</tr>
<tr>
<td>• Unaware that non-physical abuse constitutes family violence.</td>
<td>• Unaware that non-physical abuse constitutes family violence.</td>
<td>• Unaware that non-physical abuse constitutes family violence.</td>
<td></td>
</tr>
<tr>
<td>• Believes that abuse is an acceptable part of her culture and her marital life.</td>
<td>• Believes that abuse is an acceptable part of her culture and her marital life.</td>
<td>• Believes that abuse is an acceptable part of her culture and her marital life.</td>
<td></td>
</tr>
<tr>
<td>• Fear of having children removed from her care.</td>
<td>• Fear of having children removed from her care.</td>
<td>• Fear of having children removed from her care.</td>
<td></td>
</tr>
<tr>
<td>• An environment that is not conducive to disclosure.</td>
<td>• An environment that is not conducive to disclosure.</td>
<td>• An environment that is not conducive to disclosure.</td>
<td></td>
</tr>
</tbody>
</table>
### Comparison of East, Southeast Asian and South Asian communities

Within Asian communities there is great ethnic and cultural diversity, as well as some broad similarities. Yoshioka et al. (2001) found that although general themes among Asian cultures exist (such as emphasis on harmonious interpersonal relations and rejection of outside intervention); significant differences in attitudes supporting partner abuse were demarcated by ethnicity.

East and South East Asian families and communities share many characteristics, whilst the key differences with South Asian cultures revolve around dowry-giving and the acceptability of the husbands right to ‘discipline’ his wife. These differences and similarities are broadly outlined below.

### Similarities across East and Southeast Asian cultures

- Family structures and traditions are modelled on Confucian principles that set up the social hierarchy and define attitudes appropriate for each member in society. Confucianism says that women are expected to obey their husbands and to support their children with absolute devotion (Ryu, 2010).
- Traditional family hierarchies exist which are age and gender specific with older, adult males invested with formal power and authority.
- Extended, patrilineal households comprise parents residing with adult married sons, their wives, and children.
- There is high value placed on family harmony, and the greater needs of the family take precedence over the needs of any individual member.
- Within the household, informal power resides with the husband’s mother, and wives are expected to be obedient to their husbands and their in-laws.

<table>
<thead>
<tr>
<th>East Asian communities (from China, Japan, Taiwan, Mongolia, South Korea, North Korea, Macau, Philippines)</th>
<th>South East Asian communities (from Vietnam, Cambodia, Malaysia, Singapore, Indonesia, Thailand, Philippines, Burma, Brunei, East Timor, Laos)</th>
<th>South Asian communities (from India, Sri Lanka, Nepal, Pakistan, Bangladesh, Afghanistan, Bhutan, the Maldives and Fijian Indians)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• An environment that is not conducive to disclosure.</td>
<td>• Lack of routine screening.</td>
<td>• Lack of routine screening.</td>
</tr>
<tr>
<td>• Lack of routine screening.</td>
<td>• Lack of an objective and professional interpreter.</td>
<td>• Lack of an objective and professional interpreter.</td>
</tr>
<tr>
<td>• Lack of an objective and professional interpreter.</td>
<td>• Lack of privacy from the abuser or family member during screening.</td>
<td>• Lack of privacy from the abuser or family member during screening.</td>
</tr>
<tr>
<td>• Lack of privacy from the abuser or family member during screening.</td>
<td>• Lack of assessment beyond physical injuries.</td>
<td>• Lack of assessment beyond physical injuries.</td>
</tr>
<tr>
<td>• Lack of assessment beyond physical injuries.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
• In daily activities, this is particularly reflected in deference and obedience to a woman’s mother-in-law.

**Key cultural differences with South Asian cultures**

The Hindu customary practice of dowry-giving is a key difference that sets South Asian communities apart from East/Southeast Asian communities. A dowry can be defined as a gift of money or valuables given by the bride’s family to the groom and his family. If the dowry a woman brings to the family is not regarded as adequate, it can become a cause of abuse for a woman following marriage.

Secondly, there is a high level of acceptance of partner abuse as a way of teaching, disciplining, or correcting wives in South Asian communities. In an American study, Hindu women identified abuse as physical, mental, verbal, emotional, and economic (Mason et al., 2008). Participants in the study, included two additional forms of abuse, comparative abuse (i.e., “when the husband frequently compares his wife to other women and constantly puts her down”) and isolation (e.g., “limiting contacts,” “neglect”) (Mason et al., 2008).

**East Asian communities**

**Chinese communities**

**Relationships and expectations**

Understanding Chinese community perceptions of victimisation and their meanings and disclaimers can help identify situational factors that both promote and prevent family violence. For example, there is an underlying “moral code” that exists around what situations justify the use of violence.

Traditional Chinese cultural values and religious belief systems can be viewed as the “glue” that governs thought processes, social relationships and normative conduct, all of which can impact on family violence disclosure and the acceptance of intervention (Lum, 1999).

Confucian values emphasise conforming to principles about social relationships. The husband/wife relationship is an important relationship that is marked by a distinctive authority structure where husbands are the head of the household, and wives are to be obedient and subservient with the sole purpose of keeping the family intact (Ho, 1990; Xu et al., 2001). According to Confucius:

> “Woman yields obedience to the instructions of man, and helps to carry out his principles... When young, she must obey her father and elder brother; when married she must obey her husband; when her husband is dead, she must obey her son”.

**In-law conflict**

In-law conflict has particular relevance for Chinese women. A study of Chinese women in Hong Kong shows that in-law conflict is the characteristic most significantly associated with women’s reports of
violent victimisation in the family (Chan et al., 2008). Several risk factors for in-law abuse were identified in the study including (Chan et al., 2008):

- Higher education of the husband.
- Unemployment of women.
- A woman who earned more income than her husband.
- Women’s abuse of alcohol and drugs.
- A husband’s in-law conflict was strongly associated with women’s in-law conflict.

**Implications for Practice**

*Practitioners need to be alert to in-law abuse as an interfamilial form of family violence.*

**Case study: Lin-Bao**

The case study of Lin-Bao shows an example of health services providing critical intervention and support through referral to a Women’s Refuge (Ministry of Women’s Affairs, 2007a, pp 218-222).

Lin-Bao experienced physical and psychological violence from her mother-in-law. Her case demonstrates the social façade which hides violence, and the degree to which the relationship between a mother-in-law and her daughter-in-law dominates relationships between husbands and wives.

Lin-Bao is Taiwanese. She married to a Taiwanese man, Liu-Shao. The marital relationship deteriorated as Liu-Shao changed from a mild-mannered caring partner, to an abusive controlling, and often absent husband and father to her children.

Not only did Lin-Bao suffer physical abuse from Liu-Shao, she was also subjected to verbal and physical abuse from her mother-in-law.

**Life in Taiwan**

Lin-Bao worked as a nurse. She knew Liu-Shao’s family for nine years before she married him. Her mother-in-law saw Lin-Bao as a suitable match for her son. She treated Lin-Bao with great warmth and affection when Lin-Bao visited Liu-Shao’s home before their marriage. Lin-Bao married Liu-Shao in 1989, when she was 25 years old. Lin-Bao lived in the same house as her mother-in-law and sister-in-law.

However, the marriage had established a new power relationship between Lin-Bao and her mother-in-law. After her marriage Lin-Bao’s mother-in-law became a completely different person. Lin-Bao told interviewers that, “Until you become part of the family, it is hard to tell how people will turn out.” While in Taiwanese culture it is common for mothers-in-law to be domineering and controlling, Lin-Bao’s situation was much worse. Her mother-in-law had a different personality in public and in private. Lin-Bao found that two-faced aspect most difficult to deal with because even her own friends and family were not prepared to see the truth.
Liu-Shao was also abusive and controlling from the beginning of the marriage. Her husband told her: “Now you are my wife and you have to do everything for me that I ask – because you are my wife.” She found that he treated her as his property. Lin-Bao said that he did whatever he liked and that he could [throw her] out whenever he wanted to. Lin-Bao said “His family does the same thing as well, and he supports his parents to do the same – even his siblings. He supports them against me. So that means everyone is allowed to take my money or pay for things with them. So I felt quite miserable …” (Ministry of Ministry of Women’s Affairs, 2007a, pp. 219).

When Lin-Bao was pregnant with her first child, her mother-in-law abused her both physically and verbally to such an extent that she nearly had a miscarriage.

“I was sent to an emergency room because the foetus was going to drop out. I have bleeding and my mother-in-law just yells out, “Is it a boy or a girl?” My ex-husband [was] just standing next to her smiling but doing nothing” (Ministry of Ministry of Women’s Affairs, 2007a, pp. 220).

Lin-Bao wanted to move to another city as a way of getting out of the family home. She bought a new house with some money from her parents and, together with Liu-Shao and the children, they moved in. This did not mean that she had got away from her mother-in-law though. Lin-Bao’s mother-in-law would summon Lin-Bao to come to the family home and do the cleaning and washing. Lin-Bao would have to drive three hours, often after working a night shift at the hospital, to be at her mother-in-law’s early in the morning to do her housework. If Lin-Bao did not do it, her mother-in-law would complain to her husband who would then become angry with her and beat her.

Liu-Shao beat Lin-Bao when they had arguments. Mostly their arguments were about his mother. Her mother-in-law stirred up trouble between the couple. She did not like it if she found them getting on well. His sisters too were jealous and tried to sow dissension between Lin-Bao and Liu-Shao.

Lin-Bao found an advertisement about immigration to New Zealand. She calculated that she had enough points to qualify for permanent residence. She applied to Immigration New Zealand, but did not tell Liu-Shao until it was time for the interview. After a successful interview, Lin-Bao put the options before her husband. She made it clear she was going to New Zealand and that he was welcome to come with her. If he wanted to stay with his mother instead, Liu-Shao was free to do so and he could file for dissolution. In 1995, the couple moved to New Zealand. Liu-Shao stayed only a week before returning to Taiwan.

**Life in New Zealand**

Liu-Shao visited every six months but when he came, he “made life hell” for Lin-Bao. Lin-Bao suffered from depression. She did not see a doctor because she thought that, as a nurse, she could control it herself. In 1999, after a big quarrel, Lin-Bao attempted to take her life with an overdose of sedatives. She called her best friend, who sent her to a doctor who immediately referred her to the emergency department of the local hospital.
Hospital staff contacted Women’s Refuge. Lin-Bao stayed in the refuge with her younger son for one week. The day she returned, Lin-Bao says Liu-Shao was “very cruel”. A person from the refuge had dropped her off at her house and her luggage was on the drive-way. Liu-Shao returned from shopping and drove over the luggage.

**Thwarted plans**

Lin-Bao decided it would be better to move to the USA to work. Liu-Shao decided to settle in New Zealand and look after the children himself. He told the children horrible stories about “9/11” to frighten them. Lin-Bao decided she would proceed with her plans for working in the US and resolve issues relating to the children from there. Once she began working, Liu-Shao demanded money from her to support the children. Lin-Bao thought it best to pacify him until such time as she was able to take the children to the US, so she sent Liu-Shao money for his and the children’s needs. After a few months, Liu-Shao phoned her and told her he could not live in New Zealand and he had decided to return to Taiwan. He left their children with her friends in New Zealand and returned to Taiwan.

Lin-Bao was in a desperate situation, she had to sacrifice her job and return to New Zealand. On her return to New Zealand, Lin-Bao was horrified to find that Liu-Shao had left her with huge debts which she had to pay. Based on passing the US qualifying exams, the New Zealand Nursing Council gave her a certificate to practise nursing. With the certificate Lin-Bao got a job in a hospital, organised childcare for her children and began to work full time.

After her divorce was finalised, Liu-Shao returned to New Zealand. Publicly, Liu-Shao continued to behave as if he was Lin-Bao’s husband. He came to her house whenever he felt like it. He would discuss their divorce in front of the children. They would become upset. Liu-Shao acted and spoke to the children in a way that alienated them from their mother. Lin-Bao did not apply for a protection order because she felt it would only upset her children more.

**Reflection:**

Lin-Bao thinks the most important barrier for her in getting help was the people around her: “One of my friends said ‘I don’t think you are a good woman. You shouldn’t stand up against your husband’ ... so now I can say I have isolated myself from our community. At this moment I have a job, and a lot of Kiwi friends and they are very supportive, but I have only got two friends from our society supporting me.” (Ministry of Women’s Affairs, 2007a, pp. 222).

Women in the Taiwanese community encouraged her to stay with her husband because a divorcee is looked down upon. Lin-Bao thinks women in her community do not know about Women’s Refuge or the help they can get when they are in an abusive situation. She found out about Women’s Refuge only because the hospital referred her to a Women’s Refuge.
Korean communities

Relationships and expectations

In Korean culture, women are expected to be subservient to their husbands. The concept of Sam-Jong-Ji-Do’ which forms the basis of cultural perceptions of women’s roles states that a woman needs to obey three people in her life. Before marriage, she has to obey her father, after marriage her husband and when they have a son, she is obliged to obey the son (Ryu, 2010).

Wives are expected to stay at home and are responsible for household tasks. Husbands are the financial providers for the family. Husbands have final decision making authority and the power to enforce their decisions. As in all Asian societies, children are expected to defer to parental wishes (Byung-Soo Seol, 2008). This strong patriarchal ideology around gender roles, especially if a woman wishes to seek work outside the home, can lead to considerable conflict.

A Korean proverb says “a wife needs a good smacking every three days” (Ryu, 2010). It is believed that women deserve to be “smacked” as they are more prone to making mistakes. This legitimises partner abuse as a way of disciplining wives and makes it culturally acceptable in Korean society (Ryu, 2010).

Saving face, social discrimination

Saving face is a crucial part of Korean culture, if breached there are harsh consequences for women. Accordingly, women continue to stay in abusive environments or delay leaving until the last possible moment.

Women leaving violent marriages can expect little or no family support:

“People said women need to be blind for 3 years, deaf for 3 years after marriage, so that became my thinking also. I was worried the rumour might be spread all over town and my friends if I divorced in Korea. In Korea, people don’t treat divorced women as human at all if I divorced there. Even my own family wouldn’t accept or support me. If a woman divorced in Korea, she can’t even get invited to other’s wedding (Flora).”

“I had only one friend to help me. Nobody was there except her. Even my own family couldn’t help me. My family was more scary…I’m eldest daughter so they had very high expectation. They thought it was very shameful for the family. I didn’t know that there are support services available. Nobody told me at the time (Flora).” (Ryu, 2010).

Pressure from religious leaders to remain married

Conservative religious teaching is a major barrier to separation and divorce for those who have a religious background. In Korea, religious leaders may encourage women who are victims of partner abuse to stay in abusive relationships. Victims are advised to be more tolerant towards their husbands. If women want to divorce, they are advised to ‘run away’ to other countries.
“My family is Christian family so I couldn’t talk about dishonourable things like divorce in a Christian family. My mother in law was a deaconess in a church but she was very controlling of me through my husband. She attended the worship but I was not allowed to attend as I needed to do house work when I was living with her (Biggie).” (Ryu, 2010).

Southeast Asian communities

Cambodian community

Relationships and expectations

In a study of attitudes to marital violence in Asian communities, Cambodian respondents strongly endorsed male privilege, were likely to justify violence in certain situations, and were less likely to endorse decisions to leave or divorce a batterer (Yoshioka et al., 2001).

There is strong value placed on keeping the family together, and divorce is thought to be detrimental to the family and the children. In addition, partner abuse is often viewed as the woman’s fault, and divorced women are viewed with disapproval in the community.

When problems arise between a husband and wife in Cambodia, the problem is addressed only within the family. The legal system would not be involved. Community members or the couple’s parents would advise the couple, and a woman would be encouraged to stay with her husband.

Vietnamese community

Relationships and expectations

Vietnamese society is patriarchal, with cultural behaviours based on an interweaving of Confucian and Buddhist traditions. In the Confucian tradition men are respected as they are the head of families. Women are seen as the guardians of familial relationships with their primary duty being to maintain harmony within the family. For women, an intact family is integral to life’s achievements and self-worth.

An investigation of help-seeking behaviours among 34 abused Vietnamese migrant women in the USA found that personal networks (relatives, friends, or religious leaders) were most often the first place women asked for help, emotional support, and advice in resolving problems.

However, although sympathetic, friends and relatives may not always want to intervene because they see partner abuse as “a private matter”. Some friends and relatives may advise the abused women to “accept the abuse or try not to make her husband angry” (Bui, 2003). Despite greater acceptance of divorce by Vietnamese-origin residents in the United States, many women still feared that if they were divorced they would be viewed negatively (Bui, 2003).
South Asian communities

Relationships and expectations

In traditional Indian cultures, women face a range of expectations associated with the principle of “sewa” (selfless service), such as skill in cooking elaborate food, looking after in-laws, entertaining guests, and maintaining respectful and amicable relationships. As with other Asian cultures the patriarchal family head is important. Both men and women are supposed to uphold family and community honour, but the responsibility tends to fall mostly on women. Indian women retain their honour through conforming to prescribed roles and practices (Imam, 1999; Gill, 2003). Psychological abuse may include threats to ruin a woman’s reputation among relatives or accusing a woman of being a traitor to her culture and community. This results in considerable feelings of guilt about being judged a bad wife.

In South Asian families, the dowry can remain an ongoing cause of major disputes and ongoing problems as husbands (and their families) complain of insufficient dowries, unfulfilled dowry promises, and the inadequacy of the bride’s contribution to the household. Violence connected to dowry can often underpin the extended family’s involvement in the abuse (Batra, 2003; Dasgupta & Warrier, 1996; Jutla, 2004; Lakhani, 2005).

Although these practices occur there is no cultural or religious justification in either Hindu, Muslim or Sikh faiths for men to abuse their wives and children.

Honour through marriage

For South Asian communities, cultural and religious identity and practice are a strong and positive part of family and community belonging. Women are taught that the public image of the family is more important than individual safety.

Honour and respectability are dependent on a successful marriage, and women fear the dishonour and rejection from their community if their marriage should fail (Women’s National Commission, 2003; Gill, 2004). These religio-cultural constructs of honour and shame are very powerful, fuelling women’s fears about potentially incurring the wrath of the extended family and losing access to their children.

Women will stay in an abusive marriage to protect other family members including children and daughters in particular (Imam, 1994; Choudry, 1996; Gill, 2004). Thus women remain committed to their marriage and tolerate abuse (Gangoli et al., 2005). Girls are taught by their fathers or any other older person before marriage that they should not leave their husband.

“You will be seen as a bad woman for leaving your abusive husband. People won’t come to your house, kids can’t go to parties, you will not have that social network of people around, you lose that connection with your own community...Without support it’s impossible for them to leave.”
Family support

For many women migration will mean separation from extended family support. South Asian women tend to approach their family for assistance. However, women may not have families to turn to in New Zealand.

When family condemn the actions of the perpetrator and sympathise with the women, they are a great source of help. However, this is the exception rather than the norm. More commonly, women are blamed and ostracised by extended family and are not provided with support. Women who leave a marriage may be pressurised by family to go back to their abusive husband (Gangoli et al., 2005).

British studies estimate that it takes South Asian women an average of 10 years before they leave a violent relationship (Patel, 2003). South Asian women put up with abuse for a longer period of time and are more reluctant to access services than other abused women (Ministry of Women’s Affairs, 2007a; 2007b). Furthermore, the longer the abuse goes on, or as the severity of the abuse increases, the less likely it is that South Asian women will disclose to others or leave an abusive husband (Yoshioka et al., 2003; Gill, 2004).

Case study: Sonal’s story

(Ministry of Women’s Affairs, 2007a, pp. 228-232)

Sonal’s story is significant for a number of reasons. She is a third generation Indian-New Zealander. The degree and duration of the violence she suffered is shocking. The factors that prompted Sonal to endure extreme violence are complex and include: a desperate need to maintain cultural identity; a closed community; and close-knit families that nonetheless do not protect women from violent relationships.

Equally, Sonal’s case is an inspiration to women across cultures because, despite all odds, Sonal’s is a “success” story, in that she has successfully rehabilitated herself. Today, her sons, 21 and 17, are mature, responsible young men. She has divorced her husband. She runs her own business, owns her house and wants to help other women whenever she can.

Sonal’s story

Sonal’s grandfather came to New Zealand almost 100 years ago. As is the custom, Sonal had an arranged marriage. The proposal was brought by her cousin who was married to the brother of the prospective groom, Ranjit. Ranjit lived in the Punjab. Sonal wrote to him for two years and he wrote back. Sonal learned later that someone else was writing letters for Ranjit because he did not know any English. Sonal said that “There was deceit from the very beginning.” Sonal later learnt that Ranjit had come out to New Zealand on a six month visa which would soon expire, hence the need to marry quickly.

Sonal’s family was anxious that they follow what they perceived to be tradition, even when, in Sonal’s words, “We just did not know what ‘culture’ was.” This meant her family accepted the word
of Ranjit’s family’s on “tradition”. Sonal learnt later that marriage practices in India had changed, and the old ways were not followed as strictly any longer.

Family life after marriage

Their marriage had a rough start. Ranjit could not speak English. He could not find a job. To make matters worse for him, Sonal’s younger sister married an Indian-New Zealand doctor, an event that seemed to affect Ranjit’s self-esteem. For 12 years, Sonal endured a degree of violence that would be hard for most people to imagine. There were many incidents of extreme and horrific violence. Ranjit assaulted her not only in the privacy of their home but also in public places, such as hospitals and workplaces – but still managed to escape any consequences for his violence. The first assault happened within the first week of their marriage. The beatings were triggered by trivial things like the dishes not being washed properly. Ranjit would grab Sonal by the hair and bang her head into doors and walls. When Sonal found a job at the local school, she got “a real good hiding”. She says she felt it was “worth it” because at least she felt safe at the school from 8 am to 4 pm. Ranjit made sure all her income was direct debited to his bank account. And, though Sonal worked long hours, she never had any money of her own.

Eventually, Ranjit got a job in a factory in another city. They moved and Sonal got a job in a school and fell pregnant with their first child. Ranjit had no idea of what was happening to Sonal. Even when she went into early labour, he was dismissive and insisted she was “making a fuss”. She went to work as usual, but was in considerable pain. In the early afternoon, the principal asked Sonal to call Ranjit to collect her. Ranjit eventually arrived about 5 pm but he did not take her to hospital. Instead, he took her home and wanted her to cook because he had invited friends over for dinner. Sonal eventually got to hospital with the help of her sister and brother-in-law. She is certain that she would have lost the baby had it not been for their intervention. Ranjit visited her in hospital in the morning and accused her of being “useless” because she “could not even carry a child”. Sonal stayed with her parents for three months after the birth.

During those three months, Ranjit was phoned by a brother who asked him to go and help a cousin who lived overseas and was having a hard time financially. Ranjit left immediately, leaving his wife and newborn baby. He returned to New Zealand with two cousins, quit his job, got into a partnership with them, opened a shop in another city, and moved house – all without consulting with, or even informing, Sonal.

Sonal followed Ranjit to the new city with their baby to live in a flat above the shop. She had to work long hours in the shop and long hours in the flat cleaning and cooking for Ranjit and his cousin. Ranjit sponsored a number of cousins and relatives from the Punjab to help him run the shop. Sonal had to help with the paperwork for immigration, teach them English and cook for them. When she fell pregnant for the second time, there were ten men living in their home. Sonal miscarried, but got pregnant again. Even in her advanced stage of pregnancy, she would have to open the shop early in the morning and bring in the crates of milk. Sonal had difficulties with her third pregnancy. Her doctors told her if she did not go to hospital she would lose the baby. She went to a hospital that was far away from home. There she found a supportive matron, “one of those old fashioned kinds”, in her words, who did not let Ranjit come “anywhere near me.”
Seeking protection

After her second son was born, Sonal developed Carpal Tunnel Syndrome. She could not sleep because of the pain in her hands and was beaten because she disturbed Ranjit’s sleep. Sonal had to call a Plunket nurse for help. The nurse asked Ranjit to take Sonal to hospital. Ranjit abused the nurse instead. Sonal did get admitted to hospital. When she was discharged, her doctor refused to let her go home. Instead, she lived with a friend for two weeks. During that time she found pamphlets on family violence. She decided she could not carry on living the way she did and that, for her children’s sake, she had to do something.

She found a lawyer who successfully applied for an ex parte non-molestation and non-violence orders. However, Sonal could not bring herself to enforce the orders. Ranjit came to her sister’s house with his brother and presented Sonal with 100 red roses. Her family thought that was such a nice thing to do and she was being selfish to reject his affections. No sooner, however, had she got home than she got one of her worst beatings.

A further incident involving her children led Sonal to make the final split with Ranjit. He had picked up their younger son and banged him on the floor. Sonal says that an amazing feeling came over her. She went to her school principal the following day and asked him if he thought she was a good person. “Of course you are a good person”, he said. She cried publicly that day. The incident enabled her to take carefully planned action to end the violence. Secretly, she packed her things in a suitcase, a little each day, so that Ranjit would not become suspicious. She wrote a letter to her father and posted it. She rang him and told him if he did not hear from her, he should come and look for her and that if something happened to her, her family should care for her children.

For the third time, she made an application to the Family Court. She got a protection order without notice and went to live with her parents. Even though Ranjit would come to her parents’ driveway and abuse her, this third time around Sonal made effective use of the order. If Ranjit abused her or stalked her or threatened to kill her and her family, Sonal called the police and they came. She also went to the dentist to fix her teeth which were broken due to the battering. She saw a doctor about her back pain (caused by the battering as well). She took her children for counselling. She was able to devote herself to rehabilitating herself and her children.

The role of family

Throughout Sonal’s narrative, a consistent theme is the role of her family. For example, she told her maternal grandmother about the first hiding she got within a week of getting married. Her grandmother told her mother, who told her father. It became very clear to Sonal that her family would not do anything to help. Initially, it was because they thought Ranjit was a very good man; they would not have believed her if she told them all the details of the battering. Her mother did witness the beatings and the abuse when she came to live with Sonal during Sonal’s second pregnancy, but she did nothing. Later, Ranjit’s relationship with Sonal’s parents soured, but this did not mean that they were more supportive of her. Sonal says her mother was afraid to say anything because she was afraid of what Ranjit might do to Sonal’s father, who was old and in poor health.
By the time Sonal finally separated, her parents had witnessed a decade of abuse of their daughter and had done nothing to support her. Sonal’s sisters knew what was happening. One sister worked for the police. Another sister was married to a doctor. They too were caught up in “the family thing” and too timid to confront their parents or go against their wishes. Sonal’s cousins knew too. They had witnessed the abuse and taken her to hospital. Ranjit’s relatives had also witnessed the abuse.

To Sonal, family support was the single most important thing that could have helped her take decisive action to protect herself and her children. The need for affirmation and support from her family; the power of emotional control that the family exercised over Sonal; their fears of loss of reputation and “face” in the community – these were all factors that prolonged Sonal’s suffering.

Reflection:

The doctors, the matron in the hospital, the lawyers, her work colleagues, volunteers at the refuge, staff at Work and Income, and school authorities were very supportive of Sonal and extended themselves every time she needed help.

Sonal was trapped by family ties. For her, getting out of a violent marriage also meant getting out of all family relationships, all community networks, and walking away from everyone she had loved and grown up with.

Sonal thinks the most important thing for a woman in a violent relationship is to be given support and affirmation that she has not become a “bad woman” because she walks away from violence.

For Sonal, her children’s welfare is what gave her the strength to take action. Sonal realised she was on her own and only she could protect her children. With that realisation came the knowledge about the ways in which bonds of family, community and society were intertwined.
MEA communities

Summary of cultural differences between MEA communities

Family violence is considered a private family matter in Middle Eastern and African communities (Raj & Silverman 2003). Additionally, for newly settled families the absence of extended family and supports increases women’s sense of isolation (Raj & Silverman 2003).

Middle Eastern women in situations of family violence may not receive support from family and elders. Often, the intervention of elders and leaders results in pressure to reconcile even in the case of domestic violence (Sullivan, Senturia et al. 2005).

“In [our home country] women have family to defend them, here they know they have no one to defend them, they beat them, they are at risk here” and “Here there is no one to protect them, so they (men) beat them” (Reese & Pease, 2007).

The following is a table summarising cultural differences between groups. Please note that the ethnic groups represented in the following table include many diverse languages, religions and ethnic affiliations. The statements are intended to provide perspectives on cultural practices that may influence the willingness to disclose and to accept health professional intervention. However, to avoid stereotyping, it is essential that all families and clients are assessed individually.

<table>
<thead>
<tr>
<th>Attitudes towards partner abuse</th>
<th>African Communities, including Horn of Africa (South Sudan, Somalia, Ethiopia, Eritrea) and Central Africa (Burundi, Rwanda, Democratic Republic of the Congo, Republic of Congo, and Zimbabwe)</th>
<th>Middle Eastern Communities, including these ethnicities: Algerian, Arab, Assyrian, Egyptian, Iranian/Persian, Iraqi, Israeli/Jewish/Hebrew, Jordanian, Kurd, Lebanese, Libyan, Moroccan, Omani, Palestinian, Syrian, Tunisian, Turkish (including Turkish Cypriot), Yemeni.</th>
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<tr>
<td>• Family violence interventions in New Zealand (i.e., terminating an abusive marriage, seeking refuge, obtaining a protection order) are based on western ideologies of individualism, which may be dissonant with MEA women’s collective cultural values and expectations.</td>
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<th>Perceptions of partner abuse</th>
<th>African Communities, including Horn of Africa (South Sudan, Somalia, Ethiopia, Eritrea) and Central Africa (Burundi, Rwanda, Democratic Republic of the Congo, Republic of Congo, and Zimbabwe)</th>
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<tr>
<td>• Many women do not recognise their situation as abusive, and are therefore less likely to seek help.</td>
<td>with <em>Allah</em> provides them with an important means of coping with ongoing violence.</td>
<td>• The disapproval of family, friends, and peers is an extremely powerful weapon that abusers can effectively wield against victims.</td>
</tr>
<tr>
<td>• Even if women do not immediately access such services, the knowledge they gain provides them with a sense of empowerment and will be used to check the abusive behaviours of their husbands.</td>
<td>• A women’s desire to keep their marriage intact overrides everything as divorced women, (even when there is known abuse) lose all social status in their community and are often ostracised.</td>
<td>• Abusive behaviours such as preventing wives from going outside the home and going to the mosque are used by some men as a way to control their wives and isolate them from the community.</td>
</tr>
<tr>
<td>Relationships and expectations</td>
<td>• If victims call the police or speak out about their abuse, they may face loss of support or direct intimidation from the community.</td>
<td>• Islamic regulations do not condone sexual relations between husband and wife without the wife’s consent. Therefore, forcing a woman to have sexual intercourse against her will breaches Islamic codes of conduct.</td>
</tr>
<tr>
<td>• Women are responsible for maintaining harmony within the family by respecting and supporting their husband, obeying his wishes, and not angering him.</td>
<td>• The family is central to society, and the individual is subordinate to both family and society.</td>
<td>• Because marriage in Islam is a form of religious practice and, to a large degree, defines women’s social status, its dissolution has far-reaching implications not only for family life but also for women’s social and spiritual worlds.</td>
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### Role of family

- Family is the most fundamental social unit.
- Women tend to accept their fate in a male-dominated patriarchal culture. Talking with family provides comfort, but women understand that their family will do nothing to change an abusive situation.

### Challenges that prevent migrant women from disclosing partner abuse

- Having children.
- Feeling embarrassed and ashamed to tell outsiders that they are being abused by their husbands.
- Ignorance of the law and regulations in this country.
- Inability to speak English.
- Difficulty in knowing where to go for professional help.
- The difficulty of finding another source of income, fearing the husband’s leaving, finding help to survive in society.
- A preference to live with the husband’s violence rather than going through the process of seeking legal protection, believing that there is no safe place to go if she decides to leave the violent husband.
- The belief that leaving the husband is against the teachings of the Koran (in the case of Muslim women).
- Believing that the husband’s violence will go away over time.

### Middle Eastern Communities, including these ethnicities: Algerian, Arab, Assyrian, Egyptian, Iranian/Persian, Iraqi, Israeli/Jewish/Hebrew, Jordanian, Kurd, Lebanese, Libyan, Moroccan, Omani, Palestinian, Syrian, Tunisian, Turkish (including Turkish Cypriot), Yemeni.

- While in the process and in the aftermath of divorce, Muslim women face significant family and/or community disapproval.
- Many women fear that disclosure of abuse may result in the removal of their children.

- Fear for personal safety.
- A preference for support from an Arab-Muslim health professional rather than a professional from another culture.
- The unavailability of a health professional from the same cultural background is an additional barrier for Muslim women if they decide to seek help.
- Pressure from her support system not to talk.
- Fear of legal authorities.
- Concern about bringing shame to her family.
- Concern about being ostracised by her community.
- Fear of immigration authorities and police.
- Unaware that non-physical abuse constitutes family violence.
- Believes that abuse is an acceptable part of her culture and her marital life.
- Fear of having children removed from her care.
- Ignorance of the law and regulations in this country.
- Inability to speak English.
- Difficulty in knowing where to go for professional help.
- The difficulty of finding another source of income, fearing the husband’s leaving, the difficulty of surviving in society.
- A preference to live with the husband’s violence rather than going through the process of seeking legal protection. Believing that there is no safe place to go if the wife decides to leave.
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her violent husband.
• The belief that leaving the husband is against the teachings of the Koran.
• Believing that the husband’s violence will go away over time.

African communities

An American study of African migrant women showed that when women realised that partner abuse was a crime and that services were available, they utilised that knowledge (Ting, 2010). Even if women did not immediately access such services, the knowledge they gained provided them with a sense of empowerment and they used this to check the abusive behaviours of their husbands. This knowledge is an important part of migrant women’s coping strategies.

Implications for Practice

The implication for health professionals arising from this finding is the need to provide all migrant women with information about services and their rights as victims of criminal behaviours.

Coping strategies of African migrant women

African migrant women in Ting’s (2010) study used a range of coping strategies such as:

1. Hoping for change and thinking the relationship will get better. Initially, many women coped with abuse through wishful thinking that the abusive behaviours would stop on its own, or hoped that their husbands would change:

“I had hope he would change since in my family, my father had changed. We went to live with my grandparents when my father was abusing my mother. They talked to my father, and he changed. He stopped, so I had hope my husband would too. Some men do. I believed it was possible” (Ting, 2010).

2. Looking to the future. Women coped and endured for the future good of their children:

“I was comforted by the fact that my children all turned out to be independent, upstanding. I see their success and I felt I did the right thing for them by staying, for all the opportunities they are getting here, that they would not get in Africa” (Ting, 2010).
3. Seeking God’s help and comfort in prayers, having faith. The majority of women felt their faith in God helped them cope. There were some who took comfort in their personal relationship with God:

“I prayed; I felt comfort in praying. At night I read the Bible where it said, ‘that I will be with you, as you travel, when you are suffering, I am with you.’ So that was comforting me, that God was with me” (Ting, 2010).

4. Believing in God’s will and divine justice. Not only was religion and faith a comfort to African women in the study, the belief in God’s will and divine retribution allowed women to cope with the abuse:

“Yes, I had to believe in God. “Oh God, you are mighty and you are great. You are the God who cannot fail to know everything. You hear my prayers; your eyes are sharp and see everywhere. You know where I am, how I am suffering.” I believe that God will take care of me, that God has a reason for having me suffer, and I believe that God is just, that God will punish my husband for what he did to me. Someday I will get justice and he [her husband] will get his punishment” (Ting, 2010).

5. Do nothing: stoicism, fatalism, and acceptance of fate. In addition to accepting God’s will, women accepted their fate as women in a male-dominated patriarchal culture. Many women reported that they felt they were not able to do anything, and the best thing to do was to be stoic and not fight back. This submissive behaviour was a coping strategy that allowed women to escape from further violence and abuse.

“I just let him have his way; it [his anger] will pass. I did nothing, since if I do something, he beats me more” (Ting, 2010).

6. Using behavioural distraction. Women described the use of behavioural distractions, such as focusing on their children and focusing on being grateful for their relationship with their children. Women’s special bonds with their children helped them cope:

“My son, he is very protective of me; he tells me when he grows up, he will take care of me” (Ting, 2010).

7. Cognitive reframing, avoiding, denying, and minimising the abuse. Most women minimised the severity of the abuse:

“In my country, it is okay for men to discipline their wives. I told myself this was not abuse, this was “normal discipline.” Other wives I know said the same thing, “oh yes, my husband hits me too; that’s normal,” so that is how we believed, and how we all survived” (Ting, 2010).

8. Believing in oneself, a sense of self-efficacy. African women survivors also described believing in themselves and their ability to survive the abusive relationship. Women’s narratives reflect this sense of self-efficacy:
“Women from my tribe, we are strong - we are survivors. We accept pain; women are the ones who bear children. I just tell myself, “Yeah, I’ve lived [today], and tomorrow I will live too” (Ting, 2010).

9. Receiving affirmation and emotional support from family. While some women’s narratives indicated that their families were barriers toward their help seeking, several women spoke about their sense of relief and affirmation when they reported the abuse and their families believed them. Despite the families not being able to do anything about the abusive situation since they were so far away, women reported that the verbal and emotional support from the family helped them feel less isolated and able to cope.

10. Talking to others informally. For some women, it was very helpful to tell others what was happening:

“I cried with my co-workers; I told women at work. I couldn’t hide what was going on. It was too much to keep to myself” (Ting, 2010).

11. Seeking services and formal sources of support. Formal help seeking was also described by women:

“Going to [support] group was good. They are [African] women like me there, been through the same things. We are together. I learn many things I didn’t know about that helped me, like the “cycle of abuse” and it is not my fault” (Ting, 2010).

Empowerment

Even when women were not ready to make any decisions about leaving their marriage, they were able to cope and “go on” when they knew help was available (Ting, 2010). The knowledge that support was available gave women a sense of empowerment and safety, allowing them to “get through” day by day:

“I talked to a neighbour. She’s the one who told me that you can call police; the police can help you and my husband would be arrested. He’s not supposed to abuse you, it’s a crime. And she arranged with the people from her church to help me. One day two people came to my door, knock on the door. When I opened, they just give me telephone number and said, “This is our number, call us any time; we can take you to a safe place and get you a lawyer.” And I was keeping that number in my pocket.” (Ting, 2010).

A sense of empowerment allowed women to cope with the abuse, until the time was right for them to ask for support. Even if women chose not to leave, having information provided a safety net and a bargaining tool for them. While some migrant women felt that they had some power over abusive husbands, and a way to control the abuse to keep it from becoming extreme, it should not be assumed that all women are resilient or safe.
Ethiopian communities

A study of Ethiopian women in Seattle showed that if victims of partner abuse called the police or spoke out about their abuse, they faced loss of support or direct intimidation from the community. For women whose only social support came from their ethnic community, disapproval was often too much to bear (Sullivan et al., 2005).

The way that communities react to women who are the victims of abuse exerts a strong influence on women’s coping and help-seeking behaviours. Behaviours, such as gossiping and making fun of victims; blame, hostility, and criticism for exposing domestic violence to those outside the family/ethnic community are powerful incentives to remain silent (Robert Wood Johnson Foundation, 2009).

Somali community

In the Somali culture, perceptions of domestic violence are limited to physical violence. This includes all interfamilial violence (Pan et al., 2006).

Somali women are responsible for maintaining harmony within the family by respecting and supporting their husband, obeying his wishes, and not angering him.

Somalis are Muslims, and Islamic traditions are cited as a means of reducing tension in families and, as a means of reducing the incidence of domestic violence.

In addition to Islamic traditions, family members and community elders are frequently used to resolve conflict between spouses. Traditionally, the wife would consult with the men in her family and then the men would talk to the husband. However, many Somali women in settlement societies do not have access to this type of family support.

Middle Eastern communities

Muslim communities

In Muslim communities, the family is central to society, and the individual is subordinate to both family and society. Family unity and harmony are of paramount importance and every effort is made to maintain this unity. Islamic law does not allow any form of partner abuse and husbands and wives have rights which must be respected. In Islamic law, women can leave their husbands if their rights are violated. However, social and cultural pressures mean that women who leave abusive partners may be socially ostracised and labelled ‘loose,’ ‘rebellious,’ ‘disrespectful’, ‘selfish,’ and ‘uncaring’.

American Arab-Muslim women in a study of marital violence defined abuse as either physical abuse or emotional abuse and control (Meguid, 2006).
Abusive behaviours such as preventing wives from going outside the home have no foundation in Islamic regulations although some men use this as a way to control their wives and isolate them from the community.

Islamic regulations do not condone sexual relations between husband and wife without the wife’s consent. Therefore, forcing a woman to have sexual intercourse against her will breaches Islamic codes of conduct.

However, perpetrators may misuse and misinterpret cultural or religious messages to threaten and coerce their wives.

Help-seeking

Because marriage in Islam is a form of religious practice and, to a large degree defines women’s social status, its dissolution has far-reaching implications not only for family life but also for women’s social and spiritual worlds.

In Meguid’s (2006) study, when women decided to leave their abusers, it was only after having experienced severe psychological, spiritual, and/or physical abuse. Arab-Muslim women who did seek outside help were well educated and had lived in the USA for some time. These women sought help from the following people:

- Family member(s).
- Friends.
- The imam at the mosque. The imam can be a helpful resource for social workers dealing with abuse in Arab-Muslim families.
- An Arab-Muslim professional.
- Mainstream professional help. Participants ranked formal authority and domestic violence shelters closely as the last two help sources they might seek, which might indicate that Arab-Muslim women usually keep their problems inside the house. (Meguid, 2006).

Spirituality in Muslim women’s lives

For many Muslim women, their relationship with Allah provides them with an important means of coping with ongoing violence (Hassouneh-Phillips, 2003). Coping mechanisms include listening to Koranic recitation, prayer, and meditation. For many women, Allah is a sustaining force when they have no one else to turn to. Through prayer, participants felt that they could appeal to Allah directly for help and guidance. For many women, Allah was their only source of support.

“Allah was the only one who was saving me” (Hassouneh-Phillips, 2003).

Women’s spirituality is a source of both strength and vulnerability as they endure the effects of domestic violence. In a study of American Muslim women, while some women found strength in their relationship with Allah, others found that their spiritual beliefs promoted passivity and
compliance. In this latter sense, women were susceptible to believing that they should stay in violent situations through a belief that this life does not matter (Hassouneh-Phillips, 2003).

Islamic teachings and law clearly condemn any form of violence towards wives. According to Islamic teachings, the Prophet (peace and blessings be upon him) demanded respect and kindness to women. He said:

“Fear Allah in respect of women”

“The best of you are they who behave best to their wives”

“The more civil and kind a Muslim is to his wife, the more perfect in faith he is”

Understanding the significance of women’s spiritual beliefs, and harnessing this to help women resist and recover from abuse, is an important aspect of working with survivors.

**Divorce**

As in many cultures, divorce is viewed negatively in Muslim communities. In Islamic law, there are clear rights for both husbands and wives. Violence towards one’s wife is a serious breach of the wife’s rights and allows women to apply for a divorce. Divorce, when initiated by a woman, is called *khula*. *Khula* requires a judicial decree issued by an Islamic court. The majority of Muslim women believe they have to obtain *khula* in order to be free. Women are reliant on individual Muslim leaders and scholars who may be acquainted with their abusers and may focus on maintaining the family unit.

In addition to experiencing disapproval and receiving very limited social support, women find that after divorce they no longer fit into the social structure of their communities. During the process and following divorce, Muslim women face significant family and/or community disapproval.
Supporting partner abuse disclosures

Cultural factors hindering disclosure during screening

“Culture influences how people view abuse: whether they seek help: how they communicate their experience and from whom they are likely to seek assistance” (Weber & Levin, 2003).

For migrant women in situations of partner abuse, cultural factors such as ostracism from family and community may serve to prevent disclosure.

As well, perceptions of what constitutes violence differ culturally. In some communities verbal and physical violence are not considered abuse. Accordingly, women may not consider themselves the victims of crime, or that they have rights as victims (Lay, 2006). Remember, in any cross cultural encounter, people may be communicating from very different perceptions of what ‘reality’ is, what is ‘good’, and what is ‘correct’ behaviour.

It is important for viewers of this resource to review the VIP core training on how to support partner abuse disclosures.

System challenges
Creating a partner abuse screening environment that is safe for CALD women

Women who are victims of partner abuse are high users of health services and health professionals are one of the groups to whom women are most likely to disclose abuse. However, health services have difficulty in identifying migrant women who are the victims of partner abuse. Presenting symptoms, especially depression, may be treated without addressing the violence, which is producing those symptoms (Ministry of Women’s Affairs, 2007b). Health professionals play a vital role in protecting women and children. They are vital to women’s access to the criminal justice system, child protection services and other support services.

Some of the case studies in this resource show examples of health services providing critical intervention and support for migrant women (Ministry of Women’s Affairs, 2007a). For example, hospital staff referrals to women’s refuges (see the case study of Lin-Bao, under the East Asian section). Health professionals can provide protection for women from their abusers; for example, by calling in security guards (see the case study of Sonal under the South Asian section).

Health professionals ensure successful screening for migrant women by providing privacy and an interpreter when needed. Health professionals play a vital role in intervention through linking migrant women to specialist agencies in the community.

Assessing the need for an interpreter

Health professionals may neglect migrant women and children in situations of family violence when they fail to use an interpreter. Further, when they defend inaction as “respecting cultural differences” and fail to act because they consider that they are not “qualified” to intervene.

While people may speak English at work and in the community or when greeting a health professional, these factors do not diminish the need for an interpreter. During partner abuse screening and intervention, women may talk about situations and concerns that they may only have words for in their own language, for example, referring to forms of abuse, body parts or sexual acts. Additionally, for women discussing abuse and sexual assault is highly stressful. Language competency skills decrease in stressful situations and a woman may be more fluent in her first language in a time of crisis (Hiltz & Anderson, 2002).

Use a professional interpreter. It is strongly recommended that service providers arrange for a female interpreter to be booked when non-English speaking women are being screened for partner abuse.

Providing a female interpreter may not always be possible for women from some of the smaller and/or newly arrived language groups. In these instances, and if there is a male interpreter available, the woman for whom the interpreter is needed should be asked, if possible, if she will agree to assistance being provided by a male interpreter.

Additionally, confidentiality becomes an issue in smaller communities or recently arrived groups. The woman may be reluctant to use an interpreter because she knows the interpreter and/or fears that details of the matter will be made public.
At the beginning of the interview, reassure the patient that you and the interpreter will respect her rights to confidentiality (unless there are serious safety concerns for the woman and/or her children).

**Working with an interpreter during family violence intervention**

Once an interpreter has been arranged, health professionals should brief the interpreter on the situation and the areas to be covered before the interview begins. The interpreter may offer information about relevant cultural factors relating to family violence and sexual assault. This information should be noted but should not be regarded as definitive. It must be noted that not all interpreters are familiar with family violence perspectives within their own community and some may not be able to offer any views.

Following the interview, the health professional should debrief the interpreter to ensure that the interpreter has an opportunity to share their concerns about any aspects of the case and to have these answered. It is important to thank the interpreter for their services.

It should always be remembered that the interpreter is not an advocate or a counsellor and should not be asked to provide advice, or an opinion on clinical matters (or any other assistance), beyond an interpretation of the interview between the patient/client and the health professional.

Full details on working with interpreters can be found in the eCALD® Services CALD 4: Working with Interpreters course, which can be found on www.ecald.com.
**CALD family violence case studies to reflect on**

After going through this resource we leave you with some case studies so that you can think about how you would handle similar situations in your own practice.

**Scenario 1: Shireen**

Shireen is a migrant from Pakistan. She is 18 years old and in the second trimester of her pregnancy. She has an appointment at the ante-natal clinic because she is experiencing some light bleeding. Shireen’s sister-in-law accompanies her to the appointment and serves as an interpreter during the examination. Shireen is very quiet, and the midwife conducts a routine partner abuse screen. (Refer to DHB Partner Abuse Screening policy for maternity services).

**Questions for your consideration**

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
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| What are the potential barriers for Shireen to disclose her abusive situation? | Potential barriers could include:  
  - Shireen cannot be screened in the presence of her sister-in-law.  
  - The midwife does not screen for abuse.  
  - There is no objective/trained interpreter provided for the client. |
| Is Shireen’s sister-in-law an appropriate interpreter?                    | No, Shireen’s sister-in-law is not an appropriate interpreter because she is a family member. Arrange a trained interpreter either by phone or face to face.                                           |
| Should the midwife screen Shireen for partner abuse?                     | Yes, Shireen should be screened for partner abuse.                                                                                                                                                   |
| Who should accompany Shireen to the examination room?                   | During partner abuse screening only health professionals should be present.                                                                                                                         |
| What types of questions should the doctor ask regarding bleeding?        | If a woman is admitted antenatally, for any reason, the partner abuse screening questions should be repeated. Admissions for hyperemesis, abdominal pain, antepartum haemorrhage, abruption or accidental injury should alert health professionals to the possibility of partner abuse. |
NB. CARE AND PROTECTION OF THE UNBORN CHILD: In all matters where there is risk of harm towards the life of an unborn child or it is assessed that there are significant risk factors where the unborn child is at risk during pregnancy and/or following the birth, a notification to CYF must be made following assessment. DHB’s and CYF can work together where appropriate in the care planning around the pregnancy, birth and discharge. It is best practice to have a collaborative approach with CYF as early on in the pregnancy as possible. (DHB Child Protection Policy)

Scenario 2: Fahima

Fahima’s husband accompanies her to a busy emergency department where she is diagnosed with a broken rib. Her medical record and stored digital photographs indicate that she came to ED with a broken nose three months ago which she claimed was the result of a fall. Her husband is very attentive and does not leave her side. Fahima has recently moved to New Zealand from Afghanistan and does not speak English. She believes that her community will shun her if she discloses the abuse. She fears her family will abandon her and that her husband will force her to return to Afghanistan. Her husband interprets for her. The doctor diagnoses her broken rib and prescribes an analgesic.

Questions for your consideration

Question: What are the potential challenges for Fahima in disclosing her abusive situation to a health professional?

Answer: Barriers include:

- Fahima is not screened for partner abuse.
- Fahima cannot be screened with her husband present.
- Fear of deportation.
- Lack of a trained interpreter.

Question: Should Fahima’s husband be allowed to stay in the room during the examination?

Answer: No, the patient should be screened for partner abuse on her own.

Question: What is the relevance of checking the patient’s medical history and stored digital photographs?

Answer: The medical history should be checked in order to determine whether visits to ED establish a pattern of injuries to indicate a history of partner abuse.

Question: How would you screen the patient in private while minimising any risk to the victim?

Answer: Be careful not to induce conflict between the victim and the abuser.
• Tell the abuser that it is standard practice for each patient to be examined alone.
• Use a sign stating “Patient’s only beyond this point”.
• Screen the patient during a time of privacy following a urine test or when she is being weighed.
• Request that the suspected abuser complete some administrative forms while the patient is screened in a separate room.
• The practitioner could speak to the suspected abuser concerning a routine health issue while another member of staff screens the victim.

NOTE: The routine screening interview cannot proceed without an interpreter in any of the following circumstances:

• A patient is not conversant in the English language, or
• Is not able to fully comprehend English.

Professional interpreters must be used for the purposes of carrying out the routine screening interview, including any follow up contact and intervention involving the patient.

Gender, age and tribal/clan and family affiliations are important aspects of the interpreter-patient relationship. The preferences of the patient should always be checked out before making a request for an interpreter.

It is also preferable that the interpreter is trained in partner abuse screening and intervention. Remember family members and friends, who may also be professional interpreters, cannot be used as interpreters.

Scenario 3: Noi

Noi, a woman from Thailand looks sad and reports insomnia, a lack of appetite and a loss of interest in most areas of her life. A clinical examination reveals significant bruising on her inner thighs. The nurse identifies these injuries as possibly being caused by sexual assault and partner abuse, and promptly proceeds to screen the patient for partner abuse. Noi refuses to answer the questions. The nurse feels frustrated and gives Noi the number for the Family violence hotline. Noi does not want to take the number with her and leaves it behind in the clinical room.

Questions for your consideration

**Question:** Prior to asking screening questions, how could the nurse have attempted to gain an understanding of the victim’s cultural and social circumstances and the implications of her disclosing partner abuse and sexual assault?

**Answer:** Allow the victim to explain the cause of her injuries before asking screening questions.
**Question:** Are forced sexual relations within the context of marriage a form of abuse?

**Answer:** Yes

**Question:** What are some possible reasons why Noi may not have taken the Family Violence Hotline Number?

**Answer:** Noi may fear retaliation from the abuser and deportation. She may justify the requirement to be sexually subservient to her husband because he threatens to withdraw her immigration sponsorship if she does not.

**Question:** Should the nurse screen Noi for clinical depression? Why or why not?

**Answer:** Yes, Noi has symptoms which may indicate depression or Post traumatic stress disorder. Her lack of motivation may prevent her from taking appropriate action to prevent the abuse.

**Question:** What else can the nurse do in the situation if the patient chooses not to admit that she is a victim of partner abuse and sexual assault?

**Answer:** Please refer to your own DHB or PHO intervention guidelines for Family Violence Intervention.

Information should be provided on the likelihood of the abuse becoming more severe and more frequent without intervention. Where children are involved information should be given on the impact on children of living in an abusive environment. Always leave the door open so that the patient has a future point of contact.

**Where the healthcare practitioner has reasonable grounds for believing that a patient is ‘at risk’ of harm from self or another person, and the patient/client refuses any further assistance or support, then the healthcare practitioner can:**

- Make a referral to a consulting medical professional, and/or
- Disclose the information to a DHB social worker for follow up.
- Contact the police- if there are serious safety concerns.
- Notify CYF where children are ‘at risk’.
**Scenario 4: Safia**

Safia is Fijian Indian. She is 16 years old and has been married for about six months. Her family arranged her marriage to a man in his 30’s. Safia is three months pregnant but seems to be unhappy about the prospect of being a mother. She tells the midwife that her husband screams at her and embarrasses her in front of the family. The midwife screens for partner abuse, and Safia acknowledges that her husband has hit her on two occasions. She tells the midwife that they live in the same house as her in-laws, and that her mother-in-law accuses her of being a poor wife and a bad daughter-in-law. Her mother-in-law told Safia that she deserves to be hit. Safia has not discussed the abuse with anyone from her community because she does not want to bring shame to her family.

**Questions for your consideration**

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
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<tr>
<td><strong>Question:</strong> How should the midwife respond to Safia’s disclosure of partner and in-law abuse?</td>
<td><strong>Answer:</strong> The midwife should acknowledge Safia’s disclosure by saying for example “Thank you for telling me this. I am concerned for you”. It is important to validate Safia’s difficulties and to affirm her courage in disclosing, for example, “This must have been difficult for you”. As well, it’s important to give Safia the message that she does not deserve to be abused under any circumstances “for example by saying, “Abuse is never justified”.</td>
</tr>
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<td><strong>Question:</strong> What steps should the midwife take to establish a plan of safety for Safia?</td>
<td><strong>Answer:</strong> Refer to VIP DHB Guidelines for Family Violence Intervention and Child Protection.</td>
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<td><strong>Question:</strong> What advice is it safe and appropriate for the midwife to give Safia?</td>
<td><strong>Answer:</strong> It is appropriate for the midwife to inform Safia of her options - for example - “Let’s talk about some of the ways you can get support”. Cultural support for refugees and new migrants should be provided where this is available and practicable and after checking that any person providing support is safe for the victim.</td>
</tr>
<tr>
<td><strong>Question:</strong> What advice would it be unsafe and inappropriate for the midwife to give Safia?</td>
<td><strong>Answer:</strong> Inappropriate advice: Do not recommend or suggest that a patient/client should attend couple counselling, or couples mediation to resolve partner abuse situations. This will reinforce a patient’s belief that they are at least partly responsible for the abuse and that she has to change to stop it from happening. This will place the patient in more danger and serve as a mechanism of victim control.</td>
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</table>
**Responding to the Perpetrators of Partner Abuse**

Responding to the perpetrators of partner abuse is an area of expert practice. If practitioners are providing support to the victim of abuse, it is bad practice to provide care for the perpetrator in this issue. It is the obligation of the health professional to refer to an appropriate agency if circumstances warrant this (Ministry of Health (2002)).

---

**Scenario 5: South Asian Woman - Asal**

**Background**

Asal is a 30 year old pregnant woman who presents to hospital during her 3rd trimester seeking midwifery care. She and her husband have 4 other female children aged between 2 and 12 years. Asal, her husband and their oldest daughter are migrants from a South Asian country who settled in New Zealand about 8 years ago. Asal’s husband is currently unemployed and the family struggles financially. English is a second language. This is Asal’s 4th pregnancy since arriving in New Zealand.

**Current Pregnancy**

When Asal presented to the hospital, during her ante-natal assessment she was screened [with an interpreter] for partner abuse and answered no to all the screening questions.

She received a pregnancy ultrasound scan and was advised she was having a girl, upon receiving this information Asal said she did not want another girl.

Asal did not attend any further follow-up antenatal appointments and was admitted when she went into premature labour. Her baby was born 5 weeks early.

Upon delivery, Asal refused to have contact with her baby and she discharged herself without the baby. The baby needed to remain in hospital for 5 weeks. During this time Asal did not want any contact with her baby telling nurses that this was because the baby was a girl and “she did not like her baby”. Other members of her family did not visit.

A number of nurses recorded in the patient’s medical record that they were concerned about the lack of emotional care that the baby was receiving from her mother and other family members.

Asal and her family were difficult to engage and assess when staff made attempts to meet with them. The staff made provision for the availability of interpreters. Ante-natal staff made the assessment that Asal was tired and overwhelmed by the birth of a 5th child and was possibly suffering from post-natal depression. A referral was made to mental health services. Mental health services had the same difficulties engaging with Asal and her family. Follow-up postnatal visits by the midwife were also difficult.
It was felt that Asal was tired and overwhelmed by a 5th addition to her family and was possibly suffering from post-natal depression. A referral was made to mental health services, who also had the same difficulties engaging with Asal. Follow-up postnatal visits by the midwife were also difficult.

Discharge of Baby

After 5 weeks the baby was well enough to be discharged home with her parents and siblings. A discharge meeting was held with parents, an interpreter, mental health services and a well-child provider. It was felt at this meeting that there were no child protection concerns and that there were enough services involved to support the family in the community.

Re-admission of baby into hospital

After 2 weeks post discharge, the baby was re-admitted to hospital in a seriously malnourished and neglected state.

Child Protection Indicators and Red Flags:

• During pregnancy
  1. Once the baby had been identified as a girl – it appeared that this was an unwanted baby.
  2. Asal did not attend follow-up antenatal appointments.

• Postnatal
  1. Asal did not want to hold or care for her baby directly after birth.
  2. Asal discharged herself as soon as possible post delivery.
  3. Asal refused to have any further contact with her baby and stated she did not like her baby.
  4. The baby did not receive any skin to skin contact, nurturing, emotional connection/attachment or family involvement.
  5. Health professionals were concerned about the mother’s lack of emotional attachment to her baby.
  6. Asal was deemed to be suffering from postnatal depression, to be shut down and was not responsive to her baby.
  7. Asal had other stressors, 4 other children to care for at home, no extended family support, financial difficulties.

Question:

How could health professionals have done a better job in understanding Asal’s situation, as well as protecting and supporting her and the baby?
Considerations:

The following are some issues that could have been further explored or considered:

1. Asal was trying to tell health professionals [in her own way] she did not want her baby if it was a girl. However, Asal’s comments were dismissed or not taken seriously.
2. There did not appear to be any focus on the baby’s needs or on how the lack of response from Asal and other family members would impact upon the baby’s wellbeing.
3. The baby was not identified as being neglected; this could be because her medical and physical needs were being met by health professionals.
4. It appeared that the key focus was on Asal’s mental wellbeing and other social factors. It would have been valuable to have considered the cultural importance to her of having a boy and what an additional girl would mean to her family. At no stage did there appear to be any thought given to seeking cultural guidance or support from a member/health professional from the same South Asian community regarding the importance of gender and how this family could be supported.
5. What other pressures were there for Asal i.e. from her husband?

Considerations for this cultural group: In South Asian communities having a son is highly important. Sons are seen as future breadwinners, the continuation of a family’s lineage, and the inheritors of the family’s estate.
### Resources and references

#### Glossary

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tr>
<td>ADHB</td>
<td>Auckland DHB</td>
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<tr>
<td>CALD</td>
<td>Culturally and Linguistically Diverse/Diversity</td>
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<tr>
<td>CMDHB</td>
<td>Counties Manukau DHB</td>
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<tr>
<td>CYF</td>
<td>Child, Youth and Family</td>
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<tr>
<td>DHB</td>
<td>District Health Board</td>
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<tr>
<td>FV</td>
<td>The term Family Violence in this resource refers to partner abuse and child abuse as well as other interfamilial violence, such as in–law abuse</td>
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<tr>
<td>MEA</td>
<td>Middle Eastern, Latin American, and African</td>
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<td>MOH</td>
<td>Ministry of Health</td>
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<tr>
<td>VIP</td>
<td>Violence Intervention Programme</td>
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<tr>
<td>WDHB</td>
<td>Waitemata DHB</td>
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Resources for health professionals

The following are a list of cultural and language appropriate services for health professionals to access for victims. NB: Health practitioners should look at family violence intervention resources on their organisation’s intranets and become familiar with the local support services available.

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<tr>
<td><strong>Police</strong></td>
<td>111 -Have access to interpreting services within normal working hours.</td>
</tr>
<tr>
<td><strong>Child Youth and Family</strong></td>
<td>0508 FAMILY .... Contact CYF for children/young people with actual or suspected child abuse and neglect (as per DHB Child Protection policy)</td>
</tr>
<tr>
<td><strong>Professionally Trained Interpreters</strong></td>
<td>Health practitioners working in the Auckland-metro DHBs have access to professionally trained interpreters. Those working for DHBs outside of Auckland may have access to professionally trained interpreters. All primary care organisations and general practitioners in the Auckland region have access to free telephone and face to face interpreting services subject to access criteria.</td>
</tr>
<tr>
<td><strong>Shine (Safer Homes in NZ Everyday): support and Safe House accommodation for victims of domestic abuse</strong></td>
<td>Shine offers a national toll-free Helpline (0508-744-633) that operates 7 days/week, from 9am to 11pm, which is staffed by trained professionals. Shine Safety First Advocates in Auckland Central and North shore offer support and advocacy for women and children who have experienced abuse. Shine Safe House offers safe and supportive accommodation for women and children on Auckland’s North shore. KIDshine offers support specifically for children who have experienced domestic abuse. <a href="http://www.2shine.org.nz">www.2shine.org.nz</a></td>
</tr>
<tr>
<td><strong>Family violence It's not ok</strong></td>
<td>The <strong>0800 Family Violence Information Line (0800 456 450)</strong> provides confidential self-help information and connects people to services where appropriate. It is available seven days a week, from 9am to 11pm, with an after-hours message redirecting callers in the case of an emergency. <a href="http://www.areyouok.org.nz/i-need-help/">http://www.areyouok.org.nz/i-need-help/</a> The <strong>Family Services Directory</strong> lists information about social service organisations that provide services and programmes for New Zealand families. <a href="http://www.familyservices.govt.nz/directory/searchproviderpublic.htm?categoryid=966">http://www.familyservices.govt.nz/directory/searchproviderpublic.htm?categoryid=966</a></td>
</tr>
<tr>
<td><strong>Legal Advice</strong></td>
<td>Affordable options for legal advice are few and far between. Community Law Centres may be able to offer advice or refer victims to legal advisers. Citizens Advice Bureaus may also be able to assist. Victims may also be eligible for legal aid. Some lawyers will take on cases pro bono but they are hard to find. Women’s Refuges and some community organisations may have strong relationships with certain lawyers and are able to get free/cheap services sometimes.</td>
</tr>
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</table>
Power and Control Wheels

The Muslim Wheel of Power

(Dr. Sharifa Alkhateeb)

Adapted from the Duluth Model. www.peacefulfamilies.org/dvwheel.html
The Victim Empowerment Wheel

(Weber & Levine 2003)
http://stoprelationshipabuse.org/pdfs/Power%20Control%20Wheel%20Empowerment.pdf

NB: The screening age in New Zealand is 16 years of age.
The Migrant & Refugee Power & Control Wheel

(Chomilo, 2002)

The original POWER AND CONTROL WHEEL and EQUALITY WHEEL were developed by the Domestic Abuse Intervention Program in Duluth, Minnesota.

There are wheels translated in different languages and posted on the National Center on Domestic and Sexual Violence.
Acknowledgements

This supplementary resource is for health professionals working in services that incorporate screening for partner abuse in their (clinical) practice. The resource addresses working with women, children and families from culturally and linguistically diverse clients (CALD) backgrounds. The resource is funded by the Northern Regional Alliance and produced by Waitemata District Health Board. The Northern Regional Alliance and Waitemata DHB eCALD® Services acknowledge and greatly appreciate the contributions and editing advice of the VIP teams at Waitemata DHB, ADHB and CMDHB as well as all the reviewers who assisted with the review of the resource in 2014.

<table>
<thead>
<tr>
<th>Name</th>
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<tbody>
<tr>
<td>Anne-Marie Tupp: ADHB Specialty Clinical Nurse: FV Intervention and Te Puaruruhau</td>
<td>Full document</td>
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<tr>
<td>Emma Jansen: ADHB FV Coordinator</td>
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<tr>
<td>Laurel Webb: ADHB Child Protection Coordinator</td>
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<tr>
<td>Kathy Lowe: ADHB FV Prevention Coordinator</td>
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<tr>
<td>Lesley Young: Waitemata DHB Family Violence Prevention Coordinator</td>
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<td>Lorna Wright: Waitemata DHB FV Coordinator</td>
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<tr>
<td>Nikki Hill: Waitemata DHB Child Protection Prevention Coordinator</td>
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<tr>
<td>Edith Padavatan: CMDHB FV Prevention coordinator</td>
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<tr>
<td>Dr Catherine Topham: Shine</td>
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<tr>
<td>Miranda Ritchie: National VIP Coordinator</td>
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<tr>
<td>Deepika Sarmah: PHO FVI Coordinator</td>
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<tr>
<td>Sarah Hood: Waitemata DHB CALD Project Coordinator</td>
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<td>Katrina Penny: ADHB Public Health</td>
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<td>Patrick Au: ADHB Asian Mental Health Service</td>
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<td>Laura Patterson: ADHB Funding and Planning</td>
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<td>Edith Padavatan: CMDHB FV Prevention coordinator</td>
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<td>Megan Halbert: CYFS</td>
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<tr>
<td>Jenny Janif: MSD</td>
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<tr>
<td>Khalid Shah: Service coordinator, Local Service Coordination, Mental Health Services Group Waitemata DHB</td>
<td>Indian and Muslim sections</td>
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<tr>
<td>Etetu Bowden: Interpreter</td>
<td>MEA section</td>
</tr>
<tr>
<td>Marguerite Ntawe: Interpreter</td>
<td>MEA section</td>
</tr>
<tr>
<td>Kelly Feng: Waitemata DHB Asian mental health service team leader</td>
<td>Chinese section</td>
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<tr>
<td>Grace Ryu: Waitemata DHB Asian patient support service team leader</td>
<td>Korean section</td>
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<tr>
<td>Victoria Camplin-Welch: Clinical Psychologist and Cross-Cultural Specialist</td>
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<tr>
<td>Mariska Mannes: Waitemata DHB CALD Trainer</td>
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<tr>
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<td>Shahin Payam: Waitemata DHB CALD Trainer</td>
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