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**Domestic Violence in Culturally and Linguistically Diverse
(CALD) Communities:
Perceptions, Therapeutic Approaches and Responses of
Frontline Workers in New South Wales (NSW)**

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BDS, MPH, MHM, MHIM

Submitted in fulfilment of the requirements for the Degree of Doctor of Philosophy



School of Arts and Sciences
Sydney Campus

December 2020

Declaration of Authorship

This doctoral thesis is the candidate's own work and contains no material which has been accepted for the award of any degree or diploma in any other institution.

To the best of the candidate's knowledge, the doctoral thesis contains no material previously published or written by another person, except where due reference is made in the text of the thesis.

The research presented and reported in this thesis was conducted in accordance with the National Health and Medical Research Council National Statement on Ethical Conduct in Human Research (2007, updated 2018). The proposed research study received human research ethics approval from The University of Notre Dame Australia Human Research Ethics Committee (EC00418), Approval Number # 014077S

(Signed):

03/12/2020

Oluwatoyin Abiola Dedeigbo

Date

Dedication

This thesis is dedicated to the memory of CALD women who have lost their lives to domestic violence and to my mother, Mrs Victoria Olajide, for her perseverance and love for her children.

Acknowledgements

I wish to express my gratitude to God Almighty for the success of this work. Everything I have achieved is because of You. I also would like to express my profound gratitude to the following people who in a variety of ways assisted me in the completion of this project.

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Publications Originating from this Work

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Dedeigbo, O. A., & Cocodia, E. (2016). Discourse Analysis on efficacy of therapeutic approaches for victims of domestic violence associated with Australia's CALD communities. *International Journal of Management and Applied Science*, 9, Special Issue 1, 50-54. ISSN: 2394-7926

Abbreviations

AAFS	Arabic American Family Services
AAFSC	The Arab-American Family Support Centre
ABS	Australian Bureau of Statistics
ACSSA	Australian Centre for the Study of Sexual Assault
ADFVDRN	Australian Domestic and Family Violence Death Review Network
AHMAC	Australian Health Ministers' Advisory Council
AHRC	Australian Human Rights Commission
AIC	Australian Institute of Criminology
AIFS	Australian Institute of Family Studies
AIHW	Australian Institute of Health and Welfare
AIPC	Australian Institute of Professional Counsellors
AIWN	Asian Indigenous Women's Network
ALRC	Australian Law Reform Commission
AMENSA	Arab, Middle Eastern, Muslim and South Asian
AMWCHR	Australian Muslim Women's Centre for Human Rights
ANCORW	Australian National Committee of Refugee Women
APH	Australian Parliament House
API	Asian Pacific Institute
AVO	apprehended violence order
AWAU	African Women Australia
AWAU	African Women Advocacy Unit
BAWSO	Black Association of Women Step Out
BME	Black and minority ethnic
CALD	Culturally and Linguistically Diverse
CBT	Cognitive Behavioural Therapy
CFCA	Child Family Community Australia
COAG	Council of Australian Governments
DIAC	Department of Immigration and Citizenship
DSS	Department of Social Services
DV	Domestic Violence
ECCV	Ethnic Communities' Council of Victoria
GBV	Gender Based Violence
GDP	Gross Domestic Product
GP	general practitioner
HREOC	Human Rights and Equal Opportunity Commission
HTML	HyperText Markup Language
IDVAAC	Institute on Domestic Violence in the African American Community
IKWRO	Iranian and Kurdish Women's Rights Organisation
IPV	Intimated Partner Violence

IVAWS	International Violence Against Women's Survey
KPMG	Klynveld Peat Marwick Goerdeler
MWSS	Migrant Women's Support Service
NCDV	National Centre for Domestic Violence
NCRVWC	National Council to Reduce Violence against Women and their Children
NES	Non-English Speaking
NHMP	National Homicide Monitoring Program
NOM	Net Overseas Migration
NSW	New South Wales
NSW	New South Wales
NWAC	Native Women's Association of Canada
NWAC	Native Women's Association of Canada
NYC	National Youth Commission
ONS	Office of National Statistics
PCT	Person Centred Therapy
PSS	Personal Safety Survey
SAAP	Supported Accommodation Assistance Program
STD	Sexually Transmitted Diseases
STI	Sexually Transmitted Infections
UK	United Kingdom
UN	United Nation
UNGAR	United Nation General Assembly Resolution
UNICRI	United Nations Interregional Crime and Justice Research Institute.
USA	United States of America
WA	Western Australia
WCDFVC	Women's Council for Domestic and Family Violence Services
WHO	World Health Organisation
WLSV	Women's Legal Service Victoria

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Abstract

Domestic violence is a universal public health concern (VicHealth, 2011; World Health Organisation [WHO], 2013). Domestic violence cuts across all countries, regardless of economic, social, cultural or religious differences (Ali et al., 2020; VicHealth, 2011; WHO 2013). Men are often responsible for perpetrating domestic violence against women (Australian Bureau of Statistics [ABS], 2019; Australia Institute of Health and Welfare [AIHW], 2018).

The effects of domestic violence on victims can be serious and long-term; affecting their physical and mental wellbeing, and lingering even after the exposure to violence has ended (Mitchell, 2011). That is, the effect on victims' mental health is cumulative and detrimental (Ali et al., 2020; WHO, 2013). The impact of domestic violence on the health of its victims is well known (Dedeigbo & Cocodia, 2016). Its prevalence in Culturally and Linguistically Diverse (CALD) communities is problematic because of limitations in research methodology, including sample selection and under-representation, leading to mixed findings being reported within existing studies. Globally, one of three women is a victim of domestic violence, and in Australia this figure is one in six (AIHW, 2017; Ethnic Communities' Council of Victoria [ECCV] 2012); WHO, 2013). A similar prevalence appears among Australia's CALD communities, which constitute about one fifth of the total Australian population (AIHW, 2017). In addition, the prevalence of domestic violence is likely to be underestimated as many instances of domestic violence go unreported to authorities (Australian Parliament House [APH], 2015).

Briefly, CALD communities refer to communities with diverse languages, ethnic backgrounds, nationalities, tradition, societal structures, and religions (ECCV, 2012). Therefore, they are a highly diverse group, and victims of domestic violence can belong to several communities. Despite this variation, they all tend to share a lack of familiarity with the local services available for domestic violence or the benefits of these services, and this presents as a challenge in need of further study.

There are organisations that provide help to women who have experienced domestic violence, including social services, counselling and psychotherapy (initial and ongoing), legal services, financial counselling and employment support (Australian Government's Department of Social Services [DSS], 2019). These organisations

employ the services of professionals who directly support victims of domestic violence in these many ways (DSS, 2019), including those from diverse cultural backgrounds and socio-economic classes, with varying needs.

In their role, frontline workers have firsthand knowledge about CALD victims of domestic violence who utilise their services. However, research is limited on their perceptions of CALD women, and therapeutic approaches, outcomes and challenges involved in supporting these victims. This thesis attempts to fill this important research gap.

Specifically, this thesis aims to understand frontline workers' perceptions of domestic violence in CALD communities more fully, and more fully explore the therapeutic approaches utilised with CALD women who have experienced domestic violence, as well as the consequences and behavioural impact of such approaches from the perspectives of social workers, shelter workers, health care workers, counsellors, therapists and other frontline workers. This project assessed services in the Australian state of New South Wales (NSW) for CALD communities, and situates the discussion in relation to the literature on similar services in terms of cultural sensitivity, therapeutic approaches and accessibility in selected comparable countries.

Sixty frontline workers participated in an online survey that comprised a structured questionnaire and free response sections, allowing for quantitative and qualitative analysis. Data was analysed using standard statistical parameters. In addition, seven research papers from the international literature base were selected for critical theme-analysis. Themes were identified, and syntactic analysis of the themes was performed. Also, support services for CALD domestic violence victims in the United States of America (USA), the United Kingdom (UK) and Canada were compared with those in Australia.

In this study, 85% (n=51) of the survey participants were females and had been trained in working with CALD communities. Of all participants, 83% (n=50) were counsellors, and 87% (n=52) had more than five years' work experience. Among these frontline workers, 57% (n=34) had received training in working with CALD communities, and 53% (n=32) had received specific guidelines for working with CALD communities in their organisation.

The findings also showed that frontline workers consistently drew upon a Person Centred Therapeutic approach (PCT) with CALD victims while acknowledging each client had a specific cultural identity. When other therapeutic approaches such as Cognitive Behaviour Therapy (CBT) were used, frontline workers adapted such therapies to create culturally sensitive interventions for CALD women. Hence, wide variations between clients required that therapies be adapted to meet each client's need.

The research shows that support services in Australia were similar to those in selected comparable countries. However, more services in Australia appear faith-based. Overall, the findings identified the need to develop standardised but flexible multicultural frameworks and education schemes for frontline workers to assist CALD victims of domestic violence.

CHAPTER 1 - Introduction

“There is one universal truth, applicable to all countries, cultures and communities: violence against women is never acceptable, never excusable, never tolerable” (Ban Ki-Moon, 2008).

“The variation in the prevalence of violence seen within and between communities, countries and regions, highlights that violence is not inevitable, and that it can be prevented. Promising prevention programs exist and need to be tested and scaled up” (WHO, 2010).

1.1 Introduction

Domestic violence (DV), intimate partner violence (IPV), gender-based violence (GBV) or relationship violence, pertains to violence conducted within intimate relationships and households (Davidson et al., 2021; Home Office, 2013; Morgan & Chadwick, 2009; United Nation General Assembly Resolution [UNGAR], 1993). It includes physical, psychological, emotional and sexual abuse, and economic and social dispossession, whereas family violence applies to violence among family members including violence within intimate relationships (Ali et al., 2020; Morgan & Chadwick, 2009). Thus, domestic violence is a type of family violence, and is the most common type (ABS, 2017; McGuire, 2013).

Domestic violence forms a behavioural pattern which infringes upon the rights of females and, more rarely males who are also victims of violence (Australian Parliament House [APH], 2015). However, male victims are not the focus of this study. Studies have shown that the prevalence of violence against women is far higher than the rates of violence against men (ABS, 2016; AIHW, 2019; Davidson et al., 2021; Ferrante et al., 1996; Morgan & Chadwick, 2009; Roberts et al., 1993). That is, men usually perpetrate domestic violence against females (ABS, 2016; AIHW, 2019; Taft et al., 2001; VicHealth, 2011).

Domestic violence against women includes threats of related conducts such as constraints or random withholding of liberty, happening in private or public setting, resulting in, or with the likelihood of ending in, sexual, physical or psychological trauma and pain (Home Office, 2013; UNGAR, 1993). Systematic studies have also indicated that violence perpetrated against women is a human right as well as public health issue affecting nearly one-third of women universally (Council of Australian

Governments [COAG], 2011; Garcia-Moreno, et al. 2006; Our Watch et al., 2015; Phillips & Vandenbroek, 2014). The repercussions of domestic violence on women's physical, mental and reproductive health are well known (AIHW, 2019; Ali et al., 2020; Davidson et al., 2021; McGuire, 2013). According to the World Health Organisation, (WHO) (2013), it damages victims' health and wellbeing, reducing their participation in society (AIHW, 2019). Globally, domestic violence peaks during the woman's reproductive years (United Nation [UN], 2015).

The ABS' Personal Safety Survey (PSS) (ABS, 2016) also showed that more than one in every three Australian women (36% or 6.7 million) had reported being a victim of one form of violence perpetrated by a male since the age of 15, compared to one in ten (11% or 2 million) victims of violence from a female perpetrator. The same report indicated that about one of every four females (23% or 2.2 million) had reported being a victim of a form of violence perpetrated by an intimate partner, compared to one out of every thirteen male victims (7.8% or 703,000) (ABS, 2016). According to the ABS data, females were close to three times more likely to have reported suffering domestic violence than males, with nearly one out of every six females (17% or 1.6 million) compared to one out of every sixteen males (6.1% or 547,600) reporting having suffered physical violence since the age of 15 (ABS, 2016). One out of every six females (16% or 1.5 million) compared to one in 17 males (5.9% or 528,000) reportedly suffered physical violence by a spouse (Australian Government Attorney-General's Department, 2018). Females were also more than eight times more likely to report suffering sexual abuse by a partner than males (5.1% or 480,200 women compared to 0.6% or 53,000 men) (ABS, 2016). Based on this pattern, this research has focused on domestic violence experienced by CALD women rather than men.

1.2 Research Background

Universally, there has been acknowledgment of domestic violence and the consequences of domestic violence as a social health issue for women and children since the early 1970s; however, there are limited details on its prevalence among CALD communities (Dedeigbo & Cocodia, 2016). This has led to a perception among researchers, policymakers CALD communities, practitioners, and mainstream communities of the low prevalence of domestic violence in CALD communities (Department of Premier and Cabinet, 2019; Morgan & Chadwick, 2009). There have

also been methodological limitations in conducting research among CALD communities. For example, language barriers on the part of researchers and interviewers, and other factors such as lack of attention to socio-cultural context, limited the comparability of different items of research due to the limitations of sampling criteria and data-collection methods (Department of Premier and Cabinet, 2019; Yoshihama, 2008). In addition, the absence of a culturally appropriate study framework diverted attention away from CALD communities (Department of Premier and Cabinet, 2019; Yoshihama, 2008). Hence, it is difficult to draw a conclusion on the precise nature and extent of domestic violence in CALD communities (Department of Premier and Cabinet, 2019; Tually et al., 2008).

Recent research has shown a rise in comprehension and recognition of what constitutes domestic violence in CALD communities because of community awareness programs and training, as well as generational change (COAG, 2011; DSS, 2015; Home Office, 2015; Parkin, 2017, Webster et al., 2019). However, to reduce the health burden of domestic violence, further investigations need to be conducted within CALD communities where females are more vulnerable than females in non-CALD communities (AIHW, 2018; Department of Premier and Cabinet, 2019) due to the strong social expectation to adhere to traditional gender roles; a pertinent feature of patriarchal collectivist cultures that centrally value family reputation, so will protect it at all costs (Department of Premier and Cabinet, 2019).

The motivation for this research was borne from observing cultural issues surrounding domestic violence, and how these factors impact on reporting and help-seeking in CALD communities. As a member of the CALD community with a healthcare background, I have observed that women from CALD backgrounds often refuse to notify authorities about incidences of domestic violence because of concerns about stigmatisation and sometimes ostracism (Department of Premier and Cabinet, 2019). Overstreet and Quinn (2013) have also identified a similar trend and reported that fear of stigmatisation may be a barrier to help-seeking behaviour. They also suggested a model that further expounds on the central role of stigmatisation. From their model, three types of stigmas – cultural stigma, stigma internalisation and anticipated stigma – are said to interfere with help-seeking behaviours.

CALD women are usually afraid to notify authorities of their domestic violence experience, and rather turn to their informal networks, oftentimes without considering removing themselves from the abusive situation (Femi-Ajao, 2018). In a Tanzanian study, McCleary-Sills et al. (2015) interviewed 104 key informants and found that among the 44% of women who reported suffering domestic violence only 10% accessed formal services.

The study uncovered socio-cultural interferences to help-seeking behaviour, including intersectionality (how the competing challenges facing CALD women, (e.g., assumption of homogeneity, despite coming from diverse cultural and specific ethnic groups, gender, and religious challenges and biases, isolation from family supports due to migration, disability, language barriers), gendered social norms that condone domestic violence, as well as stigmatise and shame victims (McCleary-Sills et al., 2015). Several other studies report similar findings (e.g., Ali et al., 2020; Horn et al., 2016; Mannell et al., 2016; Meyer, 2016; Petersen et al., 2005; Taha, 2019).

To break the victims' silence, there is a need to eradicate the stigmatisation and ostracism arising from being a victim of domestic violence, and this break is seen to start from the point a victim seeks support. Thus, this study has sought to understand how frontline workers perceive these issues for CALD victims of domestic violence and how their perceptions affect their intervention methods. The criticality and benefits this study will bring to the CALD community cannot be over emphasised. Although men are outside the scope of this study, possibilities are that findings from this study could also be of benefit for them (Berghuis, 2018; Listwan, 2009). Furthermore, findings will help us understand the role barriers to reporting domestic violence play so that effective outreach and assistance can be provided to victims/survivors of domestic violence from immigrant/CALD communities. The extent that the strengthening of social networks of friends, relatives and neighbours who CALD women often seek support from, and play in the overall support structure for victims, will also be better understood.

1.3 Thesis Structure

Chapter 1 presents the background, motivation and rationale for this research. Chapter 2 examines in more detail the prevalence of domestic violence in Australia and globally. It also explores the current literature on domestic violence, the

associated risk factors, perspectives on violence against women as well as the impact of domestic violence. It also examines the reporting of domestic violence and help-seeking behaviours. Chapter 3 presents various cultural perspectives on domestic violence, and the nature of domestic violence in CALD communities in Australia. Chapter 4 reviews the efficacy of Person Centred Therapy (PCT) and Cognitive Behaviour Therapy (CBT) in supporting CALD communities in the US, UK, and Canada, and how these compare to services in Australia. The chapter also examines the support services available in the three aforementioned countries, with the aim of ascertaining any gaps that exist in Australian services. Chapter 5 outlines this study's research design and methods, which are quantitative and qualitative. Chapter 6 presents the results of the quantitative and qualitative analyses. Chapter 7 discusses these in more depth. Finally, Chapter 8 presents the conclusions, remarks and recommendations emerging from this research.

1.4 Thesis Statement

Among the general population, domestic violence is considered to include all forms of physical and sexual assaults, with less recognition of social, psychological and financial abuse as components of domestic violence (Ali et al., 2020; Home Office, 2015; VicHealth, 2011; Webster, 2019). O'Donnell et al. (2002) found that the prevalence and nature of domestic violence perpetrated against women who are from CALD communities is higher, while others suggest that the prevalence is lower or the same as that among women from English-speaking backgrounds in Australia (Bassuk et al, 2006; Mouzos & Makkai, 2004). Research also suggests that women from CALD communities are affected by domestic violence in manners that differ to non-CALD women (Department of Premier and Cabinet, 2019; Gee, 2016).

Additionally, the Western Australia (WA) Department for Communities (2006) reported that CALD women were unlikely to notify police of their domestic violence victimisation or utilise support services based on a belief that there is limited understanding of their predicament, and therefore that the response by services may be inadequate (Morgan & Chadwick, 2009; Department of Premier and Cabinet, 2019). Studies have also suggested that other factors preventing CALD women from accessing services include limited availability of culturally sensitive support, insufficient knowledge of English, insufficient knowledge of the existence of services and information, insufficient access

to culturally sensitive translators and interpreters and over-reliance on perpetrators for residential or citizenship status and economic security (Department of Premier and Cabinet, 2019; COAG, 2011; Women's Council for Domestic and Family Violence Services [WCDFVS], 2006; Webster, 2019; Yoshihama & Novick, 2009). Morgan and Chadwick (2009) and Wang and Dong (2019) also reported that factors such as age and living arrangements equally predispose women to domestic violence because they can make it impracticable for the victim to exit a violent relationship.

From these studies, it is apparent that there are divergent findings on domestic violence among CALD women. This diversity also underscores the need to understand effective approaches that can support these women irrespective of predisposing factors. Thus, this research has explored the experiences of frontline workers in a bid to understand the attitudes and practices that can improve the effectiveness of support services delivered to CALD women.

1.5 Research Questions

Based on the above background, the following research questions have guided this study:

- 1) How do frontline workers perceive domestic violence and provide support to CALD women who are victims of domestic violence?
- 2) What is the relationship between culture and domestic violence in CALD communities?
- 3) How effective are person centered therapy (PCT) or cognitive behaviour therapy (CBT) therapeutic approaches in supporting CALD women, as reported by frontline workers?
- 4) How do support services in Australia for CALD communities compare with services in other developed countries?
- 5) In what ways can service provision for CALD women who have experienced domestic violence be improved in Australia?

1.6 Research Objectives

This research has sought to explore the diversity of perspectives of frontline workers regarding the effects of domestic violence in CALD communities in NSW. It has also sought to assess the consequences and behavioural impact of frontline workers' views of their approaches. This research also aims to explore their opinions on limitations of the current provision of service, the challenges faced by women from CALD communities, and how appropriate support can be provided through the adaptation of policies and management frameworks.

The answers to the above questions will be obtained by fulfilling the following aims:

- 1) To investigate the perception of frontline workers of domestic violence amidst CALD women and explore the therapeutic approaches utilised in supporting them.
- 2) To investigate the perceived roles of culture on domestic violence and examine the difficulties faced by women from the selected communities in accessing support.
- 3) To explore the challenges faced by frontline workers as they cover different cultures and the perceived limitations to the level of support offered.
- 4) To assess the effectiveness of programs that are available against domestic violence in Australia compared to other developed countries.

1.7 Research Significance

This study aims to provide a better understanding of potential strategies to employ when working with CALD women to address the post-exposure effects of domestic violence. Similarly, it will suggest support needs of survivors and victims of domestic violence among CALD women. These suggestions will assist service providers to adapt their strategies and policies to meet their specific needs. Furthermore, findings from this research in relation to domestic violence will facilitate an understanding of how to improve reporting and support help-seeking behaviours among CALD women experiencing domestic violence.

CHAPTER 2 - Literature Review

2.1 Introduction

In 1993, the United Nations General Assembly (UNGAR) made and accepted a declaration that violence against women needs to be eliminated. The declaration defined violence against women as “any gender-based violence that leads to or may predispose to harm physically, psychologically or sexually. This includes acts or threats that result in suffering, liberty deprivation or coercion whether privately or publicly”.

The Australian Institute of Criminology also described domestic violence as a form of brutality occurring between intimately related people, whether in the past or in an ongoing relationship or in a domestic environment (Morgan & Chadwick, 2009). These conducts include physical, emotional, sexual and psychological abuse.

Seminal author, Mitchell (2011), listed the different categories of domestic violence as follows:

- Verbal abuse—name calling, swearing at the victim, humiliating her both in public and private places running down her intellect, sexual instincts, body image, capability as a spouse and capability as a parent.
- Physical abuse—bodily harm such as beating, slapping and kicking, using weapons or using objects as weapons, assaulting children, refusing victims or children entry to the house, and depriving the victim of basic necessities such as sleep, food, and lodgings.
- Social abuse/Coercive control—systematically estranging the victim from friends, family and social network, goading and dominating, moving them to a place where the victim will feel lonely with no social circle or employment opportunities, keeping them under surveillance, denying and restricting accessibility to information and services for support, and restricting the person from mingling with others.
- Sexual abuse—forceful or pressured sexual intercourse and sexual coercion of any kind, forcing undesired sex, engaging in sexual humiliation, inflicting pain during sexual intercourse, using force to have sex with the victim, un-

consensually avoiding protections against sexually transmitted diseases or pregnancy, engaging in sexual slavery, finding fault, and using demeaning language (also cited in National Council to Reduce Violence against Women and their Children [NCRVWC], 2008). This also constitute coercive control.

- Emotional abuse—accusing the victim of being the cause of problems in the domestic relationship, and reducing their self-esteem and self-worth by using emotional blackmail through comparing them to others.
- Psychological abuse—intimidation, threatening the victim about the custody of any children, continuous denigration of the victim, insisting on unfavourable or unhelpful system of discipline for the victim, destruction of property, humiliation, animal cruelty as a proxy for relationship power-dynamics, as well as dangerous driving, and ignoring the victim.
- Economic abuse—managing all funds, restricting access to bank accounts, giving insufficient money, forbidding the woman from getting a job, and taking all the earnings from the victim.
- Spiritual abuse—subordinating the victims through the incorrect use of religious and cultural beliefs or practices, and intentionally misconstruing spiritual and cultural traditions as a justification for violence and abuse.

As stated earlier, domestic violence has been described in other terms that include:

- Intimate Partner Violence (IPV)—which denotes any behaviour in a domestic relationship that brings about physical, sexual, emotional or psychological harm to people in such intimate relationship (Krug et al., 2002).
- Gender Based Violence (GBV)—violence aimed at a person on gender basis and “constitutes a breach of fundamental right to life, liberty, security, dignity, equality between women and men, non-discrimination and physical and mental integrity” (Council of Europe, 2006; World Bank, 2014).
- Family Violence—a wider expression of domestic violence. It applies to violence among members of the same family and also violence between people in intimate relationships (COAG, 2011; VicHealth, 2017). This phrase also includes an intricate array of behaviours beyond physical violence (The Australian and New South Wales Law Reform Commission [ALRC], 2010). The Australian and New

South Wales Law Reform Commission (ALRC, 2010) reviewed family violence law and recommended that “state and territory legislation should provide that family violence is violent or threatening behaviour, or any other form of behaviour, that coerces or controls a family member or causes that family member to be fearful” (ALRC, 2010; Mitchell, 2011).

2.2 Prevalence of Domestic Violence

The impact of domestic and family violence is difficult to quantify because it involves violence within private relationships, and in many cases, incidents are unreported (AIHW, 2019). According to Grech and Burgess (2011), less than half of victims of domestic violence inform police of the incidence.

The seriousness of the problem is also not fully perceivable for three reasons. Firstly, the data on violence varies according to the definition of the term (ABS, 2012; Department of Premier and Cabinet, 2019; Davidson et al., 2021; Phillips & Vanderbroek, 2014; UN, 1993). For example, if only violence on wives by their husbands is included, the reported data excludes violence between *de facto* partners or dating partners. Secondly, violence happens within any type of intimate relationship, for instance between spouses, in-laws, dating partners, live-in relationships, and even between ‘friends with benefits’ and other more fluid categories of relationship identity (ABS, 2016; AIHW, 2019). These sometimes loose definitional frameworks add granularity to the data, which makes macro-level research complex. Thirdly, for a variety of reasons, a large number of incidents are not reported to various regulatory agencies, so the available data is based only on the incidents of violence that have been self-reported to them (Phillips & Vanderbroek, 2014; AIHW, 2019). In spite of these highlighted limitations, this review will attempt to highlight the prevalence from both the global and Australian perspectives.

2.2.1 Global Prevalence of Domestic Violence

The World Health Organisation (WHO, 2013) performed a first-ever intercontinental systematic review of the prevalence of domestic violence against women utilising population data from around the world. This review enabled WHO to obtain global data on the burden of domestic violence and its effect on the health of women. The

prevalence of domestic violence worldwide and regionally was extracted from the data of 79 countries¹ and five Australian states and territories (see Table 2.1).

States	Female Victims of Domestic and Family Violence-related Assault	Total number of Domestic and Family Violence-related Assault
New South Wales	20,338	30,467
South Australia	5,926	7,740
Western Australia	13,291	18,274
Northern Territory	3,351	4,076
Australian Capital Territory	510	693

Table 2.1: The number of female victims of domestic and family violence from selected states and territories of Australia, 2015 (ABS, 2016).

According to this report, 35% of women, globally, had reportedly lived through some kind of violence, physical and/or sexual, in the course of their lives with the majority of this being intimate partner violence. One stark statistic was that 38% of homicides were committed by intimate partners. The reported prevalence of domestic violence was 30% among all women that have ever been in a relationship. The regions of

¹ Countries included by WHO: Low- and middle-income regions: Africa (Botswana, Cameroon, Democratic Republic of the Congo, Ethiopia, Kenya, Lesotho, Liberia, Malawi, Mozambique, Namibia, Rwanda, South Africa, Swaziland, Uganda, United Republic of Tanzania, Zambia, Zimbabwe) Americas (Brazil, Chile, Colombia, Costa Rica, Dominican Republic, Ecuador, El Salvador, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Paraguay, Peru, Plurinational State of Bolivia) Eastern Mediterranean (Egypt, Iran, Iraq, Jordan, Palestine) Europe (Albania, Azerbaijan, Georgia, Lithuania, Republic of Moldova, Romania, Russian Federation, Serbia, Turkey, Ukraine) South-East Asia (Bangladesh, Timor-Leste (East Timor), India, Myanmar, Sri Lanka, Thailand) Western Pacific (Cambodia, China, Philippines, Samoa, Viet Nam) High income: Australia, Canada, Croatia, Czech Republic, Denmark, Finland, France, Germany, Hong Kong, Iceland, Ireland, Israel, Japan, Netherlands, New Zealand, Norway, Poland, South Korea, Spain, Sweden, Switzerland, United Kingdom of Great Britain and Northern Ireland, United States of America

Africa, the Eastern Mediterranean and South-East Asia recorded the highest prevalence of domestic violence; 37% of ever-partnered women disclosed an experience of some form of intimate partner violence at least once in the course of their lives. The next highest prevalence came from the region of the Americas, with 30% prevalence. The lowest prevalence (23%) was reported in the European and Western Pacific regions.

Across ten low- and middle-income countries, the WHO report showed that in the 15 to 49 year age group, an estimated 15% of female Japanese and 71% of female Ethiopians had reportedly experienced violence, physical and/or sexual, perpetrated by an intimate partner in the course of their lives (WHO, 2013). However, there is no restriction to middle and low-income countries when it comes to domestic violence.

Developed countries are also facing this same issue. For instance, in the year ending March 2021, the Office of National Statistics (ONS) in the United Kingdom (UK) reported that 73% women disclosed that they had experienced domestic violence-related crime and 93% of women reported that they had suffered some form of domestic-violence relate sexual offences (Office of National Statistics [ONS], 2021). Figure 2.1 presents the prevalence rates of intimate partner violence based on geographical distribution according to the WHO report (2010).

Additionally, reports from studies conducted across these jurisdictions indicate that intimate partner violence occurs in a considerable proportion of homicides of women. Research from the United States of America, Israel, Canada, South Africa and Australia all showed that, in various jurisdictions of the countries mentioned, between 40 and 70% of murders of females were committed by their partners, spouse or boyfriends, often in an environment of a perpetual violent relationship (WHO, 2013).

Results from decades of international studies similarly affirm this prevalence. These results further emphasise the untoward effect of domestic violence on women's well-being globally (Ali, et al., 2020; AIHW, 2019; Rueness et al., 2020).

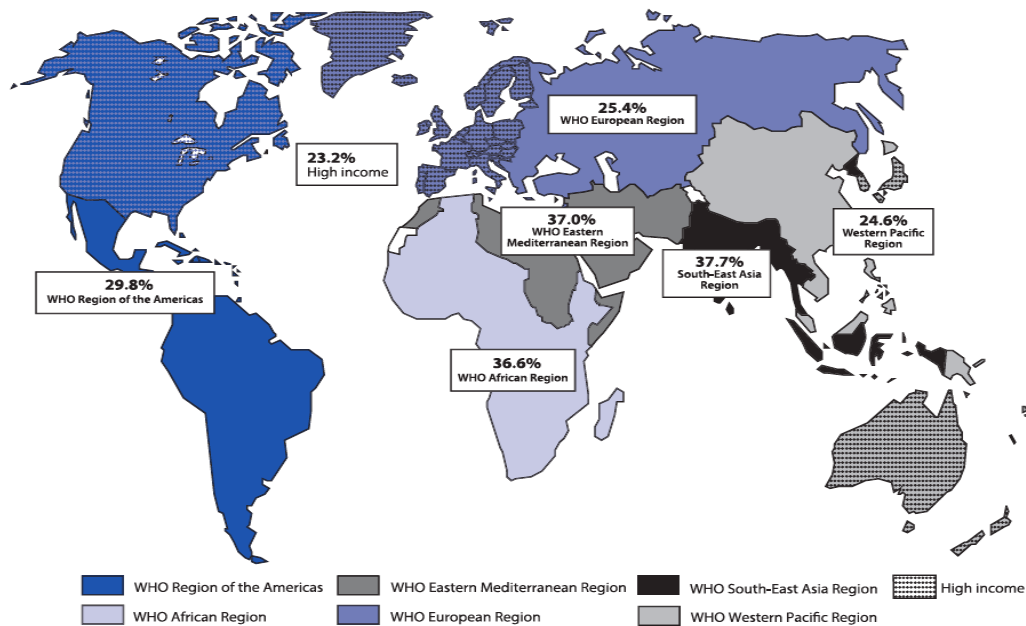


Fig 2.1: Geographical distribution of the prevalence rates of intimate partner violence in different regions of the world for 2010 (WHO, 2013).

2.2.2 Domestic Violence in Australia

Prevalence of Domestic Violence Against Women in Australia

Domestic violence is widespread in Australia and intimate partner violence remains the most frequent kind of violence experienced by women (AIHW, 2019; Stewart & Vigod, 2017). For example, more than 54% of women who reported being a victim of domestic violence had said they had experienced one or more violent incident (AHRC, 2017). A report by PriceWaterhouseCoopers (2015) also estimated that 27% of Australian women reported having suffered violence from a current or ex-partner. Likewise, Bryant and Bricknell (2017) reported that from 2012-13 to 2013-14, an average of one woman died every week in Australia due to domestic violence from a current or previous partner. In 2013-14, an average of eight women were hospitalised per day due to assault by their spouse or partner (AIHW, 2017).

Similarly, in 2014, New South Wales reported fatalities in 24 women who died from family and domestic violence incidents, and 42% of homicides had underlying domestic inherencies (Mitchell & Mitchell, 2015). The seriousness of the problem compelled the Australian government in 2015 to propose a package of measures

costing \$100 million for the protection of victims of domestic and family violence (Mitchell & Mitchell, 2015).

Additionally, the Australian Bureau of Statistics (ABS) in 2015 released a meta-analysis regarding family and domestic violence victims based on records from police investigations. According to this report, there were 158 victims of domestic or family violence-related homicide in Australia. This amounted to over 38% of total homicide victims recorded nationally by police, 103 (65%) of these victims were women and the victimisation rate was seven victims per 1 million persons (ABS, 2015).

Although domestic violence rate has remained stable from 2005 to 2016, women still reported experiencing a higher rate of partner violence as compared to men (ABS 2006, 2017). Studies show that females are more likely to be victims of family and domestic violence-related assaults (ABS, 2015; AIHW, 2018; George, 2016; Orpin et al., 2017; WHO, 2017).

Domestic Violence in Australia, Sources of Data and Main Points

Information on domestic violence and its prevalence in Australia is reported in the ABS' Personal Safety Survey (PSS) of 2016, the Australian part of the International Violence Against Women Survey (IVAWS) and ABS' Women's Safety Survey (ABS, 2016). The first two are usually referred to in domestic violence research when considering the Australian context.

It has been established that domestic violence in Australia is extensive. The risk of a woman being murdered in her home by her male spouse is higher than the risk of her being murdered anywhere else or by anyone else (Alexander, 2010).

Findings from different studies also reveal that many women refuse to notify police of intimate partner violence, especially if the violence is perpetrated by a current spouse (Mouzos & Makkai, 2004; Logan et al., 2006; AIHW, 2018). According to the ABS' Personal Safety Survey (2016), two-thirds of women (69% or 734,500) who had experienced physical violence perpetrated by a male did not report to police (ABS, 2016; Day et al., 2018).

2.3 Domestic Violence and Associated Risk Factors

Although no factor can be singled out as a predisposing factor to domestic violence, a number of elements exist that could be linked with perpetration and victims' experience

of domestic violence. Factors such as alcohol and drug use by perpetrators, childhood experience of abuse by victims, separation and pregnancy increase the risk of domestic violence (Almeda et al., 2017; Mohajer, 2019; Morgan & Chadwick, 2009; Subramani et al., 2017;). Other factors such as stress (both personal and financial), and an absence of social support also appear consistently in women's self-reported experiences with domestic violence (Department of Premier and Cabinet, 2019). Hence, researchers have suggested that violence occurs due to a complex interaction of socio-cultural, situational, personal, relationship, and environmental components, with no factor identified as the most important (Department of Premier and Cabinet, 2019; Dutton, 1995, as cited in WHO, 2013; Parkin, 2017).

2.3.1 Patriarchy and Masculinity Factors

Research across cultures has identified a number of socio-cultural factors which may account for the higher levels of domestic violence in some communities. Levinson (1989, as cited in WHO, 2013) used statistical analysis of coded data from 90 communities to explore the consistent elements which differentiated populations where wife battering was rampant from those where it was non-existent. Wife battering refers to recurrent act of violence (sexual, psychological and/or physical) by the assaulter against the wife to control her through infliction of pain and induction of fear (Herbert, 1983). The conclusion drawn indicated that spousal abuse is rampant in more patriarchal communities, where men have the financial prowess and power to make decisions in the family, where divorce is not easily accessible by women, and where violence is a routine form of conflict resolution for adults (Shaheen et. al., 2020). Communities with female workgroups did not experience battering. Thus, Levinson posited that engaging all-women workgroups reduces the incidence of wife-battering because it provides women with alternatives that facilitate social networking and financial independence from their spouses and households.

Other researchers (e.g., Alsaba & Kapilashrami, 2016; Ekhato-Mobayode et al., 2022; Freedman, 2016; Heidari & Garcia-Moreno, 2016) suggest that domestic violence is more rampant within conflict zones, where violence is seen as a norm and weapons are easily accessible, and there is disruption of social relations and roles of women and men. In these types of socio-economic disruptions, men's ability to fulfil their traditional cultural role, emphasised to varying degrees, as providers and protectors is

limited (Heidari & Garcia-Moreno, 2016; Tanaya, 2020). These situations make women less dependent, and they acquire more economic independence. Unfortunately, this may aggravate spousal violence, although there is limited empirical evidence to support this view. Current data has suggested that the more empowered some women are, the more susceptible they are to domestic violence (Krung et al., 2002, Tanaya, 2020; WHO, 2013). Other researchers have proposed factors such as lack of structural equalities between women and men, stiff gender roles and the belief that manhood requires dominance, aggression, and male honour (Ali, 2011; Dozo, 2015; Edsröm et al. 2015; Harders, n.d.; UNFPA, 2014; Webster et al, 2019). These elements are wrapped up with the problematic identity construct of 'masculinity' which is intimately tied to domestic violence (Tanaya, 2020; Webster et al., 2019). More empirical studies are needed to clarify the relationships among these various interwoven elements.

2.3.2 Personal Factors

In a review of the predisposing factors to intimate partner violence, the likelihood of a man being physically violent towards an intimate partner was associated with factors such as demographics, personality and personal history of abuse, with low income and young age also frequently emerging in the set of demographic factors (Das, et al., 2020; Gillum, 2019, Zaccour, 2019). Other studies have also suggested an association between physical violence and an interplay of educational attainment and socio-economic status (Sardinha et al., 2019). These findings were drawn from a 21-year New Zealand Health and Development Longitudinal Study of cohort of births (between April 1972 and March 1973) in Dunedin (1972-1994), which investigated intimate partner violence. This study revealed a strong predisposition to perpetration of intimate partner violence by the 15 to 21 years age group where families lived with poverty in early life, low academic attainment, and aggression (Moffit & Caspi, 1999, as cited in WHO, 2013). However, this is not to say that domestic violence does not occur in high income and high educated socio-economic groups.

2.3.3 Mental Health Disorders

Studies have shown a strong association between intimate partner violence and some mental health disorders. Population-based longitudinal research in Sweden found an

association between all mental health disorders studied, except autism, and an increased risk of intimate partner violence against women by men with a hazard ratio of between 1.5 to 7.7 (Yu et al., 2019). This study found that men who have been diagnosed with depression, anxiety, substance use disorder, disorder of personality and attention deficit hyperactivity disorder (ADHD) had higher risk of perpetrating intimate partner violence against women than their healthy siblings who were used as controls in this study (Yu et. al., 2019).

Reports from Canadian and American studies also revealed that men that perpetrate spousal violence against women demonstrate insecurity and emotional dependence, have low impulse control and low self-esteem and display excessive anger and acrimony compared to their non-violent peers (Kantor & Jasinski, 1998, as cited in WHO, 2013; Nnawulezi et al, 2018; Théorêt et al., 2020). They are also more likely to be depressed and to rank high on specific personality disorder scales relating to aggression, antisocial behaviour, and borderline personality disorders (Black et al., 1999).

A similar finding was reported by Jaydip (2019), where men with borderline personality disorder had an increased risk of expressing violence toward their spouses. Other studies have also demonstrated an association between traits such as anger, fear of abandonment, delusion, impulsivity, emotional dysregulation and psychopathy with intimate partner violence (Howards, 2015; Jaydip, 2019).

Generally, there seems to be higher rates of mental health disorder among men who perpetrate violence towards their wives; however, not all men who perpetrate violence have mental health problems (Krung et al., 2002). The prevalence of intimate partner violence associated with mental health problems may be relatively low. Nevertheless, psychopaths can be perpetrators of domestic violence (Krung et al., 2002).

2.3.4 Alcoholism and Illicit Drug Use

Consumption of alcohol and illicit drug use is another risk factor that is consistent across male perpetrators of intimate partner violence (Mohajer, 2019; Subramani et al., 2017; WHO, 2013). The meta-analysis that reviewed association between alcoholism or its excessive use and perpetration of intimate partner violence established that it was a notable risk factor for perpetration of violence, with correlation co-efficients in the range of 0.21–0.57 (Black et. al. 1999). According to AIHW (2017),

alcohol use was involved in 34% (one in three) of intimate partner violence incidents. The correlation between the drinking habits of men and risk of a woman experiencing domestic violence was also demonstrated by population-based surveys in South Africa, Brazil, El Salvador, Cambodia, Venezuela, Canada, Chile, Nicaragua, Colombia, Spain, Costa Rica, India, and Indonesia (WHO, 2013).

Intimate partner violence may also be aggravated by excessive alcohol consumption manifesting as an increase in the intensity of arguments in intimate relationships. Consensus among several scholars is that alcohol works as a catalyst, aggravating tendencies to be violence through loss of self-inhibitions, impaired sense of judgement, and loss of ability to make sense of social cues (Australian Government Attorney-General's Department, 2018; Curtis et al., 2019; Mohajer, 2019; Subramani et al., 2017). Other researchers are of the opinion that culturally-dependent relationships between alcohol use and domestic violence can only be exhibited in situations where the general belief is that certain conducts are excused or caused by alcohol consumption. In such situations, men use alcohol in a pre-planned way to physically abuse their spouses as part of social norms (Gelles, 1993, as cited in WHO, 2013; Mohajer, 2019; Subramani et al., 2017). Questions have been asked about true causal relationship between alcohol use and domestic violence, and some of these debates are discussed in Section 2.7.

Logistic regression modelling of data from the International Violence against Women's Survey (IVAWS) showed a significant correlation between partners' domineering behaviour, levels of alcohol use and aggression, all of which were predisposing factors for intimate partner violence perpetration (Mouzos & Makkai, 2004).

In the most extreme cases, a significant proportion of intimate partner deaths are related to excessive alcohol use. From 2000 to 2006, 44% of intimate partner deaths were related to excessive alcohol use (Deardon & Payne, 2009). About 87% of intimate partner homicides in Indigenous communities were related to the consumption of alcohol (Deardon & Payne, 2009). According to Mitchell (2011), alcohol use is a risk factor for domestic assault, especially among Indigenous communities. In a longitudinal analysis of the concentration of alcohol stores, the author observed a relationship between availability of alcohol and incidence of domestic violence. Stores that sell packaged liquor and alcohol for off-premises

drinking were most to blame for domestic violence (Livingston, 2011). Thus, it can be said that alcohol is a risk factor but cannot be claimed as the cause.

In their literature review, Bennett and Lawson (1994) noted a clear association between substance abuse and domestic violence. On the other hand, the correlation between domestic violence and other drug abuse was unclear (Feingold et al 2015). Based on the review of evidence to date, Lipsey et al. (1997) concluded that although some evidence of an association between drug abuse and domestic violence exists, firm evidence is lacking.

Considering the complex relationship between drinking and domestic violence, perhaps the general conclusion is that men who are heavy drinkers have higher tendencies of perpetrating physical violence on their female spouses, since alcohol reduces inhibitions, and therefore can increase the severity of assault (Subramani et al., 2017). This is consistent with the results of a Canadian survey where women were found to have a five times higher risk of being assaulted by heavy drinking spouses compared to those whose partners were non-drinkers (Johnson, 1996, as cited in WHO, 2013; Löbmann et al., 2003; Rodgers, 1994; Subramani et al., 2017).

2.3.5 Community Factors

There is a general perception that a wealthy socio-economic background reduces the likelihood of intimate partner violence (Gillum, 2019; Spencer et al., 2020; WHO, 2013); however, there are exceptions. Research from various communities has shown that intimate partner violence cuts across all socioeconomic boundaries, even though women from lower socio-economic backgrounds are affected much more (Gillum, 2019; Schuler et al., 1996, as cited in WHO, 2013; Spencer et al., 2020). The exact relationship between poverty and increased risk of domestic violence remains blurred. It is not clear whether the low income itself is the primary factor, or poverty-related problems such as hopelessness and overcrowding, are the more important factors that increase the risk of domestic violence (AIHW, 2019; Das & Roy, 2020).

For some men, living in poverty is a stressor (Gibbs, et al., 2018a; Spencer et al., 2020). Poverty can create feelings of inadequacy, frustration and a sense of failure for not living up to the culturally-expected provider role as a man (Gibbs, et al., 2018a). These pressures vary by family, personality, culture and religion—and all the more so

for CALD communities (Garcia-Moreno et al., 2005, Gillum, 2019) as discussed in Chapter 3. Poverty may also exacerbate marital conflicts or make it harder for women to escape a violent or dissatisfying relationship (Gillum, 2019, Gibbs, et al., 2018a) Regardless, it is apparent that poverty does play an important role in the risk of violence to women (Gillum, 2019; Spencer et al., 2020; Tanaya, 2020).

Each community's, and the national response, to domestic violence can also impact the extent of abuse in such communities and the nation (Webster et al., 2019). Based on a study of sixteen communities with either high or low domestic assault rates, Counts et al. (1992, as cited in WHO, 2013) found that communities that had the lowest rates of intimate partner violence were those in which there were communal sanctions against domestic violence and where sanctuary in the form of family support or shelters were accessible to the victims. The communal penalty or prohibition could be in the form of formal legal punishment or social pressure for people living nearby to intercede if a woman was abused (Simon-Kumar et al., 2017; WHO, 2013). The "sanctions and sanctuary" framework proposes that partner violence in intimate relationships will be high in communities where the social position of women is still in a state of evolution, or where women's rights are not respected (Counts et al., 1992, as cited in WHO, 2013, Simon-Kumar et al., 2017).

Feminism also plays an important role in the experience of domestic violence, which disproportionately affects women and is associated with cultural assumptions about gender role in society (Lompard & Whiting, 2015 as cited in Goel & Goodmark, 2015). In societies where women have low social status, male domination is more frequently enacted through violence (Adjei et al., 2021; Tanaya, 2020). Conversely, in societies where equality for women is more respected, they are likely to have acquired enough collective power to alter their traditional subjugation (Counts et al., 1992 as cited in WHO, 2013, Sardinha et al., 2018; Tanaya, 2020). In more traditional cultures, partner violence often arises when women start to undertake non-traditional roles or enter the workforce (WHO, 2013; Nam et al., 2011).

2.3.6 Relationship Factors

Discord in relationships is the most consistent indicator frequently mentioned for intimate partner violence in marriages (Gibbs et al., 2018a; Kuskoff et al., 2020: Rahmani et al., 2019). The meta-analysis of Black and associates (1999) showed a

moderate to strong correlation between conflict in marriage and intimate partner violence perpetrated by men. Drawing from a systematic analysis, a positive correlation between verbal conflicts in marriage and/or male dominance intimate violence perpetration towards women was found (Vives-Cases et al., 2009). Thus, male domination and verbal conflict in relationships could predispose to spousal violence.

According to a report by WHO (2013), in a population-based study in South Africa and Thailand, marital conflict was affirmed as a predictor of intimate partner violence. Similarly, a 20-year-old review (1987–2006) explored empirical literature in China and found a relationship between intimate partner violence and long marriage duration, poor quality marriage, conflicts in marriage, extra-marital affairs, sexual jealousy, power inequality between partners, inadequate social network and extended family structure (Tang & Lai, 2008).

In a study in Thailand, after controlling for men's stress level, socio-economic status, and other marital factors such as stability and companionship, the correlation between intimate partner violence and marital conflicts of verbal nature was still significant (Hoffman et al., 1994, as cited in WHO, 2013). Women may be more prone to domestic assaults during pregnancy and at times of separation (Almeida et al., 2017; Broughton & Ford-Gilboe, 2017; Ziaei et al., 2016) According to Mitchell (2011), since turning 15, about 36% of women suffered violence in pregnancy from an ex-partner, 18% reported that first-time exposure to intimate partner violence was in pregnancy, 15% claimed they suffered domestic violence from a current partner during pregnancy, while 8% of this number claimed it was their first time.

Depending on a variety of factors, this violence may commence before or after separation, or become worse or more frequent after separation. Studies from other countries show that the decision to leave a partner that is violent can heighten the risk of more brutal, and even the lethality of, assaults (Broughton & Ford-Gilboe, 2017; Campbell, 2001; Turk et al., 2017).

2.3.7 Family History of Domestic Violence

A family history of domestic violence plays an important role in the perpetration of partner violence by men. Studies conducted in Indonesia, Cambodia, Venezuela, Spain and South, Central and North America demonstrated a higher incidence of

violence against women whose husbands had a childhood experience of domestic abuse or had witnessed the abuse of their mothers in childhood (WHO, 2013).

The results of both the ABS and IVAWS surveys indicate a connection between the experience of violence in childhood and perpetration later in life and reception of abuse in adulthood. The IVAWS concluded that women with a childhood experience of abuse were one and a half times at risk of experiencing adulthood violence than women who had no prior experience of abuse in childhood (Mouzos & Makkai, 2004). The Personal Safety Survey (ABS, 2005) revealed that persons with a childhood experience of abuse when they were 15 years and under were at increased risk of becoming intimate partner violence perpetrators in adulthood (after turning 15 years) than those who had no prior experience of domestic violence in childhood. Those who had a childhood experience of physical violence have a two times higher risk of becoming victims of intimate partner violence than those who did not experience such physical violence during childhood (ABS, 2005; Phillips & Vandebroek, 2014). There is three times the likelihood that those who had a childhood experience of sexual abuse would experience intimate partner violence in adulthood than those who did not have childhood experience of sexual abuse (Mitchell, 2011; Phillips & Vandebroek, 2014). Male perpetrators of intimate partner violence may have experienced violence in childhood. However, not every man with a childhood history of domestic violence will end up being a perpetrator of intimate partner violence (Caeser, 1998, as cited in WHO, 2013).

2.4 Domestic Violence and Culture

Cultural specificity and traditions existing in various parts of the world are sometimes used to justify specific social conducts that can perpetuate domestic violence (Akotii, 2018; Mshweshwe, 2020; Klingspohn, 2018; Rai & Choi, 2018; Sawrikar, 2019; WHO, 2002). The nature and scope of the murder of intimate partners in different countries are defined by cultural factors, crime rates, and logistical issues such as the availability of weapons. In the US, guns are more commonly used for the murder of women than all other types of weapons combined (VPC, 2018). On the other hand, in India, guns are rarely used for this purpose; more common is the beating of women and death by fire (WHO, 2002). One method commonly used is to saturate a woman with kerosene, immolate her, then claim that a “kitchen accident” was the reason for her death

(Karkal, 1985). In countries such as India, public health officials believe that official statistics are obscured by incidents such as the murders of women, often categorised as “accidental burns”. The extent of this can be drawn from a study in the mid-1980s which found that 20% of deaths among women aged 15–44 years within urban areas of Maharashtra state were attributed to “accidental burns” (Karkal, 1985; WHO, 2002).

2.5 Vulnerable Groups

As already stated, violence in domestic relationships traverses socio-economic boundaries. However, there are mixed findings regarding the roles of educational attainment, household income, and workforce status on domestic violence (Francis et al., 2016; Kuskoff, & Parsal, 2020, Webster et al., 2019). The IVAWS revealed little variation between the experiences of women victims of intimate partner violence during the preceding twelve months based on educational attainment, employment status, or family income (Mouzos & Makkai, 2004).

Still, some evidence showed that women living with violent husbands were more likely to possess lower literacy levels than women who had no experience of intimate partner violence (Martz et al., 2020; Webster et al., 2019; Women’s Health Australia, 2005). The 2005 ABS report showed a higher risk of intimate partner violence for women not in the workforce in comparison to women who were. Women who were dependent on allowances and pensions from the government as their sole family income were also more vulnerable to intimate partner violence in their lifetime (ABS, 2005; McCarthy et al., 2019; Webster et al., 2019).

Factors like ethnic background, Indigeneity status, environment, age, English-language proficiency, and disability play a significant role in the vulnerability of women to domestic violence. It also contributes to their reluctance to leave such violent relationships (ABS, 2005, McCarthy et al, 2019; Kaur et al., 2018, Swift et al., 2018). These different vulnerable groups will now be explored.

2.5.1 Domestic Violence and CALD Women

Currently, migration is a major contributor to population growth in Australia (ABS, 2019). The estimate of net overseas migration as of December 2018 was 2.8% (248,400 people). This number is 6,800 higher than the number recorded in December 2017 (241,700) (ABS, 2019) (see appendix 1 for charts).

According to the Department of Immigration and Citizenship (DIAC, 2011), about 50% of the current population of Australia were either born overseas or are the children of migrants. Morgan and Chadwick (2009) point to the conflicting results of surveys and other research findings on the scope and forms of domestic abuse in CALD communities. There is a diversity of refugee and immigrant communities in Australia, and this is increasingly the case as immigration grows. As noted by Pease and Rees (2008), immigration status and cultural identity add further intricacies to the web of factors associated with domestic violence. Further, Ghafournia (2011) identified immigration as the cause of socio-cultural disruption and aggravation of domestic violence.

Data from the ABS (2011) indicated that the highest number of reported physical violence in Australia was for people whose country of birth is Australia, closely followed by people born in countries whose main language is English (United States of America, United Kingdom, Ireland, New Zealand, Canada and South Africa). The prevalence was lower among people born in countries whose native language is not English. The ABS Personal Safety Survey (ABS, 2016) found that women who were born in Australia have more likelihood of reporting the experience of both sexual and physical violence in the twelve months preceding the survey than those who were born overseas. The survey also discovered that 2% of women over 15 years of age had experienced present-partner violence; this rate was the same for both Australian-born women and women born in non-English speaking countries. Nevertheless, 16% of Australian-born women, 19% of women born in other English-speaking countries and 7% of women born in non-English-speaking countries reported intimate partner violence from an ex-partner since turning 15 years old.

Substantive studies on domestic violence in Australian CALD communities are limited; the commonly seen reports are silos of studies on certain types of violence among certain ethnic communities (AIHW, 2019; Webster, et al., 2019). The IVAWS showed higher rates of all forms of violence among women from English-speaking backgrounds in contrast to women from non-English speaking backgrounds (NESB) across their lifespan (Mouzos & Makkai, 2009). Nonetheless, Mouzos and Makkai (2009) point out that many NESB women with experience of domestic violence may not have participated in the survey because of religious, cultural, personal and language issues, or that those women who took part in the survey were unlikely to

disclose an experience of domestic violence or publicly talk about such an issue with the interviewers. This would be consistent with the findings of Bonar and Roberts (2006), and more recently, Webster et al. (2019) that CALD women usually refuse to disclose domestic violence to authorities or access services. In the case of CALD women, their varied cultural values and, oftentimes, lack of permanent residency status were barriers to reporting violence or accessing services (Riveroll, 2016, Webster et al., 2019). The extent to which the relative prevalence of violence between CALD and non-CALD women is reliable therefore remains unclear.

Pointing out the high rate of domestic violence among Indian migrant women, Colucci et al. (2014) reported that out of the 641 women who accessed the Melbourne Immigrant Women's Domestic Violence Service between 2008 and 2009, only 54 (8%) were Indian women. Only 16 cases of male and female violence were handled by the Federation of Indian Associations of Victoria.

Although the general impression is that domestic violence is more prevalent in CALD communities (Cox 2015; Webster et al., 2019), there is also contradictory evidence suggesting a lower likelihood of domestic violence among them compared to the general population in Australia. For example, Bartels (2011) reports that only 6,922 migrant women suffered domestic violence compared to 12,292 per 100,000 Australian population. Violence among migrants from non-English speaking countries was lower at 5,710 compared to the general figure of 8,995 per 100,000. Both male and female victims were lower for migrants from these countries than for the general population of Australia.

Commencing in 2005, the Victorian government runs community programs on domestic violence as part of its 20-year plan (VicHealth 2011). In a 2015 review of the plan, Neave et al. offered several findings. There were significant increases in reporting, support by police and court, and a healthy uptake of programs aimed at violence prevention and mitigation. The dependence of support services on language services for their effectiveness was also highlighted in the report of Professionals Australia (2015) to the Royal Commission into Family Violence.

Orticio (2015) discussed some points related to CALD communities. Their physical health problems include alcohol-related ones. Discrimination in employment and at workplaces leads to frustration. Psychosocial support is required for children entering

Australian schools. Domestic violence occurs very frequently among them. Effective interventions are required. The social isolation of the elderly also needs to be tackled. As reported by Woodlock (2015), a survey of 546 domestic violence workers by the Domestic Violence Research Centre Victoria (DVRCV) from 2014 to 2015, identified technology and social media as tools for abuse. Text messages and Facebook posts can be avenues for abuse. Monitoring women and threatening to distribute private photos and videos is also a technology-dependent form of abuse (AIHW, 2019). These challenges are especially more significant in the case of CALD and Indigenous women (Webster et al, 2019). CALD women are more vulnerable to technology-enhanced violence due to factors such as isolation, limited English language skills, limited access to professional employment, limited knowledge of legal rights and uncertainty on their legal status (Leyton et al., 2021).

2.5.2 Domestic Violence and Indigenous Communities

Many Indigenous communities prefer the term 'family violence' because it embraces different kinds of violence in the extended family, intimate relationships, kinship and other settings where there is shared responsibility and support (NSW Health Dept., 2011; Australian Government Attorney-General's Department, 2018). The domestic violence rate is higher in Indigenous communities as both a 'cause and effect' of social disadvantages and intergenerational trauma (Bartels, 2010). The land and cultural dispossession that Indigenous Australians have suffered from more than 200 years ago has resulted in emotional, social, economic, psychological, and physical problems (Memmoth et. al., 2001).

In Indigenous communities, family violence may be different from any perception of a person beaten up in privacy (Prentice et al., 2017; Webster et al., 2019). Most incidents of family violence involving Indigenous communities take place in open places and can involve many people (Willis, 2011). According to Blagg (2002), there is a likelihood that Indigenous women will fight back more than non-Indigenous women when they come face to face with violence.

Significant inadequacies exist in the accessible data and survey statistics regarding the scope and pattern of family violence among Indigenous communities. Existing data shows that the experience of violence, including family violence, by Indigenous people is significantly higher than that among other Australians (Human Rights and Equal

Opportunity Commission [HREOC], 2006; Webster et al., 2019). An appreciable number of victims do not disclose their experience of domestic violence to police, and the percentage of non-disclosure is significantly more among Indigenous communities than among their non-Indigenous counterparts (Australian Government Attorney-General's Department, 2018; Prentice et al., 2017; Willis, 2011).

Apart from the well-known reasons for not disclosing violence common among other communities, some reasons are specific to Indigenous communities (Mitchell, 2011; Prentice et al., 2017). There is fear of the outcome and aftermath, especially in small, close-knit, and remote communities where victims could be easy to identify (Blagg, 2002; Prentice et al., 2017). The victims are sometimes afraid, and may or may not trust the justice system, police, and other government organisations (Memmoth et. al, 2001; Prentice et al., 2017). When Indigenous communities are compelled to interact with welfare organisations and police, many of them may manifest signs of anxiety (Prentice et al., 2017; Webster et al., 2019). There are also cultural constraints of close attachment, kinsmanship, duty and obligation, which prevent Indigenous communities from disclosing family violence (Willis, 2011). Shame and kinship obligations may exacerbate, for Indigenous women, the problem of women maintaining silence after being a victim of family violence (Mitchell, 2011). Lack of awareness or the limitations of access to available support services may also impact the disclosure of family violence in Indigenous communities (Mitchell, 2011).

The rate at which Indigenous people, especially those who live remotely, encounter family violence is usually more than double that experienced by their non-Indigenous counterparts (AIHW, 2018). Indigenous women are more prone to victimisation than their non-Indigenous counterparts (Mitchell, 2011). In 2014-2015, 14% (1 in 7) of Indigenous women suffered domestic violence in the preceding twelve months, out of which 28% (1 in 4) of the perpetrators was a partner (AIHW, 2018). Data collected from 2001–2010 by the NSW Bureau of Crime Statistics and Research revealed that the rate at which Indigenous women report domestic violence to police is above six times that of non-Indigenous women (Gretch & Burgess, 2011). Between 2012 and 2014, 41% (2 in 5) of deaths of Indigenous victims due to homicide were by previous partners; this is twice the rate (22%) of their non-Indigenous counterparts (Bryant & Bricknell 2017).

The National Aboriginal and Torres Strait Islander Social Survey (NATSISS) carried out between 2014 and 2015 gives the most recent statistics (as of June 2019), on both real and threatened violence within the Indigenous population. Although it provides an insight into the extent of violence, there is no single question in the survey that gives precise information on the experience of individual or family violence (ABS, 2016). However, other data shows that 22.3% of Indigenous Australians 15 years and older disclosed they have been victims of physical violence or threats of physical violence in the twelve months preceding the survey (ABS, 2016); Indigenous women are 2.5 times likely of reporting being victims of physical violence or intimidation compared to non-Indigenous women (Australian Health Ministers' Advisory Committee [AHMAC], 2010); 50.2% of Aboriginal and Torres Strait Islander people in the 15 years and over age group who had suffered physical violence in the twelve months preceding the survey confirmed that the perpetration of the most recent domestic violence episode was by a family member, including a current or ex-partner and 63.3% of these victims were females while 34.6% were males (ABS, 2016). In this survey, one out of every four people mentioned that family violence was a problem related to their community locality.

The AIHW compared the rates of assault-related hospitalisation among Indigenous and non-Indigenous Australians between 2003 and 2004 (Mitchell, 2011; Al-Yaman et al., 2006). It was found that 2,513 Indigenous women were admitted into hospitals for assaults compared to 2,014 Indigenous men. For women, 41% of these hospital admissions were the outcome of intimate partner violence, compared to just 7% for males. About 50% of the hospital admissions for women assault victims were due to family violence, compared to 19% for men. Rates of hospitalization for Indigenous men for intimate partner domestic assaults was 27 times that of other men, while the rate of hospital admission for Indigenous women was 38 times that of other women for intimate partner domestic assaults (Al-Yaman et al., 2006).

2.5.3 Younger Women and Domestic Violence

Some young women are turning to social media to seek relationships. However, technologies could have an adverse effect on them including gender-based violence, harassment and bullying (deRidder & Van Bauwel, 2015; Powell & Henry, 2017; Shaw, 2015). According to the National Survey on Community Attitudes to Violence against

Women (2017), young people understand that domestic violence is a crime, but compared to older respondents may not understand the intricacies of violence in relationships, including the extent and importance of conduct that amounts to domestic violence (Politoff et. al., 2019).

An independent organisation whose target is 'engaging men to make women's safety a man's issue too', the White Ribbon Foundation, highlighted gender roles as important factors in the vulnerability of young women to intimate partner violence, which is further complicated by immaturity, age gaps in relationships, and limitation of access to support and services (Flood & Fergus, 2008).

Research of the experiences of young people and their attitudes towards domestic violence was conducted on 5,000 Australians aged 12–20 years across Australia by the Crime Prevention Branch in 2001. Young men, Indigenous young people, and people with lower socioeconomic standing have a higher likelihood of possessing a positive outlook towards violence. In addition, pro-violence stances were most prevalent among young people aged 12–14 years; this declined with increasing age (Indermaur, 2001).

Reports from the ABS (2016) showed that physical and sexual violence is experienced more by younger women than older women (as cited in Mitchell, 2011). The ABS Personal Safety Survey (2016) observed that approximately 12% (129,100) of women in the 18–24 years age group experienced a minimum of one domestic violence incident in the previous twelve months in comparison to the nationwide women prevalence rate of 4.7% (444,700). Experiences of violence declined with age with an estimated 1.2% (21,200) of women aged 65 years and over claiming suffering violence in the twelve months preceding the survey. About 38% (421,400 or two in five) of women in the 18–24 years age group encountered sexual harassment in the previous twelve months. The number of women encountering sexual harassment in the twelve months preceding the Personal Safety Survey went up from 15% in 2012 to 17% in 2016 while the incidence of physical and sexual violence declined with age to below 1% for women aged 65 years and over (ABS, 2016).

While IVAWS used wider terms to define violence, the finding of this survey, which used narrower definitions, is similar: younger women were more victimised than older women (Mouzos & Makkai, 2004). A similar finding was reported in earlier research.

Up to one third of women aged 12–20 years, who had an intimate relationship, had experienced physical violence in these relationships, which increased to 42% for women aged 19–20 years (Indermaur, 2001). Other studies also support the finding of the ABS Personal Safety Survey that younger women suffer domestic violence more than older women (Gibbs et al., 2018b; Pathak et al., 2019; Yakubovich et al., 2018).

These reports are contrary to the global prevalence of domestic violence among women reported by the WHO. There, the estimate of domestic violence was 38% among women aged 40-44, 29% among women aged 15-19 and 15% among women aged 55-59 (WHO, 2013). However, WHO collects less data on cohorts of women outside the child-bearing ages of 15-49 and mostly from higher income countries, which makes an estimate for women outside these age groups less reliable.

2.5.4 Domestic Violence and Women living in Remote and Rural Communities

Confirming the rates of domestic violence is difficult in any context as many cases are not reported, but much more so in remote and rural areas than urban areas (Campo & Tayton, 2015; Phillips & Vanderbroek, 2014). However, the reported cases of family violence and domestic violence are higher in remote, rural and outer regional communities (10%) compared to major cities or inner regional areas (6%) (AIHW, 2018; Campo & Tayton, 2015). Social and geographical factors, as well as distinctive norms and social values of living in small communities, lead to characteristic experiences of domestic violence in these communities (Campo & Tayton, 2015). Researchers attribute domestic violence in rural and remote areas to marginally-formulated beliefs about manliness that push orthodox gender roles, the carnality of the labour of country men, and alcohol drinking as risk factors relevant to countryside and rural communities (Carrington, 2007). The social norms and beliefs also affect women's responses and ability to look for help and access services, which compounds poor knowledge of domestic violence by health, legal and social services in these regions (Campo & Tayton, 2015; Loddon Campaspe Community Legal Centre, 2015). Non-disclosure of domestic violence is more likely in remote and rural communities due to the self-reliance ethos, unofficial penalties, and communal restraints (Hogg & Carrington, 2006; Gee, 2016). There is an acceptance in non-urban communities that domestic violence is a "family problem" that should not be disclosed to 'outsiders'. This

culture tends to silence victims of domestic violence and limits them from reporting (Campo & Tayton, 2015; Owen & Carrington, 2015). The fact that remote and rural communities are small compared to urban communities could create fear of community gossip, shame, stigma and absence of answerability on the part of the perpetrator (NDFV Bench Book, 2018; Australian Government Attorney-General's Department, 2018). An absence of privacy because of the high possibility that police, healthcare providers, and domestic violence frontline workers are known by both the victim and spouse perpetrating the violence could stop women from seeking help or willingness to use local services (George & Harris, 2015; NDFV Bench Book, 2018,). An amalgamation of these factors may aggravate the seclusion already experienced by victims of domestic assaults as part of the violence (Australian Government Attorney-General's Department, 2018; Campo & Tayton, 2015; Morgan & Chadwick, 2009).

From a study of domestic violence cases disclosed to NSW police between 2001 and 2010, it was found that out of the 20 areas of highest domestic violence, 19 were in regional or rural LGAs; the highest five were remote LGAs (Bourke, Coonamble, Moree Plains, Walgett and Wentworth) (Gretch & Burgess, 2011). The information provided by the ABS' 2010 General Social Survey on the experience of physical violence or threats of violence by Australians in the twelve months before the survey suggested there was a slightly higher probability of people in the age group 18 years and over, living in regional or remote communities (12.2%) experiencing violence than those who live in major cities (9.5%) (ABS, 2010; Phillips & Vandebroek, 2014). One possibility is that domestic violence was reported more often in remote and rural dwellings compared to metropolitan areas, but this is counterintuitive given the greater difficulties of service access for rural and remote people (Grech & Burgess, 2011; Mishra et al., 2014; WESNET, 2000).

2.5.5 Domestic Violence and Women with Disability

The picture of abuse against people with disabilities is not wholly clear. However, the works of Bartels (2010), Brownridge (2006), Healy et al. (2008) and Swift et al. (2018) showed that women with disabilities were at higher risk of domestic violence compared to women without disabilities. McLachlan and associates (2013) and Swift et al. (2018) noted that women with disabilities were more prone to all forms of violence because

of their escalated reliance on others and the socio-cultural disadvantages associated with disability. Penury, illiteracy, and low job opportunity exacerbate the power variance, which, according to McCarthy et al. (2019) and Salthouse (2007), facilitates the growth of domestic violence.

Healy et al. (2008) and McCarthy et al. (2019), found that some forms of abuse, such as the threat of institutionalisation, taking away their accessibility device(s) and refusing to provide necessary medication, were distinctive to people with disabilities. Exploitation image-based abuse and sexual abuse are common risks faced by people with disability, especially if they have intellectual or psychiatric disabilities, as noted by Swift et al. (2018) and Murray and Powel (2008). More than 58% of the ABS Personal Safety Survey (2016) respondents with disability claimed to have been victims of image-based abuse, 53% claimed they have had their nude or sexual images taken without their permission and 42% said such images have been distributed without their consent (AIHW, 2018).

When the main carer happens to be the abuser, people with disability experience abandonment, segregation and severe susceptibility to abuse. Because of their circumstance, it may be difficult to access support (Hague et al., 2008; Swift et al., 2018).

There is limited data in Australia that is more specific to domestic abuse among people who have disabilities. However, 2016 ABS Personal Safety Survey data demonstrated that people with disability have around 1.8 times the likelihood of experiencing domestic violence from the hand of a current or ex-partner in the preceding twelve months before the survey (ABS, 2017). According to this report, there were 25% (748,000) reported cases of sexual violence since becoming 15 years old by women with disability compared to 15% (980,000) of women without disability, and 2.5% (72,300) of women with disability in comparison to 1.3% (83,700) women without disability had experienced intimate partner violence.

The NSW Ombudsman (2018) made an inquiry into 358 abuse-related reports and neglect of adults with disability from August 2015 to October 2018. The results found that 58% (206) of the reported cases required action, 37% (77) involved physical abuse, 25% (52) involved financial abuse, 12% involved sexual abuse and 17% (35) involved intimate partner.

2.6 Perspectives on Violence Against Women

Beliefs, perspectives, ideologies and teachings are elemental to the diverse attitudes of people and communities to domestic violence. Each person's perspective affects the prevalence, community reaction, and their help-seeking behaviours (Meyering, 2011). In Australia, a comparison of the findings of the National Community Attitudes to Violence against Women Survey 2009 (AIC, 2010) against the results obtained by the Office of the Status of Women in 1995 (AGPS, 1995) reveals the following facts. In 1995, 93% of participants concurred that domestic violence is a crime and expressed willingness to intercede if they witnessed domestic violence. In 2009, the rate increased to 98%.

However, Mitchell (2011) found that a very limited number of people comprehended the reasons for women refusing to leave violent relationships; 18% of respondents from the samples of the general population and 45% from selected CALD population samples justified domestic violence as an emotional outburst, when the perpetrator becomes so upset they lose control for a short period of time. In addition, 22% of the general population sample and 59% of the CALD sample were willing to accept domestic violence if the perpetrator expressed sincere regret for their action post-factum. Mitchell (2011) also found that the duration of residency in Australia reduced tolerance levels in regard to the condoning of violence. The most significant indicator of violence-supporting opinions was 'maleness' and low level of support for gender equity and equality. Maleness refers to socially dominant forms for men, that men can assume a "divine" position of dominion, superiority, control and authority (Owino, 2010; Our Watch et al., 2015). This specific form of masculinity creates and legitimises the privilege and power that a man as the masculine one holds in his personal relationships with a woman. This stereotypic norm, and rules about masculinity drive violence against women (Our Watch, 2019).

A more recent study conducted in 2018 by the Australian Institute of Criminology (AIC) investigated the comprehension and encounters of violence and sexual coercion within young female African migrant and refugee communities by exploring current awareness and documenting how domestic violence agencies respond to sexual violence (Chung et al., 2018, as cited in AIHW, 2019). In this study, 23 professionals who worked with women were recruited from 81 non-government and government

establishments from South and Western Australia, and 12 in-depth interviews and one focus group discussion were also conducted with young women from an African background. The study found an increased recognition of sexual violence; however, opinions differ on what constitutes sexual violence. Taboos surrounding speaking publicly about sex and sexual violence were spoken about by these young women as acting as a barrier to community education, hence indicating limited knowledge and understanding of the laws on sexual violence and available support. These limitations predispose the unlikeliness of young women from African communities in Australia disclosing sexual violence or seeking help.

2.7 Impact of Domestic Violence

The probability of serious health consequences among women victims of intimate partner violence is high compared to those who have no experience of any violence (Almeida et al, 2017; AIHW, 2019; Gibbs et al., 2018b; Our watch et al., 2015; WHO, 2013; Webster et al., 2019; Ziaei et al., 2016). The WHO (2013) report described the extent of assaults on women by men in intimate relationships as well as sexual abuse by non-partners. The report also discussed how significant the consequences of domestic violence crimes can be on women's overall health and well-being, which will now be described.

2.7.1 Causal Pathways of Domestic Violence and its Health

Outcomes

Studies on the impact of different forms of violence on the health of female victims are limited, and the exact effects and pathways are poorly understood (Krung et al., 2002). However, Domestic violence has many potential health impacts, including morbidity and mortality, on women who have experienced it (Almeida et al, 2017; Gibbs et al., 2018b; WHO, 2013; Ziaei et al., 2016).

As discussed by Krung et al. (2002), using population-based and cross-sectional data, causal pathways emerged from limited, meticulously controlled, prospective clinical and epidemiological research. The probable causal pathways linking all forms of experience of violence and various health effects are in the process of being better understood and documented. Sometimes, there are complexities in these pathways, with the probability of consequent disease and ill-health being influenced by context-

specific, behavioural, physiological and other elements. The consequent health impact of domestic violence is broad. Figure 2.2 describes the possible pathways by which intimate partner violence results in various kinds of morbidity and mortality.

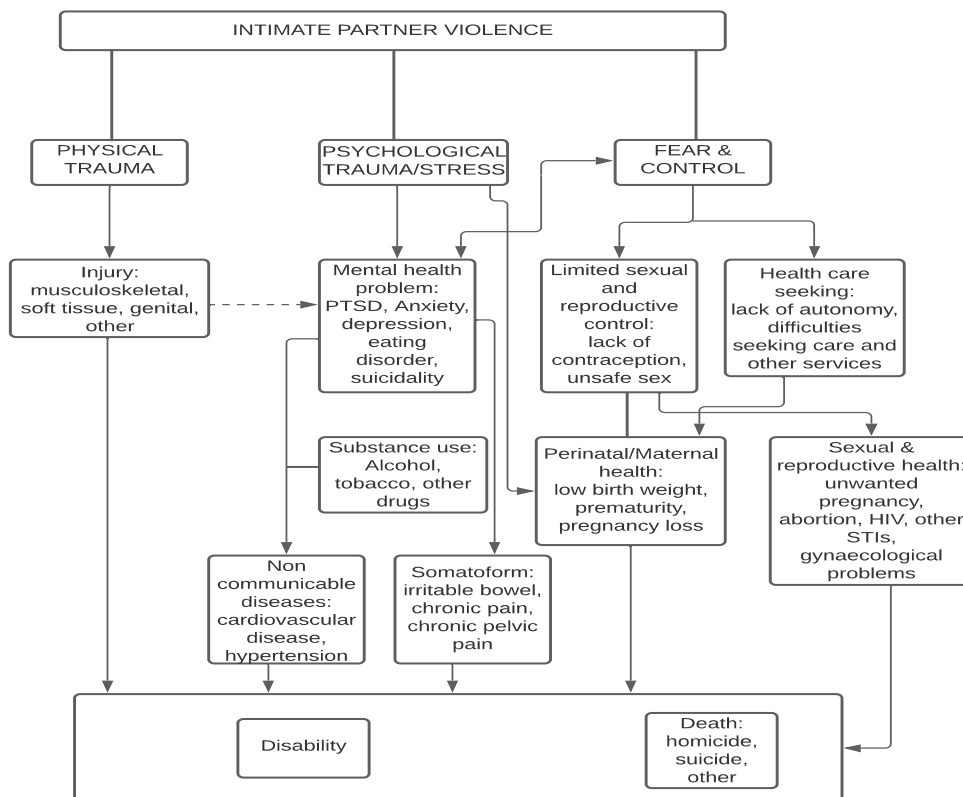


Fig 2.2: Pathways of health effects of intimate partner violence. Adapted from WHO (2013).

There is the direct pathway of assault causing harm and loss of life, and other indirect pathways for several consequences on women's health, including maternal and pregnancy-related health conditions (WHO, 2013). A secondary pathway, generated as reactions to stress, has been reported by many workers (Krung et al., 2002). The existence of fundamental physiological processes of connection between the experience of violence and the resultant diverse detrimental effects on health have been widely demonstrated (Davison et al., 2021; Ma & Pun, 2016; Ziaei et al., 2016). A complicated interconnection of neural, neuroendocrine and immune reactions to short-term and long-term stress was shown to occur in the findings of Black and Breiding (2008), Black (2011) and Howard et al. (2010). For instance, according to Miller (1998, as cited in WHO, 2013), in the case of continuous or short-term stress,

some parts of the brain (prefrontal cortex, hippocampus, and amygdala) go through structural transformations. These have consequences on psychological health and mental functioning and they can also predispose the person to psychiatric problems, physical illness, and other chronic conditions (Adjei et al., 2022; Rueness et al, 2020; Rahmani, 2019).

Stress can damage the immune system, worsening metastasis of cancer and the spread of bacterial and viral infections. Miller (1998, as cited in WHO, 2013) established a link between acute and prolonged high-stress levels and the development or exacerbation of gastrointestinal disorders, high blood pressure, cardiovascular disorders, development of diabetes mellitus and chronic pain. Low birth-weight in newborn babies has also been linked to antenatal stress, as elevated blood cortisol causes narrowing of the blood vessels, reducing the flow of blood to the womb. In addition, the response of the hypothalamic–pituitary–adrenal complex can initiate contractions of the uterine muscle, causing premature labour and the birth of preterm babies (Altarac & Strobino, 2002; Wadhwa et al., 2011).

Furthermore, other risk factors and some behavioural elements affect the association between negative health outcomes and intimate partner violence. To cope with the repercussion of violence, some women resort to using alcohol, smoking and/or prescription or other drugs, as observed by Campbell (2002) and Ellsberg et al. (2008). Every one of these coping mechanisms jeopardises health and well-being and is a component of the complex association between victimisation due to domestic violence and adverse health outcomes (Krung et al., 2002; Riley, 2013; (Adjei et al., 2022; Rueness et al, 2020; Rahmani, 2019).

Another less-researched pathway is psychological and cohesive control. Men might try to dominate and/or restrict the actions and social networks of their spouses. This can manifest in various ways, including restricting family interactions and socializing, maintaining consistent observation of her whereabouts, behaviour, social circles and appearance, suspicions and/or accusations of unfaithfulness, expecting permission to seek health care, getting upset if seen speaking to another man, and so on (Kaur & Atkin, 2018). Typically, cohesive co-exists with physical violence and sexual abuse, and is very common in violence-filled relationships. Violent partners can restrict woman's capacity to make decisions about their own sexual and reproductive life,

access healthcare and compliance with medical treatment, all of which can negatively affect their health (WHO, 2013, Ferranti et al., 2018; Turk et al., 2017).

2.7.2 Pathway and Health Effects of Domestic Violence

Violence in intimate relationships can impact women's health by numerous pathways. Figure 2.2 points out three pathways/mechanisms that explain many of these effects. Psychiatric disorder and substance abuse could be the direct consequences of any of the three indicated pathways, which can, in turn, aggravate risks to health and well-being. Nevertheless, psychiatric disorders and substance abuse are not necessary prerequisites for negative health-outcomes (WHO, 2013).

2.7.3 Domestic Violence Aftermaths on Female Victims

The consequences of violence are extensive; the negative effect is felt on the health, well-being and self-esteem of the person, and by extension affects the wellness of society more broadly (Almeida et al, 2017; AIHW, 2019; Gibbs et al., 2018a; Our watch et al., 2015; WHO, 2013; Webster et al., 2019; Ziaei et al., 2016). As discussed by Garcia-Moreno et al. (2005), remaining in a violent relationship impacts a woman's pride, self-confidence and capability to engage with the world. Research has confirmed that women who lived with violence are frequently limited in their capability to access information and services, engage in community life, and accept emotional assistance from families and friends (Almeida et al, 2017; WHO, 2013). Such women find it difficult to engage in self-care and care for their children properly or to get into the workforce or pursue their careers (Ferranti et al., 2018; Garcia-Moreno et al., 2005). Some of these consequences are discussed below.

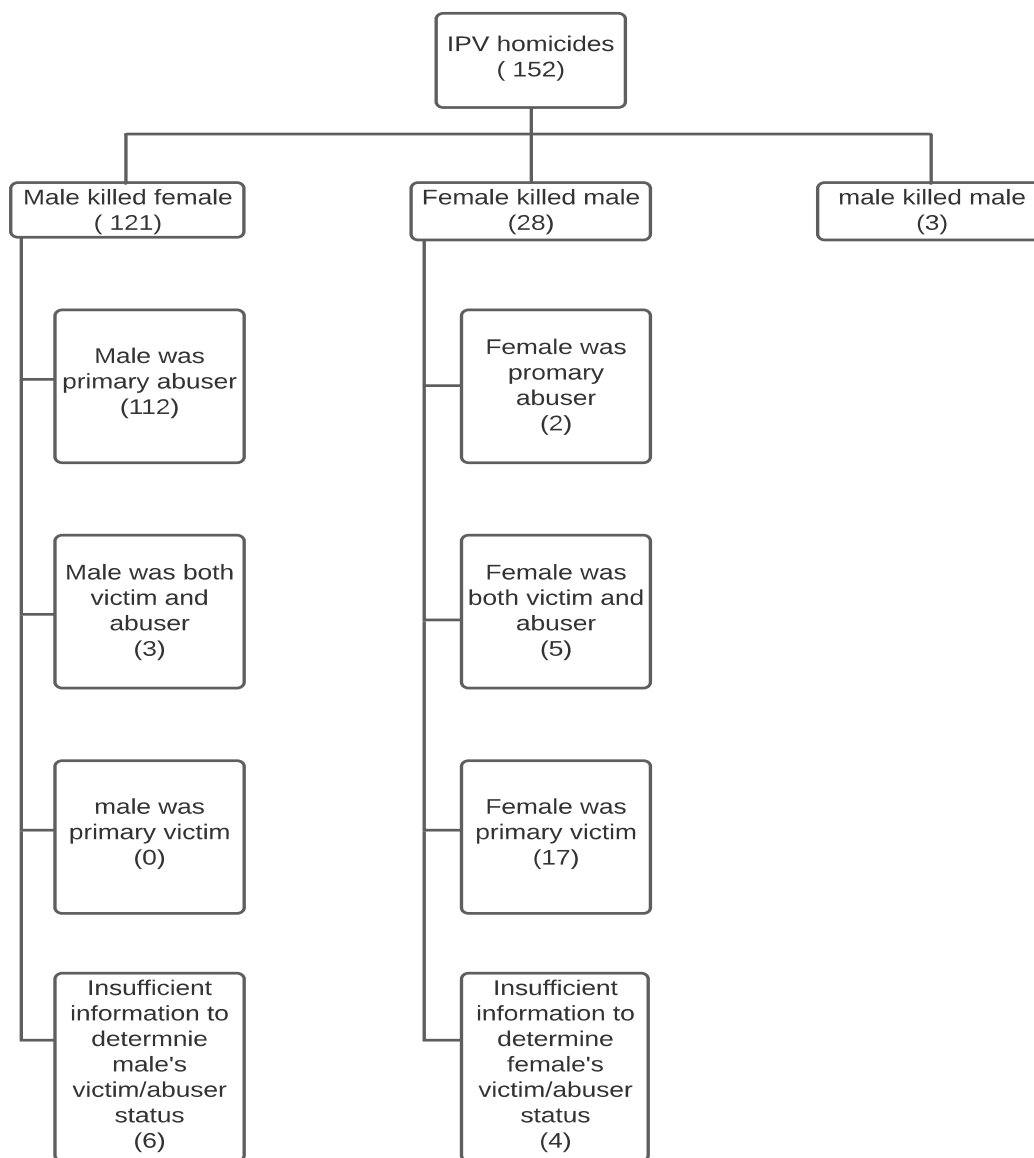
Homicide

Domestic violence may culminate in homicide. From international data available since the year 1982, the WHO (2013) report estimated that the median prevalence rate of homicide resulting from intimate partner violence was about 13% of all female homicides. The report also estimated that the rate of homicide by an intimate partner was 38% of all female homicides. The South-East Asian region recorded the highest (55%) median prevalence of intimate partner homicides among all murdered women, followed by the high-income region (41%), African region (40%), and the American region (38%), which was the lowest.

The AIC monitors the course and order of murder all over Australian states and territories through the National Homicide Monitoring Program (NHMP). To date, the most comprehensive data has been collected by the NHMP on murders in Australia, giving information about the victims, the offenders, and the situation of the incidents. Between 2014-15 and 2015-16, 218 people were victims of domestic homicide as a consequence of 198 incidents (Bryant & Bricknell, 2017, as cited in AIHW, 2019).

Out of these 218 victims, 109 were victims of intimate partner homicide. Females accounted for 59% (129) of domestic homicide victims, about two out of three (64% or 82) females and more than one out of four (28% or 25) males were murdered by an intimate partner, over three out of four (75% or 155) perpetration of domestic violence homicide were by male partners (AIC unpublished, as cited in AIHW, 2019). In 2017, one in three murders documented by police were domestic violence-related, and domestic and family violence accounted for 126 victims of recorded homicide; this consisted of 75 murders and 41 attempted murders (ABS, 2018, as cited in AIHW, 2019).

Similarly, the Australian Domestic and Family Violence Death Review Network (ADFVDRN), over a 4-year period (between July 2010 and June 2014), confirmed 152 domestic violence-related adult homicides in Australia (Figure 2.3), where a person was murdered following an established experience of domestic violence from a current or previous intimate partner (ADFVDRN 2018, as cited in AIHW, 2019). Of the reviewed domestic violence homicides, four out of five (80%, or 121) were committed by a man against a woman (Figure 2.4) (AIHW, 2019). Killing of a current or previous male partner by a female accounted for almost one out of five (18%, or 28) of the homicides while the rest were committed by males against males. Men were the primary abusers in 93% (112) out of the 121 reviewed cases of homicides where a male was killed by a female partner (Table 2.2) (AIHW, 2019). Out of 28 reviewed cases of homicides, women were identified as the primary abuser in only 2 cases where a male partner was murdered by a female partner (Figure 2.3) (ADFVDRN, 2018).



*Fig 2.3: Intimate partner homicides of domestic violence, July 2010–June 2014
(Source: ADFVDRN, 2018 in AIHW, 2019).*

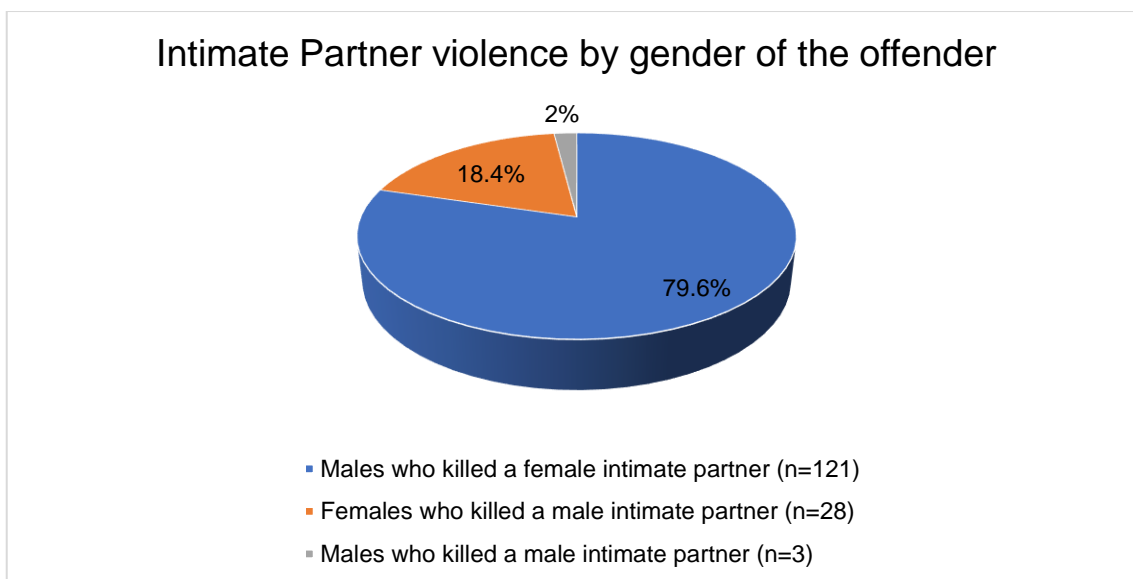


Fig 2.4: Intimate partner violence offender's gender (Source: ADFVDRN, 2018).

Domestic violence status	Male offender	Percentage (%)
Primary domestic violence abuser	112	92.6
Primary domestic violence victim	0	0
Both a domestic violence victim and abuser	3	2.5
Unknown	6	5
Total	121	100

Table 2.2: Male homicide offenders who killed an intimate partner violence (Source: ADFVDRN, 2018)

There were 44 Indigenous victims of domestic homicide recorded by the NHMP from 34 incidents between 2014-15 and 2016-16, and 19 were victims of intimate partner homicide. More than 50% (16 out of 26) of domestic homicides of Indigenous females were committed by a male intimate partner, whereas three out of 18 domestic

homicides of Indigenous males were committed by a female intimate partner (AIC unpublished in AIHW, 2019).

Between July 2010 and June 2014, 43.8% (53) of heterosexual intimate partner homicides reviewed by ADFVDRN happened in the shared residence of the offender and the victim (Table 2.3) (ADFVDRN, 2018). Hence, the home was the most probable setting for the murder of an Australian woman by an intimate partner.

Site of homicide	Male offenders	Percentage (%)
Victim's residence	28	23.1
Offender's residence	13	10.7
Shared residence	53	43.8
Other residence	9	7.4
Workplace	2	1.7
Public/open place	16	13.2
Total	121	100

Table 2.3: Male homicide offenders who killed female intimate partner by location of homicide (Source: ADFVDRN, 2018)

Health Impact

The effects of domestic violence on both the physical and mental health of victims are severe and persistent. VicHealth (2004) estimated the burden of disease for victims of domestic abuse and established that domestic abuse is an important risk factor for murder, disability and sickness among women aged between 15 and 44 years in Victoria.

Evans (2007) noted that the adverse effects of domestic violence on the health of victims persist after the violence has ceased. A longitudinal study (Women's Health Australia, 2005) discovered there is a negative personal health perception and more

frequent visits to health service facilities by women who have been exposed to domestic violence even after the violence has stopped, compared to women who have no exposure to domestic violence.

The National Council to Reduce Violence against Women and their Children (NCRVWC) (2009) noted that domestic abuse has cumulative effects on the cognitive function and mental well-being of victims. One ABS (2015) analysis explored the interplay of intimate partner violence, physical violence and gender-based violence and mental health. In responding to the survey question — “Were you ever badly beaten up by a spouse or romantic partner”— about 8% of respondents affirmed they had suffered intimate partner violence over the course of their lives. Women who had been exposed to intimate partner violence or gender-based violence disclosed a higher degree of serious co-morbid psychiatric disorders, more physical illnesses, general disability, impairment of quality of life, more mental-health-related disorders and a higher rate of attempted suicide (Rahmani et al., 2019; Rees et al., 2011; Turk et al, 2017).

Increasing numbers of research data show that having a domestic relationship with a violent partner can have devastating effects on a woman’s health. A variety of health consequences, both acute and chronic, have been linked to abuse (Ayre et al. 2016; GBD 2016 Risk Factor Collaborators, 2017). Although these can be direct health outcomes like injury, exposure to violence also magnifies the risk of chronic health problems in a woman (Krung et al., 2002).

Several studies (Kuskoff & Parsel, 2020; Matrz et al., 2020; Rahmani et al., 2019) have found that women with childhood or adulthood experience of physical or sexual violence experience poor health with respect to physical activeness, mental well-being, and engaging in other dangerous habits such smoking, alcohol and substance use.

Physical Health

The most obvious consequence of domestic violence is physical injury. The severity of physical violence can range from lacerations, grazing and bruises, to permanent disability or loss of life. According to a variety of research studies based on population-level data, 40–72% of women who had experienced physical abuse had sustained an injury at least once in their lifetime (Ellsberg et al., 2000; Tjaden & Thonnes, 2000).

The most common sites of injury resulting from partner abuse in 2016–17 were the head and/or neck. Injuries to the head and/or neck due to assault by a spouse resulted in almost 2 in 3 (63% or 2,200) hospitalisations of women (AIHW, 2019). Following this are musculoskeletal and genital injuries.

Domestic violence frequently results in physical injury. According to the IVAWS report, two-fifths of respondents reported having sustained physical trauma in the most recent intimate partner abuse incident (Mouzos & Makkai, 2004). The most common forms of physical trauma were grazes, swelling and contusion, laceration, abrasions and burns. The report also included data on more severe injuries at the rates of 10% for bone fractures or fractured noses, 6% for head or brain trauma, and 6% for internal organ injuries. Roughly 29% of injuries required medical treatment, and 30% of women thought their lives were in jeopardy during the most recent attacks (Mitchell, 2011).

However, physical injury is not the most common physical consequence of intimate partner violence; the most common outcomes are “functional disorders”, which are a range of sicknesses that at most times do not have any recognisable medical cause (AIHW, 2019).

In 2016–17, a spouse or intimate partner was the perpetrator for 47% (or 248) of women’s and 2% (or 27) of men’s hospitalisations from brain injury associated with assault (AIHW, 2019; Brain Injury Australia et. al., 2018). Brain Injury Australia (2018) reviewed acquired brain damage prevalence among both perpetrators and victims of domestic violence and estimated the extent of brain trauma associated with family violence, including presentations to the emergency department, hospital admissions and major trauma by analysing Victorian hospital data from July 2006 to June 2016, and supplementing findings from the literature. Domestic violence was found to contribute significantly to many cases of traumatic brain damage. Out of the 16,296 victims of domestic violence that attended Victorian hospitals during this 10-year span, 40% (6,409) had sustained trauma-related brain damage (AIHW, 2019), and 14% of major trauma incidents with severe brain damage resulted in death during the admissions, compared with 2.9% of patients² without a severe brain damage. Brain damage is responsible for 14 out of 17 domestic violence-related deaths (AIHW,

² using the word client or patient is dependent on the facility attended for care as hospital refers to these categories of people as patient. For instance, clinician will refer to these people as patient while therapists will refer to them as clients

2019). They also reviewed available international reports on brain trauma among perpetrators of domestic violence, and though available studies were limited on this issue, the reviewed information proposed that the rates of brain damage were two times higher among perpetrators compared to the general population (Brain Injury Australia et al., 2018; AIHW, 2019).

Reproductive Health

Heise et al. (1999) and Heise et al. (1995) report that it is often hard for women in relationships with violent partners to protect themselves from diseases and unplanned pregnancies. Violence can result directly in sexually transmitted diseases (HIV, herpes, and so on) and unplanned pregnancies through forced sex. It can also indirectly affect a woman's choices regarding the use of contraceptives and condoms.

In the early 1990s, there was an increase in awareness of the role played by intimate partner violence in the susceptibility of women to sexually transmitted diseases (STDs) (Maman et al., 2000). Fernandex-Botran et al. (2011) and Newton et al. (2011) found that the susceptibility of women living in domestic violence relationship to STDs can be increased compared to the general population due to direct infection from coerced sexual intercourse in addition to the possibility of increased risk from the overall result of protracted stress exposure. Women who are living with violent partners, or fearful of their relationship becoming violent, may not have as much control over the occurrence and setting of sexual intercourse, and they may not have the ability to suggest the use of condoms or other contraceptive strategies (Zjaei et al, 2016; Broughton & Ford-Gilboe, 2017).

Violence in an intimate relationship may also be a significant decider of separation, which may result in increase in the risk of a woman contracting STDs if she enters into a sexual relationship with one or more new partners. In addition, evidence supports the fact that men who are violent towards their female spouses are at risk of engaging in behaviours that increase the risk of contracting STDs (Broughton & Ford-Gilboe, 2017; Cofie, 2015; Dunkle, 2006; Zjaei et al, 2016). Studies have shown that factors such as having more than one sexual partner, patronising sex workers, having a sexually transmitted infection (STI), avoiding STI treatment options, drug use (which exacerbates HIV risk in particular), and habitual use of alcohol, which increases the likelihood of other risky activities (Cofie, 2015; Dunkle, 2006;). All these factors

increase the risk of women victims of domestic violence contracting STDs in contrast to women who have no exposure to domestic violence. Moreover, contracting an STD can add a significant stress burden, further exacerbating the mental disorder burden of victims of domestic violence (Gilbert et al., 2007, as cited in WHO, 2013).

Extensive cohort studies from India and Africa (as cited in WHO, 2013) have demonstrated a connection between exposure to intimate partner violence and the physiologically-verified occurrence of STDs. Further research is needed to establish the correlation between the experience of violence and the incidence of STDs and HIV in at-risk populations (Mackay, 2013).

A variety of associations exist between partner violence and the prevalence of AIDS across various communities. For instance, Brown (1998) noted that in some African countries, fear of social exclusion and consequent family violence was a major factor in the choice of a significant proportion of pregnant women to decline HIV tests or to not return to obtain their test results. Also, in a study in rural Uganda on heterosexual HIV transfer, women who reported forced sex in the last twelve months had an eight times higher risk of contracting an HIV infection than women who have no such experience (Quigley et al., 2000).

Various studies have consistently proposed that the prevalence of domestic violence in large families with many children is higher (Tjaden & Thoennes, 2000). These investigators concluded that having many children is a stressor that predisposes families to violence. However, data from Nicaragua by Ellsberg et al. (2000) complicates this finding. Ellsberg et al. (2000) found that in Nicaragua, abuse usually started before the woman gave birth; 80% of violence starts in marriages within the period of the initial four years. The exact cause-and-effect and prevalence of violence in large families, remain to be fully explored across a variety of contexts.

Violent relationships typically involve dominant behaviour and fear. This may explain why women who are in these relationships face more negative consequences to their reproductive and sexual health. The proportion of negative reproductive outcomes can be higher due to the direct impacts of sexual violence. This has led women in violent relationships to have more unplanned pregnancies. These findings were reported by Goodwin et al. (2000), Pallito et al. (2005) and Silverman et al. (2007).

Violence also takes place in the antenatal period, which can affect the woman, the foetus, or both. Low birth weights can result from either intra-uterine growth restriction or premature birth (Silverman et al., 2007). Both of these have direct associations with stress (Pallito et al., 2005). Remaining in violent and unsafe relationships can cause prolonged stress and therefore jeopardise pre-and post-natal maternal health and birth weight (Goodwin et al. 2000).

Low birth weight has been described as any birth weight less than 2.5kg. Pre-term birth occurs when the child is born within 37 weeks of conception. Intra-uterine growth restriction and short gestational age denote a birth weight under the tenth percentile (Sharma, 2016). A systematic review by the WHO (2013) observed that, despite adjusting for confounding factors, there were positive correlations between intimate partner violence and preterm birth (aOR = 1.41, 95% CI = 1.21 to 1.62) and with low birth weight (aOR = 1.16, 95% CI = 1.02 to 1.29).

In the United States, approximately 3% to 11% of adult women, and 38% of low-income, teenage mothers, reported that they had experience violence during pregnancy (Ballard et al. 1998). A large number of studies have demonstrated an interrelation between violence during pregnancy and late registration for prenatal care, miscarriage, premature labour and birth, foetal injury, stillbirth and low birth weight (Murphy et al., 2001). These factors could be responsible for many infant deaths in developing countries.

Given the consistent correlation between, and causal mechanisms associated with, stress and neonatal birth weight, the WHO (2013) concluded that intimate partner violence is a significant contributing factor for many small-for-gestational-age newborns.

Mental Health

Mental health issues are the largest component of the burden of disease resulting from domestic violence with the largest portion (43%) attributed to depressive disorders, then anxiety disorders (30%) followed by suicidality and self-inflicted injuries (19%) (Ayre et al., 2016, as cited in AIHW, 2019). Domestic violence has a deleterious effect on mental health, which can induce suicidal ideation, anxiety and depression, and post-traumatic stress disorder (PTSD) (Broughton, & Ford-Gilboe, 2017; Rahmani et al., 2019; Randle & Graham, 2011; Turk et al., 2017; Zjaei et al., 2016).

Traumatic stress is a major mechanism linking intimate partner violence to depression and suicide ideation. Traumatic stress can degenerate into anxiety, fright and isolation. These may in turn contribute to depressive disorder and suicidality (Hyde et al., 2008). This relationship can also be inverted in the sense that women with mental health disorders can be more prone to exposure to intimate partner violence (Khalifeh & Dean, 2010; Mcpherson et al., 2007).

Bifulco et al. (2006) and Doumas et al. (2008) noted that both violence and depression could be predicted by the experience of violence and other traumas early in life. Results from studies by Roberts et al. (1998), Ellsberg et al. (1999), Fikree and Bhatti (1999) and Danielson et al. (1998) in Australia, the United States, Pakistan and Nicaragua demonstrated that women who experience partner abuse suffer depression, phobias, stress and anxiety symptoms at higher rates than women who have no exposure to abuse (WHO, 2013). Studies by Abbot et al. (1995), Amaro et al. (1990), Bailey et al. (1997), Bergman et al. (1991), Kaslow et al. (1980) and Rosales et al. (1999), also showed that women who have been through partner abuse are at increased risk of suicide and suicidal tendencies (WHO, 2013).

Harmful Use of Alcohol

According to Graham and Homel (2008), evidence exists to demonstrate a strong association between the consumption of alcohol and domestic violence (as cited in Morgan & McAtamney, 2009). Apart from the fact that alcohol significantly facilitates men's use of violence, evidence also suggests an association between frequent alcohol consumption by women and violence against women (Curtis et al., 2019; Subramani et al., 2017; Vos et. al., 2006). Women may indulge in alcohol so as to deal with the consequence of abuse, which may increase the likelihood of future abuse (Graham & Homel, 2008; Martz et al., 2020). On the one hand, the use of alcohol by women may lead to partner abuse because of the partner's belief that women should not drink, while on the other hand use of alcohol by women may decrease their ability to maintain control of a situation to prevent an outbreak of domestic violence (Gibb et al., 2018b; Graham & Homel, 2008; Mohajer, 2019). Although excessive consumption of alcohol is not encouraged, a woman should not have to watch her drinking of alcohol solely for the fear of being violently abused.

Longitudinal studies on women's health in Australia evaluated the link between alcohol abuse and intimate partner violence. Devries et al. (n.d.) and Vos et al. (2006) found a relationship between alcohol drinking and intimate partner violence, arguing that the connection between domestic violence and alcohol use is bidirectional, creating a vicious cycle. That is, alcohol use increases the likelihood of intimate partner violence, and intimate partner violence increases the likelihood of alcohol use. In some instances, both alcohol consumption and intimate partner violence are attributable to one or more underlying factors, such as drug use or poor mental health. Such factors could make women more vulnerable to abuse (Curtis et al., 2019; Mohajer, 2019; WHO, 2013).

Use of Health Services

Domestic violence has an impact on the use of health services, which has cost implications for the economy. Violence against women costs the global economy almost 2% of gross domestic product (GDP) borne by patients, perpetrators and communities (Puri, 2016). Domestic violence perpetrated against women and children cost the Australian economy an estimated \$22 billion in 2015-16 (AIHW, 2018; KPMG, 2016)

Due to the prolonged consequences of violence on women's wellbeing, female victims of violence tend to become chronic users of health services. This increases the cost of health care to the individual and society, as it is dependent on the funding arrangements of each jurisdiction. In Australia, \$10.4 billion (nearly 50%) of the \$22 billion costs of domestic violence perpetration on women and children in 2015-16 were related to the chronic impacts of violence on women's physical and mental health (AIHW, 2018; KPMG, 2016). Depression and anxiety alone account for 60% of this health cost. This cost is consistent with the findings of research that identified mental health issues as the major component of the health burden of domestic violence among women (Ayre et al., 2016). Of the total cost of domestic violence perpetration against women and children in 2015-16, \$11.3 billion (52%) was paid by victims of domestic violence, \$6.5 billion (29%) was paid by the community (children of the victims, perpetrators, friends and family of victim and employers), and the remaining \$4.1 billion (19%) was borne by the Australian federal, state and territory governments (KPMG, 2016).

Impact on Children

Children who witness domestic violence between their parents are susceptible to a broad array of behavioural and emotional difficulties. These include apprehension, depression, poor performance in school, low self-worth, insubordination, night terrors, and associated physical health problems (Adjei et al, 2022; Jouriles et al., 1989, as cited in WHO, 2013; Rueness et al., 2020).

Other studies propose that violence may also affect child mortality either directly or indirectly (Ásling-Monemi et al., 2003; Jejeebhoy, 1998; WHO, 2002). Investigators from León in Nicaragua (Ásling-Monemi et al., 2003), after accounting for confounding factors, discovered that the children of women who have exposure to an intimate partner's physical and sexual abuse have a six times higher rate of dying before reaching the age of five years than the children of women who had no experience of any abuse. Intimate partner violence was the cause of as many as one-third of child mortalities in the population studied.

Living with violence at home increases the risk of exposure to emotional, physical and sexual abuse in children, (Adjei et al., 2022; Holt et al., 2008; Rueness et al., 2020). Bromfield (2010) pointed out that domestic violence, parental drug use and mental health issues are the most common factors responsible for child abuse and neglect in homes where parents frequently engage in these activities. It is hard to separate the consequences of any factor by itself. For Richards (2011), no doubt exists about the effects of domestic violence on adults as well as the children who might have witnessed it.

Studies on children exposed to domestic abuse shows a variety of effects that such children may likely experience, including apprehension and anxiety, temperament problems, anti-social conducts, low self-esteem, trauma symptoms, loneliness and difficulties at school, peer conflict, mood disorders including depression and increased anger and irritability, lower social competence, pervasive terrors and nightmares, impairment of cognitive functions and higher probability of substance abuse (Adjei et al, 2022; Bruton et al., 2016; Mitchell, 2011; Richards, 2011; Spangaro & Ruane, 2014; Rueness et al, 2020). Flood and Fergus (2008) state that such behavioural, social, psychological and emotional impacts may also have a lifetime effect on educational and employability outcomes.

The prevalence children's exposure to domestic violence varies due to the sensitivity of this subject and some degree of complication associated with its evaluation. According to the 2016 ABS Personal Safety Survey report, 68% (418,000) of women who had suffered violence from a previous partner and had their children with them at the time of the incident claimed the violence was witnessed or heard by their children. The IVAWS reported that 36% of women abused by an intimate partner (excluding women who were not caring for their children at that time) disclosed their children were witnesses to a violent incident (Mouzos & Makkai, 2004). Earlier research by Indermaur (2001) indicated that 23% of young people (12-20 years) had been witnesses of their mother or stepmother's abuse, and the rate was 42% for Aboriginal and Torres Strait Islander (ATSI) peoples. Goddard and Bedi (2010) pointed out that pressurising a child to dwell with continuous violence amounts to both psychological and emotional abuse.

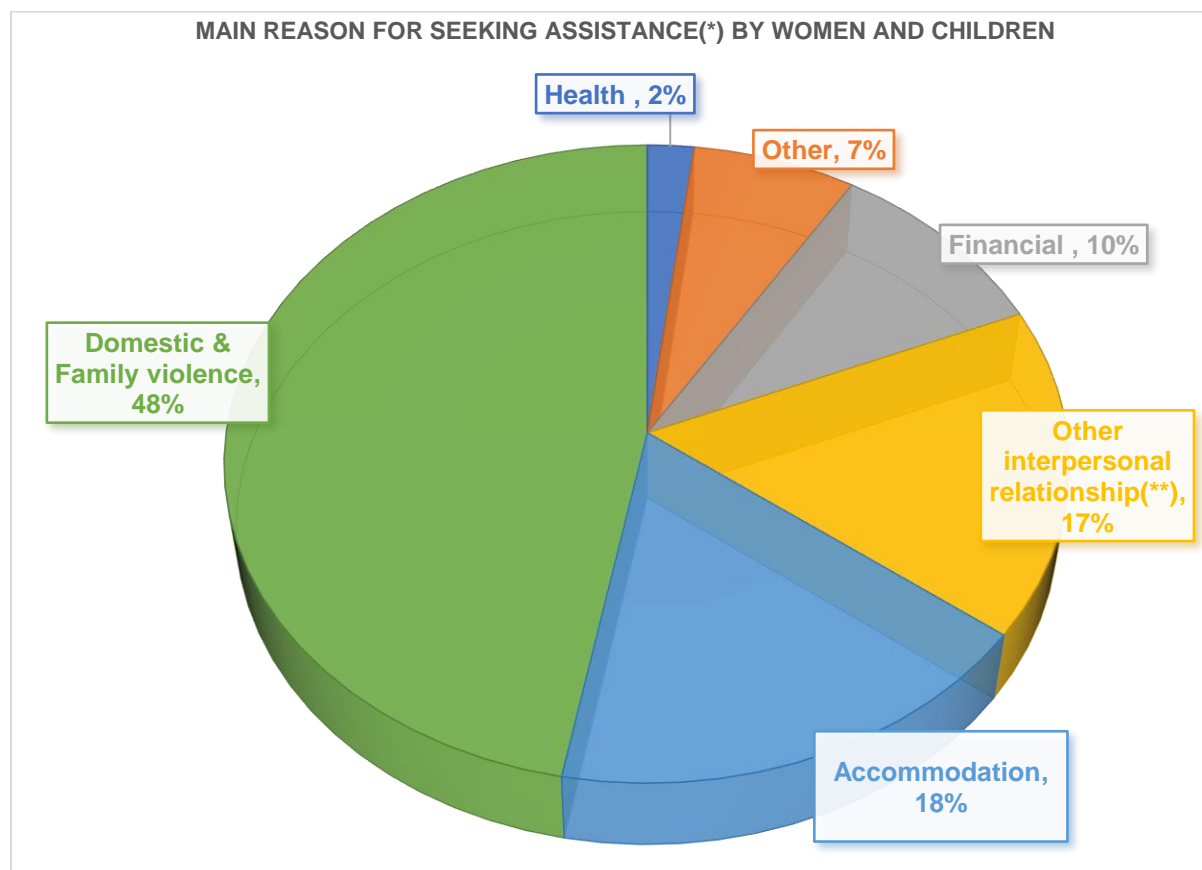
Homelessness

According to Spinney (2012), the major cause of women and children leaving their homes in Australia is domestic violence and it is the most common reason they have consistently sought assistance from specialist homelessness agencies. The Supported Accommodation Assistance Program (SAAP) defined homelessness as "not having as a minimum standard a small rental flat, with a bedroom, living room, kitchen, bathroom and an element of security of tenure" (Tually et al., 2008). Johnson et al. (2008) noted that in Australia domestic violence is among the 'classic pathways' leading to homelessness for women. SAAP, a major government program for homeless people in Australia, acknowledged that the welfare of an individual's or family's home is determined by their homelessness status.

In addition, there are other factors like affordability, whether housing affects the health of a person and whether it offers a sufficient level of amenity, as discussed by Tually et al (2008). Mitchell (2011) pointed out that there has been an increase in homelessness among women due to domestic and family abuse, and these cases have been progressing into a group with multiple difficult needs, as they also have alcohol and drug dependency, mental health problems and/or disability. In 2015-16, women and children constituted 92% of people who sought specialist homelessness services for domestic and family violence-related problems (AIHW, 2017).

One major reason for women approaching SAAP is domestic or family violence, which accounts for 22% of the required support (AIHW, 2011). SAAP clients support only homeless women with children and not the entire homeless population. Domestic or family violence is responsible for 48% of support needs from SAAP (Mitchell, 2011). Figure 2.5 explains this and other reasons for seeking SAAP assistance in detail.

There is an over-representation of Indigenous females in SAAP, as the AIHW (2011) report shows. Between 2008 and 2009 Indigenous women represented 25% of support periods for women getting out of violent relationships. This is very high considering they represented only 2% of the Australian female population. Other women, who were born in Australia, represented 52% of the period of support, while 19% were women from non-English speaking (NES) countries and those born in English-speaking countries represented 4%.



(*) Percentages are more than 100 because of rounding the figures. (**) Includes other reasons e.g., relationship/family breakdown.

Fig 2.5: Main reasons for women domestic violence victims with children to seek assistance (Source: AIHW, 2011).

Tually et al. (2008) believe that homelessness due to domestic violence is different from other causes of homelessness. This is because women who had experienced domestic abuse enter and exit the homeless program more frequently; more than others in the wider population (as cited in AIHW, 2011).

Part of youth homelessness can also happen due to domestic violence. The National Youth Commission Inquiry into Youth Homelessness (NYC, 2008) observed that family violence and breakdown were common factors causing homelessness. According to the findings of AIHW (2011), strains in domestic relationships were the most common reason people who are less than 25 years of age ask for SAAP support; 18% of young women search for homelessness assistance due to domestic or family violence during their support periods compared to about 3% of young men requesting support due to domestic or family violence (AIHW, 2011).

Housing is a serious problem for domestic violence victims. In research conducted on the economic well-being of women during and after domestic violence by Braaf and Barret (2011), women named locating suitable, safe, affordable housing after separation as their most important problem. The financial implications of moving away from home were significant as they included moving and storage costs.

The housing troubles of women also had ripple effects on other facets of their economic status. Attempts to find a shelter in time are demanding and trying. But, necessarily it has precedence over other requirements including employment and education, as found by AIHW (2011).

Economic Effects

Apart from human costs, violence is a huge financial responsibility on any society in terms of lost work efficiency and a surge in the utilisation of social services. Though it is hard to precisely quantify, the monetary value of assault amounts to billions of dollars in annual healthcare disbursement internationally, and billions more of the country's wealth in terms of days of work lost, lost venture and law enforcement (AIHW, 2011).

The 2016 ABS Personal Safety Survey collected data on whether women and men who experienced domestic violence from a current or ex-partner stayed in their employment in the 12 months after the most recent incident of intimate partner

violence. They found that one out of 11 women (9.6% or 26,500) took time off work due to domestic violence due to domestic violence from an ex-spouse (ABS, 2017).

The cost of domestic violence is increasing in Australia. Access Economics (2004) approximated the value of domestic violence in Australia as \$8.1 billion during 2002-2003, incorporating \$3.5 billion in value ascribed to pain, agony and untimely death. The cost of both domestic and non-domestic assault on women and their children to the Australian economy was estimated by NCRVWC as \$13.6 billion in 2009 (NCRVWC & KPMG, 2009). This value has increased to close to \$22 billion in 2016 (KPMG, 2016), and \$10.4 billion of this cost is ascribed to pain, agony and untimely death, while \$4.4 billion is ascribed to consumptions including replacement of damaged properties and defaulting on bad debts and relocation costs (Table 2.4).

Cost categories	Description	Cost (\$)
Pain and suffering	Long-term effects on psychosocial and physical health and victim's premature mortality	10.4 billion
Consumption	Replacement of destroyed property, debt default and cost of relocation	4.4 billion
Health system	Costs associated with the treatment of women's domestic violence associated injuries	1.4 billion
Production	Absences from work, and employer administrative cost (replacement of employee)	1.9 billion
Administrative	Police, incarceration, court system, counselling, violence prevention programs	1.7 billion
Transfer payments	Loss of income tax, welfare payment, victim compensation, other government services	1.6 billion
Second generation	Cost of children witnessing and living with violence, child protection services, increased juvenile crimes	333 million
Total		21.7 billion

Table 2.4: Estimated costs of violence against women and children to the Australian economy, 2015–16 (Source: KPMG, 2016).

Braaf and Barret (2011) discussed the economic consequences on a personal level for domestic abuse victims. Domestic abuse generates complicated financial problems for women and their offspring and upsets their immediate and long-term lives. Irrespective of their earlier financial situation, a lot of women go through economic hardship or penury because of domestic violence. The hardships impede their upswing and ability to take control of their lives. An experience of domestic violence pointedly impacts on women's economic stability in important areas of their lives: banking, bills, debts, child support, lodging, migration, employment, transport, health and legal issues.

Employability is crucial for making the economic future stable for survivors of domestic violence and their progenies. Staying in a paid job may be severely jeopardised by continuing violence and its aftermaths. Mitchell (2011) found that in Australia some women were disallowed from working while being in a violent relationship, and found it hard to get into or go back into their past workforce after separation. This underscores the fact that domestic violence is not just an impediment to getting an education, paid job or training, but it potentially increases the difficulties of victims trying to get the benefits offered by various schemes (Mitchell, 2011). To continue dominating their partners, abuse perpetrators may even sabotage women's efforts at becoming self-sufficient.

Proneness to an interrupted work history, or to become a casual or part-time worker, has been noted in the case of women who had lived in domestic violence contrary to women who have had no experience of it. Franzway et al. (2007) summarised the overall economic problems of women who have experienced domestic violence, as mostly those of the underprivileged and those vulnerable in the job market. Some investigators like Costello et al. (2005) contend that in Australia the main response to domestic assault has been crisis-aligned and concentrated on the provision of shelter, social services and urgent support assistance for women and their children, virtually ignoring the aspect of employment hunting and training to give them economic security, free of social service organisations.

2.8 Reporting to Police and Help-Seeking Behaviour

Numerous women, irrespective of the health systems in their community, decline to look for healthcare attention for harm and injuries resulting from intimate partner violence, and if they did seek help many health facilities do not gather information about the perpetrator (Our Watch et al., 2015; Tjaden & Thoennes, 2000; Webster et al., 2019). In other reports, it was observed that even when women were interviewed about their abuser, they were hesitant to reveal the true cause of their injury and ascribed their wounds to some other source (ABS, 2016; AIHW, 2018).

When recognising abuse as a criminal act, victims separate partners from strangers. The IVAWS found that violence perpetrated by strangers was recognised as 'crimes' more frequently (in 42% cases) than that perpetrated by intimate partners (in 26% cases). Also, only 11% (1 in 10 women) of respondents who suffered violence from a present spouse recognised the newest incident as a criminal act in comparison with 38% (almost 4 in 10 women) who were victims of violence from the hand of an ex-spouse. In the case of women who encountered violence from present boyfriends, 18% recognised the newest incident as a crime compared to 22% who had suffered violence from ex-boyfriends (Mitchell, 2011; Mouzos & Makkai, 2004).

According to reports on domestic violence obtainable from the police administrative data warehouse, police are not notified of a significant percentage of domestic violence cases, and the non-disclosure rates are higher in Indigenous communities compared to their non-Indigenous counterparts (AIHW, 2018). Studies showed that the non-disclosure rate of experience of violence by Indigenous women may be as high as 90% of cases (AIHW, 2018; Taylor et al. 2007; Willis 2011). Gretch and Burgess (2011) noted that incidents of violence experienced by older women, married women and sufferers of violence that involved no weapons or those who did not suffer any lethal injury were not likely to be disclosed to police.

Women were especially hesitant to disclose violence perpetrated by present partners to police. As stated in the ABS (2005) report, among all women that suffered physical or sexual violence perpetrated by a man in the preceding year, there was the highest hesitance to disclose the abuse to the police when the offender was the present partner. According to the 2016 Personal Safety Survey, 82% of women declined to

contact the police following an experience of domestic violence from a current partner (ABS 2017; AIHW, 2018).

Research by the AIC that evaluated the peculiarities of domestic violence incidents and whether there was police notification found that women would report domestic violence more than men and that reporting depended on the severity of the violence (physical assault in contrast to other forms of gender based violence) and/or sustenance of physical injury (AIHW, 2018). Also linked to higher reporting is the frequent occurrence of violence before the reported incident, children witnessing the violent incident, the presence of a weapon and the use of alcohol by the perpetrator (Voce & Boxall, 2018). Investigators noticed that women were able to recognise sexual violence by an ex-partner better than from the present intimate spouse. They may feel confounded, be devoted and magnanimous about a present partner. According to Duncan and Western (2011), a more precise evaluation of violence comes out only when the relationship breakdowns, with elapsed time and the virtue of wellbeing and hindsight.

A limited number of women who had suffered domestic violence may look for support from a professional organisation. Mouzos and Makkai (2004) reported that only 16% of women who had suffered intimate partner violence reached out to organisations like a crisis centre, a hotline, a shelter, women's centre or counsellor. On the other hand, women who had suffered violence from some other men who were neither their current nor past partner were more unlikely to look for help from any one of these organisations. Only 9% of such women reached out to any kind of professional organisation. More probably, a woman will discuss the encounter with someone else they know rather than talk to the police or reach out to professional bodies (Table 2.5).

Source of advice	Experience of current spouse violence (%)	Experience of ex-spouse violence (%)
General practitioner	33.3	26.1
Other health professional	20.1	17.6
Counsellor or support worker	25.1	25.4
Telephone helpline	10.8	7.5
Refuge or shelter	4.3	7.9
Police	16.7	34.0
Friend or family member	66.9	64.9
Work colleague or boss	5.0	8.0

Table 2.5: Women's sources of advice for intimate partner violence, 2016 (Source: ABS, 2017)

Mitchell (2011) found that about 75% of women discussed the violent incident involving an intimate partner with someone else. It shows that most women prefer to talk to a confidant, an acquaintance or an immediate family member rather than go to police or service organisations. It was also noted by Mitchell (2011) that only 10% of all the women who had suffered spousal violence from a current partner at any time since becoming 15 years old had a violence order issued. It was 25% in the case of women who had experienced ex-partner violence since becoming 15 years old.

There are quite a few systematic and cultural hindrances that prevent women from accessing help. These barriers also contribute to some migrant CALD women in Australia staying in abusive relationships. They may be hesitant to reach out for police or legal assistance because they are afraid that their complaints will not be taken as seriously as in their home countries (Our Watch et al., 2015, Webster et al., 2019). For those who are undocumented immigrants or on a spouse/de-facto visa, the mistrust is often aggravated by the apprehension that police or the court system may inform the immigration authority. Their visa may be cancelled and they could be repatriated back to their countries of origin (Mitchell, 2011; Our Watch et al., 2015, Webster et al., 2019).

According to Boas (2009), the legal system in many African countries failed to address the dilemma of domestic violence as the laws in existence are ineffectively imposed. Hence, many CALD female victims of domestic violence may not be familiar with using

the legal system for help and support. Women may also be ignorant of the laws that exist to protect sufferers of domestic abuse and they may, at the onset, be unacquainted and ill-at-ease about dealing with law enforcement agents and the legal system. Due to these facts, CALD female sufferers of domestic assault may turn to their religious leaders, community leaders and relatives who may dissuade them from disclosing the abuse or leaving the perpetrator. Even those who make up their minds to leave the abuser, may not know, at first, where to look for help and support. The extensive presence of domestic violence refuges is not observable in a lot of African countries while some have no refuge at all. Also, psychological counselling is scarce in most African countries and is even deemed culturally and religiously inappropriate in some countries.

2.9 Frontline Workers and Domestic Violence

Frontline workers include social workers, psychologists, counsellors, therapists, police and caseworkers, who have regular contact with women who have experienced domestic violence in various workplaces and health care facilities (Ali et al, 2020; Baker et al., 2010; Davison et al, 2021; Dedeigbo & Cocodia, 2016). The real challenge for these frontline workers is the need to understand the cultural perspectives of CALD women who have been through domestic violence relationships. Overcoming this apprehension could enable them to prescribe more effective services and more effectively reach out to these communities. The support services may encourage victims to report abuse whenever it occurs, to avail all protection possible under Australian law and to look for support in the form of counselling and psychotherapy (Dedeigbo & Cocodia, 2016).

Comprehending different cultural perspectives may be baffling as frontline workers and other support staff may not have been trained in handling clients from different communities. According to Allimant and Ostapiej-Piatkowski (2011), working with women from CALD communities involves frontline workers being brought face-to-face with concealed scars, multifarious viewpoints and personal experiences welded within the cultural tradition and spiritual ethics women adhere to, in the middle of attempting to make sense of their new surroundings. Hence, support for these women is one where the frontline worker can empathise with their values, knowledge and life experience (COAG, 2011; Our Watch et al, 2015; Rees & Pease, 2007; Taylor & Putt,

2007; Webster et al., 2019). Victims of domestic violence from CALD communities may be unable to get this kind of empathy and help because of the absence of training and limited knowledge of frontline workers and support staff (Allimant & Ostapiej-Piatkowski, 2011; Our Watch et al, 2015; Webster et al., 2019).

A group of researchers in the UK identified gaps in research while exploring reports on social workers' interventions in relation to domestic violence (Heffernan et al., 2012). They identified the need for reports that encourage evidence-based practice. Macy et al. (2010) noted that according to some directors of agencies that support victims of domestic violence, the most ideal services for CALD survivors of domestic violence to achieve safety and recovery are still unknown as are the challenges and barriers they encounter when accessing mainstream services. So far, a large-scale study on the effectiveness of services in supporting CALD women in Australia is limited; only pockets of information are available in international literature (Page et al., 2007; Webster, 2019; Department of Premier and Cabinet, 2019). Research evidence on effective adaptation of existing services for domestic violence among diverse groups of survivors including women of colour and immigrant women is limited. Also, there have been only a few studies on frontline workers' responses and views of domestic violence and the impacts on CALD victims/survivors in Australia.

There is a need for strengthening policies on domestic violence with evidence-based research and information for decision-making (Dedeigbo & Cocodia, 2016) to reduce the prevalence of domestic violence among these communities (Morgan & Chadwick, 2009) and to provide adequate services when it does occur. This research sought to address the identified limitations of research on frontline workers. Frontline workers supporting victims of domestic violence in NSW were asked what methods work and what methods do not with women from these communities and how this can be combined with current Australian government policies to reduce incidences of domestic violence.

CHAPTER 3 - CALD Communities and Domestic Violence

3.1 Introduction

According to Allimant and Ostapiej-Piatkowski (2011) “Culturally and Linguistically Diverse (CALD) refers to people from a range of different countries, races and ethnicities, who speak different languages and follow various religious, political and philosophical beliefs, while non-English speaking background (NESB) refers specifically to individuals whose first language is a language other than English” (p. 2). Statistically, the ABS (2006) classifies people from CALD communities as those born overseas, in countries other than the ‘main English-speaking countries’ – the United States of America, Canada, New Zealand, the Republic of Ireland, South Africa, and the United Kingdom (Wales, England, Northern Ireland, Scotland).

CALD people who speak good English may be accustomed to some Western culture and tradition and the c/overt wisdom that comes with the knowledge of English language (Allimant & Ostapiej-Piatkowski, 2011). However, many migrant women from CALD backgrounds are socially isolated, have inadequate English language skills, are financially insecure and have the most basic understanding and mastery of the techniques required to steer through different social services (Box et al., 2001; Weerasinghe & William, 2003; ABS, 2010, Our Watch et al., 2015; Webster et al, 2019).

3.2 CALD Communities in Australia

Australia has a fast-growing demographic of the CALD population (Dedeigbo & Cocodia, 2016). According to the ABS (2017), 28.5% of Australians (6.9 million) were born outside Australia, and about two-thirds of these cohorts were born in non-English speaking (NES) countries. As of 31 December 2018, Australia had an estimated resident population (ERP) of 25 million. Out of this, 7.3 million (29%) were born outside the country (ABS, 2019). The net overseas migration (NOM) for the year ended 31 December 2018 was estimated at 248,400 (28%), and this contributed 61.4% to total population growth (ABS, 2019).

Women of CALD origins may have entered Australia as spouses, refugees or humanitarian entrants, migrants, family members of an Australian resident, unaccompanied minors, returning Australian residents or international students (ABS, 2019; Our Watch et al., 2015, Webster et al., 2019). CALD women coming to live in Australia have varying degrees of education and literacy levels, with different cultural ethics, socioeconomic classes, rural and urban experiences, religious and belief contexts, family circumstances and races and ethnicities, and therefore the needs of each CALD individual in Australia are different (Australian Institute of Family Studies [AIFS], 2011, Our Watch et al., 2015, Webster et al., 2019).

3.3 CALD Communities and Domestic Violence

There is large diversity among immigrant and refugee populations in Australia. Their diverse cultural practices and immigration statuses increase the complexities of cases of domestic violence involving CALD women (Australian Human Rights Commission [AHRC], 2017; Pease & Rees, 2008).

Categorisation of the various patterns of violence, its perpetrators and their victims in CALD communities, is complex and this is further compounded by the diversity of living arrangements, families and intimate relationships that exist in Australia (ABS, 2010; Mitchell, 2011). Although the most common and “universal” pattern of violence affecting females are generally violence perpetrated by intimate partners and sexual coercion, there are some peculiarities to violence in CALD communities based on cultural and historical conditions of the country including “honour killings”, female genital cutting, trafficking of girls and women, and violence against women during armed conflicts (Garcia-Moreno et al., 2005; Ekhtor-Mobayode et.al., 2022; Shaheen et al., 2020; Wikholm et.al., 2020).

These complexities also act as barriers to reporting and accessing assistance and protection from further domestic violence. Bonar and Roberts (2006) found that women from CALD communities were unlikely to notify police of incidence of domestic violence or access mainstream services (Department of Premier and Cabinet, 2019; Our Watch et al., 2015; Webster et al., 2019). According to UN Economic and Social Affairs (2015), less than 40% of women seek support for their domestic violence incidents. Research conducted by the National Family and Parenting Institute in found that CALD communities, especially African and other ethnic minorities, accessed

services less in comparison to mainstream women (Katz et al., 2007). CALD women in Australia experience similar issues when it comes to accessing services; these issues relate to displacement, cultural identity, and feelings of belonging and acculturation (Department of Premier and Cabinet, 2019; Sawrikar & Katz, 2008; Sawrikar & Hunt, 2005; Webster et al., 2019). Boas (2009) pointed out that, in spite of there being laws against domestic violence, female CALD victims continued to be restricted in their access to justice by both systemic and cultural barriers. These will now be discussed.

Lack of support from extended family

Migrant families often have limitations in their ability to obtain support from their extended families if their extended families have not migrated with them (Department of Premier and Cabinet, 2019; Office of Women's Policy, Victoria, 2002; Our Watch et al., 2015; Rees & Pease, 2007). In their homelands, the elders from extended families can act as agents of dispute resolution (Benevolent Society, 2008, Lelurain et al., 2018; Mshweshwe, 2020; Pease & Reese, 2008). However, in a foreign country, these women may find themselves without this support. This lack of support from extended family also acts as a barrier for CALD women of migrant communities from exercising choice when it comes to decision-making (Our Watch et al., 2015; Pease & Reese, 2007; Webster et al., 2019). This leads to a reduced socialisation for such women, who may be experiencing emotional and social isolation, and cultural disconnection in a foreign land (Ghafournia, 2011; Our Watch et al., 2015, Webster et al., 2019). This emotional and social isolation, coupled with the cultural disconnectedness experienced by CALD women, can add to their sense of insecurity. CALD women may have no choice but to continue to live through the abuse being perpetrated against them.

Limited proficiency in English language

This is one of the principal factors that restricts women from CALD communities from reporting violence (Box et al., 2003; Our Watch et al., 2015, Webster et al., 2019). Also, there are often limited translator services available at service providers (Bonar & Roberts, 2006). Frequently, female CALD victims of domestic violence may not even be aware that some service providers offer translator services (Benevolent Society, 2009). Incidentally, perpetrators can also exploit the victim's lack of language skills to

perpetuate their abuse (COAG, 2011; Our Watch et al., 2015, Webster et. al., 2019).

Financial and economic dependency

CALD female victims of domestic abuse are usually dependent on their spouses for finances. Sometimes, CALD women are in Australia due to their husbands' employment and have restrictions on their own employment opportunities due to their visa status (Office of Women's Policy Victoria, 2008; Our Watch et al., 2015, Webster et. al., 2019). Such women may not have access to their own funds and may not have personal bank accounts, either in Australia or their home countries. The perpetrator may use this as a tool for exerting power over the woman (Boas, 2009).

Limited awareness of personal legal rights

Women from CALD communities may have limited awareness of their own rights. CALD women may be unaware that the legal system in Australia forbids family violence. Ghafournia (2011) notes that few women who are members of CALD migrant communities are acquainted with their legal rights or possess knowledge about family allowances and other benefits provided by the Australian government (AIFS, 2017). For many women, their sources of information are their husbands, who may misguide them (Our Watch et al., 2015, Webster et. al., 2019). These women may also be unaware of the support services they can access in Australia, including housing, court advocacy and legal aid (Dedeigbo & Cocodia, 2016). Only 14% of women from CALD communities actually access some of these services, according to the 2004–05 national data (AIHW, 2006), such as SAAP services (Ghafournia 2011). Ghafournia (2011) also comments that this lack of knowledge and the consequent limited ability to access services may increase the loneliness felt by CALD female victims of domestic violence.

Difficulty in accessing services

According to Ghafournia (2011), there is limited availability of culturally sensitive translation and interpreters' services. This could limit the ability of victims with limited English language proficiency to seek help, thus placing themselves and their children in dangerous situations. Women from CALD communities can be unaware of the availability of such services. Their spouses could withhold this information from them in order to exercise more power over them. The Australian Department of Human Services (DHS) states that people seek assistance from specialist homelessness

agencies mostly because of homelessness caused by family and domestic violence. The AIHW (2017) states that 38% of those who received assistance from homelessness agencies in Australia in 2015–2016 were escaping from family or domestic violence, an increase of 15% from 2014–2015. This means that if women from CALD communities who have experienced domestic violence are made aware of these services, more of them may be persuaded to escape the danger in which they are living and seek out other living arrangements.

Limited understanding of the legal system

Female migrants from CALD backgrounds may be unaware of the intricacies of Australian immigration law. This may give rise to the fear that if they notify Australian authorities of violence incidents, it could jeopardise their stay in Australia, or limit their access to various programs or services. Many of these fears are justified. Allimant and Ostapiej-Piatkowski (2011) point out that CALD women living in Australia with limited visas, such as student visas and bridging visas, may be ineligible for healthcare, income support, safe-house/refuge-homes or crisis accommodation. Some have work restrictions while their applications for residency are under consideration (Immigration Act, 1958). This process may take months or even years (Australia Government Department of Immigration and Border protection, 2017). Ghafournia (2011) observed that fear of the possibility of deportation can be a reason for migrant women continuing in a domestic violence relationship. It can also be used as a powerful weapon by perpetrators to continue their abusive behaviour. Sometimes, women from CALD communities may be suspicious of authorities, including the police. This fear and suspicion may stem from their experiences in their homelands where authorities might have been corrupted or have a culture of ignoring woman's complaints about domestic violence (Noah & Yusuf, 2000). In some countries, although their constitution is against violence, they are usually not implemented when cases of domestic violence are reported and perpetrators are caught (USA's Department of State, Country Reports on Human Right Practices, 2012; Bazza, 2012). Tavares and Wodon (2018) conducted an analysis of the World Bank Legal data for 2013, 2015 and 2017 of 141 countries³.

³ The 141 countries: Albania, Algeria, Angola, Argentina, Armenia, Australia, Austria, Azerbaijan, Bangladesh, Belarus, Belgium, Benin, Bolivia, Bosnia and Herzegovina, Botswana, Brazil, Bulgaria,

In 2017, over 95% of the world population of adult women (2.7 billion out of 2.8 billion global estimate) was accounted for by these 141 countries. Global trends were estimated for all countries together, as well as by regions. These countries were grouped into regions (17 countries in East Asia and Pacific, 46 countries in Europe and Central Asia, 21 countries in Latin America and Caribbean, 14 countries in Middle East and North Africa, two countries in North America, five countries in South Asia and 36 countries in Sub-Saharan Africa (Table 3.1).

z	Regions (countries in Sample)							World (141)
	EAP (17)	ECA (46)	LAC (21)	MENA (14)	NA (2)	SA (5)	SSA (36)	
Domestic violence								
2013	0.0	19.6	4.8	85.7	50.0	0.0	50.0	29.1
2015	0.0	13.0	4.8	71.4	50.0	0.0	50.0	25.5
2017	0.0	13.0	4.8	64.3	50.0	0.0	47.2	24.1
Physical Violence								
2013	0.0	21.7	4.8	92.9	50.0	0.0	50.0	30.5
2015	0.0	13.0	4.8	78.6	50.0	0.0	50.0	26.2
2017	0.0	13.0	4.8	71.4	50.0	0.0	47.2	24.8
Sexual Violence								
2013	35.3	39.1	14.3	92.9	50.0	0.0	58.3	44.0
2015	35.3	30.4	14.3	78.6	50.0	0.0	58.3	39.7
2017	29.4	28.3	14.3	78.6	50.0	0.0	52.8	36.9
Emotional violence								
2013	5.9	19.6	4.8	92.9	50.0	0.0	52.8	31.2
2015	5.9	13.0	4.8	78.6	50.0	0.0	52.8	27.7
2017	5.9	13.0	4.8	71.4	50.0	0.0	50.0	26.2
Economic violence								
2013	58.8	63.0	38.1	92.9	100.0	20.0	61.1	60.3
2015	52.9	54.3	38.1	85.7	100.0	20.0	61.1	56.0
2017	52.9	52.2	28.6	78.6	100.0	20.0	52.8	51.1
Unmarried intimate partners								
2013	70.6	71.7	23.8	100.0	50.0	100.0	77.8	69.5
2015	70.6	69.6	23.8	100.0	50.0	100.0	77.8	68.8
2017	70.6	69.6	23.8	100.0	50.0	100.0	75.0	68.1

NB: EAP = East Asia & Pacific, ECA = Europe & Central Asia, LAC = Latin America & Caribbean, MENA = Middle East & North Africa, NA = North America, SA = South Asia, SSA = sub-Saharan Africa.

Table 3.1: Percentage of Countries without Laws against violence by Region (Source: Taraves & Wodon, 2018)

Burkina Faso, Burundi, Cambodia, Cameroon, Canada, Chad, Chile, China, Colombia, Congo (Democratic Republic), Congo (Republic), Costa Rica, Côte d'Ivoire, Croatia, Czech Republic, Denmark, Dominican Republic, Ecuador, Egypt (Arab Republic), El Salvador, Estonia, Ethiopia, Fiji, Finland, France, Gabon, Georgia, Germany, Ghana, Greece, Guatemala, Guinea, Haiti, Honduras, Hong Kong (China), Hungary, Iceland, India, Indonesia, Iran (Islamic Republic), Ireland, Israel, Italy, Jamaica, Japan, Jordan, Kazakhstan, Kenya, Korea (Republic), Kuwait, Kyrgyz Republic, Lao PDR, Latvia, Lebanon, Lesotho, Liberia, Lithuania, Macedonia FYR, Madagascar, Malawi, Malaysia, Mali, Mauritania, Mauritius, Mexico, Moldova, Mongolia, Montenegro, Morocco, Mozambique, Namibia, Nepal, Netherlands, New Zealand, Nicaragua, Niger, Nigeria, Norway, Oman, Pakistan, Panama, Papua New Guinea, Paraguay, Peru, Philippines, Poland, Portugal, Puerto Rico (U.S.), Romania, Russian Federation, Rwanda, Saudi Arabia, Senegal, Serbia, Sierra Leone, Singapore, Slovak Republic, Slovenia, South Africa, Spain, Sri Lanka, Sudan, Sweden, Switzerland, Syrian Arab Republic, Tajikistan, Tanzania, Thailand, Togo, Tunisia, Turkey, Uganda, Ukraine, United Arab Emirates, United Kingdom, United States, Uruguay, Uzbekistan, Venezuela (RB), Vietnam, West Bank and Gaza, Yemen (Republic), Zambia, and Zimbabwe). These countries were grouped into regions (17 countries in East Asia & Pacific, 46 countries in Europe & Central Asia, 21 countries in Latin America & Caribbean, 14 countries Middle East & North Africa, two countries in North America, five countries in South Asia and 36 countries in sub-Saharan Africa).

Of note, Algeria, Belarus, Kenya, Latvia, Lebanon, the Netherlands and Saudi Arabia changing their legal reforms in the four years before the analysis. Still, the results show that 75.9% (107) countries have laws on domestic violence, approximately 24% (34 or one out of four) of these countries have no specific laws on domestic violence, legal protection for domestic violence in the form of sexual assault was weak where there is no law in more than one out of every three countries.

50% of the countries do not have specific laws for economic violence and intimate partners who are not married have no protection under the domestic violence legislation in two out of every three countries, with gaps in laws being most significant in Sub-Saharan Africa, the Middle East and in North Africa. Over one billion women do not have laws protecting them from a sexual violence perpetrator who is a family member or an intimate partner, while approximately 1.4 billion have no law protecting them from domestic violence in the form of economic violence, and a very slow progress in a long period in both cases (Table 3.2).

		Regions (countries in Sample)							World
		EAP (17)	ECA (46)	LAC (21)	MENA (14)	NA (2)	SA (5)	SAA (36)	(141)
Domestic violence									
2013	Number	0.0	101.9	3.5	113.8	15.0	0.0	104.0	338.3
	Share	0.0	26.2	1.6	95.3	10.3	0.0	39.8	13.2
2015	Number	0.0	89.2	3.6	106.4	15.3	0.0	110.8	325.4
	Share	0.0	22.8	1.6	85.7	10.4	0.0	39.9	12.4
2017	Number	0.0	89.1	3.8	95.3	15.6	0.0	103.0	306.8
	Share	0.0	22.6	1.6	74.2	10.4	0.0	34.9	11.4
Physical Violence									
2013	Number	0.0	104.3	3.5	116.5	15.0	0.0	104.0	343.2
	Share	0.0	26.8	1.6	97.5	10.3	0.0	39.8	13.4
2015	Number	0.0	89.2	3.6	109.3	15.3	0.0	110.8	328.3
	Share	0.0	22.8	1.6	88.0	10.4	0.0	39.9	12.5
2017	Number	0.0	89.1	3.8	98.4	15.6	0.0	103.0	309.9
	Share	0.0	22.6	1.6	76.6	10.4	0.0	34.9	11.5
Sexual Violence									
2013	Number	640.8	184.8	11.6	116.5	15.0	0.0	138.4	1107.1
	Share	75.2	47.5	5.1	97.5	10.3	0.0	52.9	43.3
2015	Number	646.8	170.7	11.9	109.3	15.3	0.0	147.7	1101.6
	Share	74.8	43.6	5.1	88.0	10.4	0.0	53.1	41.9
2017	Number	650.0	168.4	12.2	112.9	15.6	0.0	139.3	1098.4
	Share	74.1	42.8	5.1	87.9	10.4	0.0	47.2	40.8
Emotional violence									
2013	Number	3.5	101.9	3.5	116.5	15.0	0.0	108.2	348.5
	Share	0.4	26.2	1.6	97.5	10.3	0.0	41.4	13.6
2015	Number	3.5	89.2	3.6	109.3	15.3	0.0	115.3	336.2
	Share	0.4	22.8	1.6	88.0	10.4	0.0	41.5	12.8
2017	Number	3.6	89.1	3.8	98.4	15.6	0.0	107.8	318.2
	Share	0.4	22.6	1.6	76.6	10.4	0.0	36.5	11.8
Economic violence									
2013	Number	659.1	296.4	35.5	116.5	144.6	8.1	138.9	1399.1
	Share	77.3	76.2	15.7	97.5	100.0	1.4	53.1	54.7
2015	Number	664.0	264.3	36.6	118.9	147.3	8.3	148.2	1387.7
	Share	76.8	67.5	15.7	95.7	100.0	1.4	53.3	52.8
2017	Number	670.3	262.6	23.5	108.5	149.9	8.5	139.3	1362.5
	Share	76.4	66.7	9.8	84.4	100.0	1.4	47.2	50.6
Unmarried intimate partners									
2013	Number	750.4	255.2	43.3	119.5	15.0	566.5	168.7	1918.6
	Share	88.1	65.6	19.2	100.0	10.3	100.0	64.5	75.0
2015	Number	761.3	255.4	44.7	124.2	15.3	588.4	180.1	2005.6
	Share	88.0	65.2	19.2	100.0	10.4	100.0	64.8	75.0
2017	Number	771.7	256.7	46.0	128.5	15.6	610.1	177.1	2005.6
	Share	88.0	65.2	19.1	100.0	10.4	100.0	60.0	74.4

NB: EAP = East Asia & Pacific, ECA = Europe & Central Asia, LAC = Latin America & Caribbean, MENA = Middle East & North Africa, NA = North America, SA = South Asia, SSA = sub-Saharan Africa.

Table 3.2: Number of women (billion,) aged 15 and over, not protected against violence by region (Source: Taraves & Wodon, 2018).

When it comes to all forms of domestic violence, it was found that every country in the Pacific, East Asia and South Asia that were included in the study have written legislations. There is also substantial diversity in content of the legislations from region to region in those countries with adequate laws. On the other hand, only one in every

three countries in the Middle East and North Africa have written laws, in North America and in Sub-Saharan Africa, the ratio is one out of every two countries. Laws against domestic violence in existence fail to tackle the four patterns of violence (physical, sexual, economic, and emotional) in three out of every four countries, and neither include intimate partners who are not married. Although there is progress in the number of countries that are adopting Domestic Violence Acts, the proportion of women protected under this law has not significantly increased, and population growth is partly responsible for this.

Fear of breach of confidentiality

Many CALD communities belong to collectivist cultures in which individuals typically rely on family members as the main support. In such cultures, family issues are usually not discussed with non-family members due to the perception that if family issues are shared with outsiders and are known to non-family members, it could compromise the family's standing in the community (AIFS, 2008). Hence, many CALD female victims of domestic violence hesitate to approach service providers as they are considered outsiders and are afraid of breaching the confidentiality of the family or community unit. Many cultures also place significant value on family honour and reputation (Akangbe, 2020; Dedeigbo & Cocodia, 2016; Kokanovic, et. al., 2006; Msheswwe, 2020; Sikweyiya et al., 2020; Youssef & Deane, 2006). Women from such cultural backgrounds may be afraid to approach service providers due to the fear of their family honour being jeopardised if such 'secret' is exposed (Dedeigbo & Cocodia, 2016). Victims of domestic violence are generally scared of retribution in cases of breach of confidentiality. In the case of women from CALD communities, this fear is amplified as they may feel they do not have any alternative but to remain in the relationship with the perpetrator.

Limited access to resources

Resources such as income, assets, education and employable skills can provide CALD domestic violence victims with enough financial independence to exercise options when subjected to violence. However, inability to access these resources can compel victims to continue living with the abuse perpetrated against them (AIFS, 2008, Mshweshwe, 2020). Additionally, for some women, the new dimension of being in a foreign land, where the sole breadwinner is often their husband makes them

dependent on their spouses and limits the opportunity to leave (Australian Refugee Council, 2009; Immigrant Women's Support Service [IWSS], 2006; Mshweshwe, 2019).

Cultural aversion to therapy

Cultural aversion to therapy may prevent CALD women from seeking counselling for an abusive relationship. In many African cultures, seeking therapy, especially for a private matter such as marital relations, is frowned upon (Pease & Rees, 2007). Pease and Rees (2007) interviewed 42 CALD refugees (17 men and 25 women) and found that male participants believed that seeking the help of external bodies to address family issues undermines male authority within the family and disrupts family cohesion. This attitude discourages women from CALD backgrounds from seeking help from external bodies in abusive situations. A therapist would not be the first option that a CALD woman would consider when seeking for help (Allimant & Ostapiej-Piatkowski, 2011; Sawrikar & Katz, 2008).

Also, CALD communities may believe that therapy in Australia follows the individualistic model (Bond, 2002) in which individuals are socialised to be more autonomous and disclose family problems to non-family members or seek help externally (Bhugra, 2007; Broadhurst, 2003). CALD female victims of domestic violence may believe that therapies are designed to make them conform to the hegemonic culture whereby the provider is imposing the "white right" model through attitude that favour Western way of life and tacitly condemns other's culture as "cruel" or "inferior" (Allimant & Ostapiej-Piatkowski, 2011). Hence, CALD women may believe that such services are offensive to their ethnic community and culture and are inappropriate for their particular cultural needs, and therefore fail to engage appropriately. Another point raised by Allimant and Ostapiej-Piatkowski (2011) is that some CALD communities may not believe their affairs are matters that require therapy. For instance, some Asian families have reported that domestic violence relates to behavioural or spiritual difficulties; hence they seek the help of religious leaders who usually encourage more religious activities and education to solve them.

Differences in perception

Different perceptions and understandings exist in different CALD communities as to what is accepted as domestic violence. Domestic violence definitions in some cultures

do not include abuse that is emotional, psychological and sexual in nature. Among certain CALD communities, particularly the more patriarchal ones, some forms of violence are considered to be the right of the husband. In Sub-Saharan African cultures, for instance, the dominant view is that violence against a wife is an acceptable tool by which husbands can chastise his wife to correct her (Akangbe, 2020; Oyediran & Isiugo-Abaniher, 2005; Sikweyiya et al., 2020; Tonsing & Tonsing, 2019). Commonly accepted justifications for wife-beating include insubordination to the husband, refusal of sex, neglecting the children and perceived failure of wifely duties such as cleaning or cooking (Mshweshwe, 2018; Mshweshwe, 2020; Sikweyiya et al., 2020).

In some African cultures, marriage entails the bride giving up all power to self-determine (Akangbe, 2020; Mshweshwe, 2020; Sikweyiya et al., 2019). In some cultures, once the bride price has been paid, it is common to believe the husband now owns his wife; the act of marriage is believed to give the husband full ownership of the wife, and the right to her body is surrendered to the husband (Arisi, 2011; Lelaurain et al., 2018; Mshweshwe, 2020; Ogunjuyigbe et al., 2005; Sikweyiya et al., 2019). This makes it difficult for women from some CALD communities to view their situations as being dangerous to their own health and well-being. Even after migrating to a different country, the cultural perceptions of CALD women can remain with them. Women from CALD migrant communities may hesitate to speak up against domestic violence due to these cultural perceptions (Dedeigbo & Cocodia, 2016). These barriers may continue to impact the willingness and ability of affected women to seek help (Boas, 2009; Our Watch et al, 2015; Webster et al, 2019), and an understanding of these barriers could impact the success of support for CALD women who have lived through domestic violence in Australia.

Societal prohibitions

Women from CALD migrant communities may belong to original cultures and societies where there is a strong prohibition against divorce (Dedeigbo & Cocodia, 2016). Pease and Reese (2007) interviewed 42 refugees from Bosnia, Croatia, Ethiopia, Iraq, Serbia and Sudan about their domestic violence experiences. The Benevolent Society (2006), an independent, non-government organisation that provides a wide variety of services for families including supports for victims of domestic violence, also carried out a similar study that involved CALD communities in 2006. Both studies elucidated how victims' religious beliefs and communities could affect their responses to domestic

violence, sometimes in negative ways by equating divorce with sin, even if it entails escape from abuse. Hence, CALD women may hesitate to report violence, seek separation and divorce or approach service providers. Ghafournia (2011) proposed that some communities have weak community sanctions for domestic violence, which encourages women to continue in abusive relationships. The majority in some cultures, for example in Nigeria, view wife-beating as acceptable and a display of love (Akangbe, 2020; Ishola, 2016; Nigeria Demographic and Health Survey, National Population Commission [NDHS, NPC] 2008; Nnamdi, 2012; Parkin & Nyamwaya, 2018).

Intersectionality

Many people relocate to a different country for different reasons, but women often relocate because their spouse who is the decision maker decides to migrate (Erez & Harper, 2018). Research has shown that migrant women are at increased risk of domestic abuses after relocation; they experience similar stressors and trauma of domestic violence as their indigenous counterparts as well as the additional burdens of immigration context and intersecting with the socio-cultural factors (e.g race, culture, religion, ethnicity, gender, class) to exacerbate their experience of abuse (Erez & Harper, 2018; Gill, 2018; Waller et al., 2021). Intersectionality underscores how the hierarchies of power and social-cultural factors (an assumption of homogeneity, despite coming from very diverse cultural and ethnic groups, and religious challenges and biases, isolation from family supports due to migration, disability, language barriers, race, immigration status, gender, culture, ethnicity, class) intersects to create interwoven and multiplicative challenges facing CALD women. These intersections increase risk of domestic violence and causes an exponential (and intersecting) increasing obstacles to be overcome to escape domestic violence and to be safe (Erez & Harper, 2018; Md Said & Emmanue Kaka, 2022; Taha, 2018).

3.4 Role of CALD Culture on Domestic Violence

Boas (2009) discussed the dynamics of domestic violence and noted that it is in many ways dissimilar across countries and cultures. Culture has a powerful part in defining the way a woman experiences domestic violence. Every culture has its own unique features relating to family, community and the legal system that could sway a woman's capability and inclination to leave a violent spouse and pursue legal assistance and

protection. To understand the impact of culture on a woman's experience of domestic violence, one must learn about the distinctive view of domestic violence from the viewpoint of the victim's culture, and the legal system of her country of origin. CALD women usually originate from societies where the laws or culture may have failed to acknowledge the right of a woman regarding control over her body (Akangbe, 2020; Mshweshwe, 2020; Ishola, 2016; Our Watch, 2015; Webster et al., 2019).

Developed countries have legal systems that protect victims of domestic violence and prosecute perpetrators. In many African countries, this is usually lacking. According to Bowman (2003), many African countries have no distinctive laws forbidding domestic violence or indicting the perpetrator. Cantalupo et al. (2006) found that legal frameworks in some African countries permit perpetrators to rationalise their violent conducts. For example, in Nigeria, a man is legally allowed to beat his wife to "correct" her as long as the chastisement does not lead to "grievous harm" (Eze-Anaba, 2006, Nnamdi, 2012). In Ghana, until 2007, a wife was not allowed to refuse sexual intercourse from her husband unless she has been separated or divorced legally (Manuh, 2007), implying a legal acceptance of marital rape.

Although the number of countries in Africa that have created laws that oppose domestic violence has increased, female victims continue to face systemic and cultural obstacles in accessing justice (Boas, 2009; Akangbe, 2020; Lelaurain et al., 2018). There is a common view in Africa that domestic disputes are "private" and not to be addressed in the public eye by the legal system (Boas, 2009, Akangbe, 2020, Mshweshwe, 2020; Mazibuko, 2017). This impacts their inclination and capability to search for help even after leaving their home countries (Webster et al, 2019; Department of Premier and Cabinet, 2019).

Majau (2013) and Akangbe (2020) noted that most Nigerian ethnic groups are of the opinion there is no gender equality between women and men, and that they must be submissive to male authorities. Women are taught that whatever the circumstances, men have the authority and she must be unequivocally obedient. If a woman reports violence to her family, she is often held responsible for the aggressiveness. She may be accused of provoking the attack, and she may be ordered to go back to the perpetrator. She may be counselled that it is normal in marriage and she needs to endure it, that the situation will improve if she is more submissive. Even the perpetrator gets away with the violent conduct when he is confronted, often with minimal or no

castigation. There is no difference to the situation when the issue gets reported to the police. In many cases, women are advised to go home and be good wives or to go and resolve the issue with their husbands because it is a “family issue” (Boas, 2009, Akangbe, 2020; Ishola, 2016). Many times, Nigerian law enforcement agents refuse to file a victim’s domestic violence complaints and often refuse to investigate or prosecute the perpetrator (Abimbola, 2012, US Department of State, 2012).

In some cases, judges have publicly held the victims liable for being abused (Amnesty International, 2005; Boas, 2009), some judges reportedly minimise domestic violence as they influence resolution, impose minimal penalties and allow withdrawal of cases by third parties (Cantalupo et al., 2006; Abimbola, 2012). The US Department of State (2007) reported that in many African countries, limited training is provided to people in positions of authority to handle domestic violence cases. Also, there is minimal enforcement of existing laws to protect survivors (US Department of State, 2012). Some officials do not want to get involved and many governments refuse to act to fight violence against women (Abimbola, 2012).

Many women decline reporting the domestic violence because it would mean admitting their marriages are not working, and for most African cultures and customs, divorce is not an option (Yoshihama & Novick, 2009; Mshweshwe, 2020; Akangbe, 2020; Burchardt, 2018). The domestic violence Acts does not favour these women in some regions of the country, pressuring them to continue to dwell with the violent partner. The penal code in Nigeria (Sections 55(1) (d) and 282(2), 1916) allows a man to correct his wife in as much as it does not cause severe bodily harm, and as long as it is according to the native laws and tradition of the couple’s community. This penal code is still being enforced in Northern Nigeria (Equality Now, 2021). This provisions in the code give few or no option to an abused woman.

Beside these institutional barriers, many women also encounter cultural hurdles that dissuade them from looking for help after being assaulted. Firstly, domestic violence is perceived as a customary tradition and a kind of penalty. The underlying belief is that violence may be employed as a kind of chastisement; this is ingrained from a tender age in some cultural contexts (US Department of State, 2008; Mshweshwe, 2020; Akangbe, 2020). Some children grow up believing that men are required to be violent to their wives as they had constantly witnessed the battering of their mothers by their fathers in the home (Eze-Anaba, 2006; Moolman, 2017). Boas (2009) and

Orpin et al (2017) mentions the widespread female genital mutilation (FGM) and female genital cutting (FGC) as a rampant cultural practice in Africa. The consequence is that all these practices may send messages to young children that their bodies are not their own to control (Mshweshwe, 2020).

In a majority of African countries, a significant number of men and women believe that men are permitted to be violent to their wives as a form of discipline for various behaviours such as leaving the house without the husband's permission, abandoning the children, arguing with the husband, declining sex, not cooking the husband's food in timely manner or for burnt food (The US Department of State (2008); Mshweshwe, 2018). As a result, women that were brought-up in such cultural environments may believe that they deserve the abuse from their husbands because they had not been good wives. Boas (2009) stated that some victims may feel humiliated and responsible for the assault, hence they may feel mortified to reveal the violence.

Mshweshwe, (2020), also noted that in many African countries, domestic violence is treated as a confidential family matter that needs to be settled unofficially by the family or community leaders. According to Akangbe, (2020), even where laws exist against violence, women may initially approach their families, spiritual or traditional leaders of the community because of their lack of faith in the capability of the legal system to protect them or look into their complaints seriously. In some cases, relatives, traditional elders and spiritual leaders may dissuade a woman from disclosing the assault to legal authorities and persuade the victim to be more submissive to her husband or be more religious to prevent further abuse (Akangbe, 2020; Ishola, 2016; Lelaurain et al., 2018).

According to Dovlo (2005) and Manuh (2007), laws against domestic violence in Africa are ineffectively enforced by governments because of the belief that such laws are contrary to the culture and traditions of such countries. Many African countries have traditions of polygamous marriage (US Department of State, 2008, Amo-Adjei & Tuoyire, 2016; Ahinkorah, 2021), in which the husband may support the favourite wife and assault the other wives in the name of discipline (Cantalupo et al., 2006; Berhma, 2019; Ebrahim & Atteraya, 2020; Jansen & Agadjanian, 2020, Health et al., 2020). Also, in some African cultures, the custom of paying a bride price for a wife may give men a feeling of ownership of the wife and a sense of entitlement to "discipline" her (Lelaurain et al., 2018; Mshweshwe, 2020). Because of a misunderstanding of

customary laws by the law enforcement agent, who also holds the power to enforce the law, the woman is considered the man's possession and he is therefore permitted to chastise her as he sees necessary (Eze-Anaba, 2006; Akangbe, 2020).

3.5 Domestic Violence in Australian CALD Communities

Presently, there is limited evidence on female immigrants or refugee residents of Australia who have suffered domestic violence (Webster et al., 2019). Also, there is limited information on the number of CALD female victims of domestic violence who are accessing services to deal with domestic violence; nor are there reliable estimates of the types of services they utilise. However, seminal authors Allimant (2005), Taylor and Putt (2007), Webster et al (2019) and Department of Premier and Cabinet (2019) note that once CALD women are in Australia, a number of elements may cause them to be more susceptible to physical and sexual violence than they would otherwise be in their home countries, including limited support and social networks, social and economic disadvantage, societal pressure and limited understanding of the rights of victims.

Economic issues become important when planning to end the relationship for CALD women victims. They may not be able to access healthcare or economic support. Also, they may not have work permits while their residency applications are still under consideration, which may take longer than anticipated (Allimant & Anne, 2008; Our Watch et al., 2015; Webster et al., 2019). CALD women also hesitate to notify authorities of violence due to the fear and threats of deportation (Lay, 2006; Taylor & Putt, 2007; AIHW, 2019). Many women are scared of being sent back to their countries of origin as they may need to confront persecution and oppression (Webster et al., 2019; Our Watch et al, 2015) In addition to low economic resources, limited access to precise information can increase the fear of CALD women victims of domestic violence (The Australian Refugee Council, 2009; Martz et al, 2020; Francis et al, 2017; Department of Premier and Cabinet, 2019).

CALD women also mention additional stresses in trying to maintain paid jobs because of economic needs and the pressure that monetary problems can generate in intimate relationships (IWSS, 2006; Webster et al., 2019). Tension also originates from the dilemma in securing jobs because of prejudice, absence of work experience in the

Australia's employment market, and inadequate proficiency in the English-language (Our Watch, 2015; Webster et al., 2019).

3.6 Support for CALD Women in Australia

It could reasonably be estimated that there might be a proportional increase in the number and complexity of domestic violence cases in CALD communities in Australia since the population of CALD communities has been steadily increasing. Even though women and girls are victimised all around the world, appreciable differences exist in the patterns of victimisation and how violence itself is discerned, comprehended and absorbed into each woman's worldviews (Davison et al, 2021, Martz et al., 2020). These perspectives are shaped by factors like the woman's background, social inclination, and cultural belief (Martz et al, 2020; Kuskoff & Parsell, 2020; Tanaya, 2020). The fundamental need is to understand the victim's experience within her social and societal contexts when in need of support (Ostapiej-Piatkowski & McGuire, 2008; Matz et al, 2020; Davison et al, 2021). Victims may feel profoundly challenged when their new society of residence differs significantly in its attitudes to women and violence compared to the woman's society of origin.

Female survivors of domestic violence may not have adequate ability to handle the hustle and bustle of everyday life such as family, settling down, adaptation, education and accessing therapeutic assistance. Women may find it difficult to move on with their lives, especially when they have passed "survival mode", and have the freedom to reminisce about their pasts in the context of a country that provides a greater degree of physical security (McGuire (2008, Our Watch et al., 2015; Webster et al., 2019). Some healthcare providers believe the initial approach in helping a CALD female victim of domestic violence is to help them in dealing with the psychological aftermaths of dwelling in that uncertainly for so long (Kiamanashe & Hauge, 2019; Ferrari et al., 2018).

Ostapiej-Piatkowski and Anne (2009) noted that many healthcare providers possess limited understanding of how to respond to CALD female victims of domestic violence because of the provider's limited cultural knowledge, and a desire not to upset the victim (Stewart, 2005). As Ostapiej-Piatkowski and Anne (2009) observed, to many healthcare providers, bold reactions to violence only seem acceptable when the violence occurs within their "own culture".

There are intervention programs in existence for victims of domestic violence, but reports on their implementation, adequacy or effectiveness for CALD women are limited. Hence, the response approaches of frontline workers to domestic and family violence in these communities needs to be explored. There is a need to listen to women in a confidential and non-deprecating environment to attain reliable information so as to craft an appropriate intervention strategy for each individual (Boas, 2009).

Frontline workers in Australia face the difficult task of comprehending the diverse cultural perspectives of domestic violence victims from various CALD communities (Boas, 2009). However, this understanding is important because it presents evidence for service improvement and more effective methods of reaching out to CALD women to persuade them to report, seek legal assistance, and obtain psychosocial and medical support (Dedeigbo & Cocodia, 2016).

Some healthcare providers frequently present all forms of violence as “culturally normal and therefore beyond the critique of Western cultural imperialists” (Pittaway & Rees, 2005–06, p. 21). However, others maintain that no culture ought to justify the violation of human rights, and that cultural diversity should not entail a vindication and indolence (Rees, 2004). Majau (2013) stated that the global society needs to reject derogatory cultural beliefs and protect victims.

CHAPTER 4 - Domestic Violence and Therapy

4.1 Introduction

Therapy can promote healing in survivors of domestic violence by helping in changing their way of thinking and improving their coping mechanism. Following a traumatic experience, victims may suffer from distorted thinking, including the perception that the world is dangerous, perceiving themselves as weak or worthless, feeling culpable, thinking they did not do enough to reduce the perpetrator's domestic-violence behaviours, including preventing injury or death and having suicidal thoughts (Kar, 2011, Rahmani et al., 2018; Mueller & Tronic, 2019; Allisic et al., 2017). Children who experience domestic abuse continue to live with the consequences even as adults, and the adverse effects of the trauma may reveal themselves through job loss, problematic relationships, unhealthy behaviours, and PTSD (Eckhardt et al., 2013, Dutton et al., 2006; Mueller & Tronic, 2019; Santini et al., 2021; Cox et al., 2021). By confronting, instead of ignoring, the aftermath of domestic violence through counselling and psychotherapy, survivors can be liberated from terror, bitterness and self-condemnation (Kaslow et al., 2010; Condino, et al., 2016; Powell & Morrison, 2017; Cox et al., 2021). Some counselling approaches may provide survivors an opportunity to recognise their part in the trauma and free themselves of any guilt (Johnson et al., 2011; Condino et al., 2016; Allisic et al., 2017).

By accepting they were the injured party and not the perpetrator, victims are able to take a new look at themselves and attain a truer sense of their self-worth and self-value, sometimes for the first time (Graham-Bermann & Miller, 2015; Graham-Bermann & Miller, 2013; Powel & Morrison, 2017; McGuire et al., 2021). Domestic violence survivors often struggle with self-respect, neglect, terror and post-traumatic stress, which can affect every aspect of their lives (Iverson et al., 2011; Powell & Morrison, 2017; Brown et al., 2020). Therapy is provided by counsellor, psychiatrist, psychologist or support person; it allows survivors of violence to gain a robust outlook on their suffering, thereby reducing the damaging impact of their experience (Johnson et al., 2011; Kubany et al., 2004; Kubany, Hill & Owen, 2003; McGuire et al., 2021; Brown et al., 2020).

Therapists play an important role in remediating victims' sufferings. The therapist's role includes helping the client manage worrying emotions, feelings and thoughts (McGuire et al., 2021; Hegarty et al., 2013; Timulak & Keogh, 2020). Therapists assist victims in looking for answers to particular problems, thus helping them recover an awareness of self-respect and authority over their own existence and self-efficacy (Hegarty et al., 2013; Timulak, 2015; Dillion et al., 2018). Therapists of different ranks and experiences can use different listening and communication strategies at various times or with a variety of clients in the hope of making their interventions as effectual and productive as possible (King et al., 2000; Sibbald et al., 1993; Evan et al., 2022; Cataldo et al., 2021). Counselling is significant in helping restore domestic violence survivors to a satisfactory level of wellbeing (King et al., 2000; McGuire et al., 2021; Arroyo et al., 2017).

Therapists must be attentive to experiences that may be difficult for victims to express verbally. This can help victims unlock the trauma, thus breaking the silence an important first step to healing (Blackburn, 2005, p. 98). Hence, counselling improves self-awareness, self-care and the ability to talk through problems. Therapists must be sensitive to the relationship between the logic of the client's thought processes and the culture of each victim. Therefore, care needs to be taken to avoid any misconceptions, and to educate therapists of the diverse norms among the various CALD cultures (Gilbert, 2006). Practitioners are increasingly recognising that multicultural counselling is generic in nature and therefore all counselling is multicultural (Benuto et al., 2019; Thacker & Minton, 2021; Lee et al., 2021; Sawrikar, 2020).

There are several therapeutic approaches that could be used in supporting victims of domestic violence including cognitive behaviour therapy (CBT) which focuses on a person's thoughts, emotions and behaviours and the effect of these on their perception and wellbeing; changing erroneous thought patterns, emotional responses, and inflated or warped behaviours (Rnic et al., 2016); Dialectical behaviour therapy (a sub type of CBT) which teach positive behavioural strategies to deal with stress, feelings and develop constructive relationships, by addressing thinking and actions based on mechanisms such as emotional control and concentrating on the present (Dixon et al., 2020; Steil et al., 2018); Mindfulness-based cognitive therapy which is a type of CBT that incorporates mindfulness (Kuyken et al., 2010; Segal et al., 2018); multimodal

therapy which proposed that psychological issues could be addressed by interlinking seven different modalities (behaviour, affect, sensation, imagery, knowledge, interpersonal factors and drug treatment) (Lazarus & Abramovitz, 2004); Interpersonal therapy which seeks to help a person deal more effectively with challenging or difficult people and situations (Dimaggio et al., 2020); emotional rational therapy (ERT) which involves identifying irrational beliefs and challenging the client to activate these beliefs by bringing them to the surface from their subconsciousness so that they are able to identify these beliefs and substitute them with thinking patterns that are more productive and ecological (Cherry, 2017; Renna et al., 2020); Family therapy which focuses on cultivating relationships within a family, and the family function as a whole by conducting therapy sessions with family members (Hogue et al., 2019) acceptance and commitment therapy whose aim is to help a person accept traumatic events, and commit to cultivating positive approaches towards them and concentrating on the present moment (Bai et al., 2020; Tanhan, 2019); Psychodynamic psychotherapy which aim to increase the mindfulness of how distressing feelings and emotions came to be (Sandu & Nistor, 2020); response-based approach which was developed as an approach to helping victims of violence relink with their histories of resistance by directing them toward the response-based distinction between the language of effects and the language of responses (Todd, 2010), person centered therapy (PCT) which is based on the hypothesis that all humans have the inborn capability to resolve their own problems and to blossom psychologically in an atmosphere that is conducive to such change and growth and that people are only able to participate in this process under certain prevailing circumstances, and the central role of person-centered therapists is to create these circumstances for their clients (Cain, 2012). Some of these therapeutic approaches are adaptation/modification of either CBT or PCT and have been recently developed.

Chapter 4 focuses on two of the oldest and mostly the original forms of therapeutic approaches that could be utilised in supporting CALD women who have lived through domestic violence in Australia, specifically Person Centred Therapy (PCT) and Cognitive Behaviour Therapy (CBT). These therapeutic approaches have been used in the management of various acute and chronic traumas and psychological problems, including PTSD, mood disorders, depression and anxiety. Therapists have used these strategies for many years in adults, adolescents and children across various cultures,

in individual and group -therapy sessions. Both PCT and CBT have been validated and shown as safe and effective overall (Kar, 2011; Minddisorders, 2012; Leitch et al., 2016; Phelps et al., 2021). This chapter explores how therapists have used these approaches in Australia and other Western countries to support CALD communities. Frontline workers have indicated that these traditional modalities have shown effectiveness in supporting CALD women however, with tailored modifications.

PCT is a humanistic counselling approach. Rogers (1959) named his therapeutic method client-centred or person-centred due to its focus on each person's personalised impression of the world. PCT is based on the concept of self-actualisation; the belief that humans are inherently good and always seeking to act in an honest and dependable manner in order to benefit others (Ceil, 2012; Renger et al., 2020; Monochristou, 2019). The principal objective of PCT is to boost the client's self-esteem and help them open up to new and better experiences (Ceil, 2012). PCT encourages clients to become involved in positive relationships with others and express their emotions in a manner that entails an increased ability to experience others' emotions (Rogers, 1986; McLeod, 2019). PCT also helps clients comprehend and embrace their real and perceived selves, and helps reduce guilty feelings, insecurities and defensiveness (Ceil, 2012; Burbridge-James & Iwanowicz, 2018; Black & McCarthy, 2020).

CBT is a behavioural approach that focuses on identifying and countering irrational thoughts and beliefs (Baguley et al., 2013; Sandu & Nistor, 2020; Norton & Tan, 2019). CBT is underpinned by the philosophy that a person's conduct and feeling is predominantly decided by their thought process and the structure of the world around them (Kolassa et al., 2010; Klein et al., 2009; Eye Movement Desensitisation and Reprocessing [EDMR], 2018). CBT focuses on two issues: lack of control, and the unpredictability that accompanies a traumatic situation (Garakani et al., 2004; Kar, 2011; Unterhitzberger et al., 2015; Cohen et al., 2016; Clark, 2019). With CBT, the processing of traumatic experiences encompasses emotionally engaging with the trauma memory, organising the narrative of the trauma and correcting any dysfunctional cognition caused by the trauma (Hembree & Foa, 2000; Kar, 2011; Cohen et al., 2016). Gradually, victims begin to think and behave in more realistic and adaptive ways with respect to their circumstances and psychological issues (Kar, 2011; Perrotta, 2019; Cohen-Chazani et al., 2021). Based on cognitive models of

PTSD, the effect of CBT is mediated by altering maladaptive perceptions and thoughts (Smith et al., 2007; Cohen et al., 2016; Perrotta, 2019).

4.2 Review of Methodology

The aim of this literature review is to explore and critically evaluate the efficacy of the two selected therapeutic approaches with respect to support for women victims of domestic violence from CALD communities. During the review process, information around the following categories were taken into consideration:

- PCT and CBT ‘gains and losses’
- Efficacy of PCT and CBT
- Multicultural Therapy

A database search of peer-reviewed papers on the use of CBT among CALD communities was conducted. Five articles were found. Due to the limited search results focusing on domestic violence among ethnic minorities in Australia, the researcher expanded the search to include studies of people from the ethnic minority groups who present with a different variety of mental health issues including depression, anxiety disorder, PTSD, domestic violence, drug addiction and/or a combination of two or more of these conditions. The keywords used for the updated database search were ‘ethnic minority’, ‘individualistic culture’, ‘collectivist culture’ and ‘multicultural competencies’.

The peer-reviewed papers were drawn mainly from the USA and UK. The two countries were preferenced for linguistic reasons, and because they have a large number of migrant communities of different cultural backgrounds, as well as the fact that the overall context of Australia is similar to those available in these countries based on historical conditions, culture, language, and values. This made it easy to draw parallels between the conditions of those countries in relation to CALD communities in Australia. The focus of the analysis was on the efficacy of the selected therapeutic approaches where CALD communities are concerned.

4.3 Concepts of CBT and PCT and their Efficacy in CALD Communities

This critical review examined available literature on the use of CBT in supporting CALD women who had experienced domestic violence by searching for articles from 1990 through 2021. Major databases searched included Medline, PubMed, Scopus, Scirus, Google scholar, CINAHL, Proquest, Cochrane, published literatures, PsycINFO, Applied Social Science Index and Abstracts, Web of Science, Sociological Abstracts, and grey literature for evidence-based information on CBT in CALD communities. Search words included “CBT” and combination of words such as “CBT and CALD”, “CBT and domestic violence”, “CBT and physical abuse”, “CBT and trauma” “CBT and PTSD”. Critical review of the published literature with secondary searching from references and bibliographies listed in the retrieved articles was also conducted for supplemental research papers that could be relevant and contribute to this study. This was further supplemented other publications identified by the key informant interviews in this study.

The peer-reviewed papers were selected based on their relevancy to culturally-specific themes and therapy approaches. However, there were limited studies available on the therapeutic approaches to support CALD victims of domestic violence in Australia.

The introduction, background, and discussion sections of the articles that met the selection criteria (those which explored culturally-specific issues and therapy approaches) were analysed to discern research themes. These sections were sifted in order to focus on sentences and paragraphs which talked about therapy and ethnic-minority communities, and therefore paid more attention to themes than the methodological rigour of studies. These sections of the review were then compiled, coded and thematically closely examined. Once coded, they were later aggregated and a list of common themes emerged. A summary of the final set of themes was presented in the subsequent section.

4.3.1 Cognitive Behavioural Therapy (CBT)

CBT is a well-grounded and extensively used therapeutic technique in the fields of counselling and psychotherapy (Meichenbaum 2010; Klein, 2009; Cohen et al., 2016;

Clark, 2019). It is a psychotherapeutic approach that helps clients recognise dysfunctional feelings, conducts and cognitive processes (Becks, 2020; Perrotta 2019). After methodical dialogue, clients are assigned carefully planned behavioural exercises to support them to self-evaluate and adjust their irrational thoughts and abnormal behaviours (Schacter et al., 2010; Beck, 2011; Sandu & Nistor, 2020; Cohen, 2016). It is grounded on the conviction that warped perceptions and maladaptive conducts play a role in the development and persistence of psychological disorders, processing skills and coping mechanisms (Hollon & Beck, 2013; Sivasubramaniam, 2016; Cohen-Chazani et al., 2021). CBT seeks to change behaviour by changing the ways in which a client thinks about an issue. CBT is influenced by Western values because it was originally developed and practised by therapists, trainers and researchers from ethnic, religious and sexual majority backgrounds (i.e., White, agnostic/Christian and heterosexual) in the West and the evaluation of the outcome of the therapy is linked to an understanding of the Western cultural values, spirituality, lifestyles and beliefs about health (Algahtani et al., 2019; Stone et al., 2018). CBT is often seen as a Westernised therapy that incorporates Western cultural values and practices (Naz et al., 2019).

According to Woodcock (2006), the optimistic outlook on human nature that informs CBT has the potential to empower some clients. However, it may be ineffective for people from CALD or ethnic minority communities who have lived through oppression, discrimination, sexism and/or racism, as these are beyond the person's power and can have long-term impacts on personality, while seeming to contradict the philosophical foundations of CBT. Woodcock (2006) also states that a client's cognitive schema may include distinctive cultural and familial practices and principles that are likely to be different from those of clients in English-speaking communities in Western countries. The beliefs and thought processes of people from CALD communities may not resonate with Western ideology as to what makes up 'a healthy cognitive schema', and vice versa. This adds complexity to the use of CBT with CALD women. The expectation of CBT that clients need to re-enact their personal experience of actuality to conform or blend with their existing environment may be harmful or oppressive for some CALD women.

Nevertheless, Woodcock (2006) does state that one benefit of CBT for CALD clients is the availability of a variety of techniques that therapists can adapt to meet the unique

demands of their client. When using CBT, the therapist does not profess recognition of what is right or wrong for clients; instead, the clients determine which thoughts are detrimental. In reality, the therapist's values and beliefs may become apparent through the kinds of questions asked that may devalue the client's outlook (Kar, 2011).

Examination and testing of automatic thoughts and images using a CBT approach may also limit its usefulness for clients from CALD communities (Woodcock, 2006). The direct characteristic of challenging cognition through actuality-testing activities may or may not blend with some cultures' or genders' socialisation framework. For instance, some of the existing models of feminist and multicultural therapies do not resonate with CBT's assumption that exposure to trauma may be solved by the therapist changing the client's way of thinking (Woodcock, 2006). According to Woodcock (2006), it is essential the therapist ensures that the CBT techniques being used are not in conflict with the client's worldview.

4.3.2 Person Centred Therapy (PCT)

As mentioned, the person-centred approach originates from the concept of humanistic psychology, which sees people as competent and independent with the capability to solve their problems and recognise their capability to transform their lives positively (Seligman, 2006; Challoner & Papayianni, 2018; Thomas et al., 2018). The person-centred approach sees the client as the expert on their own experience, having complete capacity to fulfil their potential (Mulhauser, 2011; Challoner & Papayianni, 2018; Thomas et al., 2018). Nevertheless, it acknowledges that making these possibilities real requires a conducive environment and that under adverse situations, people may not evolve and thrive in line with their potential. This is especially the case when one is deprived of acknowledgement and respect from others, or when the acknowledgement and respect that is made is tied to the individual conducting herself in a specific manner. In such situations, they could begin to lose grasp of the meaning of their own experience, and their propensity to flourish in line with that meaning may be suppressed (Mulhauser, 2011; Challoner & Papayianni, 2018; Thomas et al., 2018).

Carl Rogers (1959) stressed that the humanistic perspective creates a therapeutic relationship that encourages self-respect, genuineness and actuality, supporting clients to use their strength (as cited in Seligman, 2006). Rogers (1959) also

emphasised that the stance and individual attributes of the therapist, as well as the standard of the therapist-client connection, determine the success of the process (as cited in Corey, 2005).

Corsini and Wedding (2000) described the principles and processes of PCT. They says it initially aims to allow the client to direct the therapy, which improves their comprehension of persona, self-examination and self-ideas. Then the topic of discussion moves to the client's frame of reference and the pathways needed for a positive therapeutic outcome, all while the therapist demonstrates empathetic apprehension in a non-critical way. Presently, PCT centres on the ability of the client to establish a better awareness of themselves in a setting that gives the client the freedom to deal with his or her own situations without direct interference from the therapist.

Seligman (2006) listed the aims of the person centred approach as:

- To promote the confidence of the client and capability to exist in the present moment. This enhances the trust of the client in the exercise without the sensation that their life is being arbitrated by the therapist;
- To boost the self-recognition and self-respect of the client;
- To encourage the client to evolve;
- To foster consistency and balance in the client's conduct and feelings; and
- To support the client to gain the potential for self-actualisation and self-management.

According to Thorne (2007), PCT begins with the assumption of mutual trust and the establishment of a reliable connection between the therapist and client. This stems from the belief that every living thing, including human beings, have a basic and intuitive drive in the direction of useful achievement of its intrinsic potential. The Person Centred Therapist recognises they cannot aim to totally reveal the personal emotive world of an individual, and that only the person themselves can make this happen. In addition, an individual's perpetual world is formed by the experiences they have or have not absorbed into their self-concept. The Person Centred Therapist is continuously engaging with clients who have almost lost the grasp of the actualising

proclivity inside them and who may be encompassed by people who are not confident in the ability of humankind to proceed in the direction of achieving their ability.

Rogers (1959) observes that an inner, genuine, true self, lives and that everyone has an inherent capacity to actualise and reach their full potential. Thus, therapy is about supporting clients to make decisions according to the desires and needs of that persona to be free from outward control. When utilised in the context of female domestic violence victims, “self-determination” and individual development may not be a generalisable human quality but an advantage bestowed to some; violence and victimisation—threatened or real—restricts women’s fundamental freedoms (Bruna Seu & Heenan, 1998; Stephens & Eaton, 2020; Fillette, 2014; Tomm-Bonde et al., 2021; Veronese et al., 2021).

The concept of self or personhood, which is defined as a social and cultural paradigm that supports self-representation and self-understanding, is a key topic in psychotherapy (Christopher, 2007; Knappett, 2005; Smith, 2003). Response to therapy is influenced by ideas about "self," the locus of self-awareness and self-imagination, and "person," the cultural construct of a person as a social being. These ideas are also influenced by moral and legal ideas about agency and responsibility (Kpanake, 2018). According to Markus & Hamedani, (2007), personhood or self is best comprehended as actions that involve participating in a cultural practice and institution that presents and promotes characteristic psychological tendencies, which in turn, integrates a person into the meanings and practices of a cultural community. The concept of person' or self incorporates crucial notions of cultural and values that distinguish the person; it is a knowledge of what a person is, and an ethical sense of being a “good” person (Narvaez & Lapsley, 2009; Pronin, 2008). The concept of person or self is bound to customs and responsibilities that each culture carries for every person, with varied dimensions based on gender, age, and social rank or status (Appiah, 2004; Hitlin, 2011). The concepts of 'person' or 'self' is affected by many aspects of person’s life experiences, including illness and recovery expectations. Understanding of the ways that CALD women view personhood or self may have an important implication for psychotherapeutic approaches and research and ethical theory (Kpanake, 2018).

Cultural perceptions of self are underpinned by psychological theory in psychological assessment, social behaviour and psychotherapy (Hammack, 2008; Kirmayer, 2007).

Individual experience is influenced by their concepts of 'self' which is influenced by different cultural contexts. Most approaches to counselling, and psychotherapy for CALD women are based on Western concepts of the person despite much evidenced cultural variation (Kpanake, 2018). Psychotherapies seek to encourage adaptive change in individual's experience and behaviour; this aim is entrenched in a social and cultural perspective of specific concepts of personhood (Kpanake, 2018). If every psychotherapeutic approach relies implicitly on models of self or personhood, which is culturally diverse, the cultural concept of the person/self requires consideration inclusively in therapy techniques and intervention outcomes (Kirmayer, 2007, Kpanake, 2018).

4.3.3 Objectives of Therapy

The person centred therapist attempts to form a connection with the client that will enable the client to slowly but surely summon the courage to deal with their anxieties and confusions (Thorne, 2007; Cooper et al., 2013; Tolan & Cameron, 2016). Anxiety and confusion may be the result of the client's self-conception being threatened by their entrance into a consciousness of experiences that then becomes a mismatch to the current configuration (Thorne, 2007; Stephen et al., 2011; Cooper et al., 2013; Tolan & Cameron, 2016). The therapist focuses not on the problems and solutions, but on the development of a person-to-person relationship (Tudor & Worrall, 2006; Joseph, 2015; Jolley, 2019). Person centred therapists freely and courageously invest themselves fully into the relationship with their clients (Thorne, 2007 Cooper et al., 2013; Tolan & Cameron, 2016). The therapist views the world of the client as an emotive dedication during therapy. They may reveal themselves, if pertinent, with their own mights and weaknesses. The principal objective for the person centred therapist is to visualise, sense, and experience the world from the client's viewpoint, however this may be impossible if the therapist stands distant and remains psychologically detached for the sake of quasi-scientific fairness (Tudor & Worrall, 2006; Joseph, 2015; Jolley, 2019).

Thorne (2007) states that the intended end result of PCT is to transform the client into a fully functional person who is psychologically healthy and free to glimpse, sense and experience the world. According to Thorne (2007), clients in successful PCT usually attenuate their social facades, and resolve the constant pre-occupation with

maintaining appearances which include an internalised attitude that originates from externally-forced responsibility such as the belief that they must live up to the expectations of others. After moving away from these negative thoughts, the client moves in the direction of appreciating honesty and 'realness' in oneself and others, appreciating the innate ability to steer one's own life, valuing recompense and embracing and appreciating one's positive or negative self.

The successful outcome of PCT depends on "joining" with the client, so that they perceive the therapist as trustworthy and dependable (Joseph, 2015). There is no prescribed approach to achieving this outcome (Cooper et al., 2013; Tolan & Cameron, 2016). The assessment occurs as the therapist engages with the client to gradually open up communication (Cooper et al., 2013; Tolan & Cameron, 2016). This will eventually result in identification of problems and possible solutions. The therapist also cannot rely solely on theory of characters, to fully understand their client, even if the theory was cautiously presented (Thorne, 2007 Cooper et al., 2013; Tolan & Cameron, 2016). Thus, the role of the therapist is not that of an expert, as this may affect connecting with the client. The aim is for the client to move towards trusting their own innate resources (Seligman, 2006); in other words, striving to encourage the movement of their client "from their outer world of the condition of worth to an inner world of the valuing process, and trusting the experience of their subjective reality" (Thorne & Lambers, 2006, p. 14).

Thorne (2007) points out that the therapeutic styles of person centred therapists vary widely. However, their unified aspiration is to generate an atmosphere where the clients can start to be in touch with their own wisdom, capability for self-recognition, altering self-concept and self-protective behaviours. For person centred therapists, their ability to create this atmosphere is crucial. If they fail to do so, the hope of creating the kind of connectivity with the client that could bring about the expected therapeutic outcomes may be non-existent.

Clients could be empowered through the strategy of giving respect, unreserved positive regard, self-disclosure by the therapists, and permitting the clients to direct the therapy process. Marecek and Kravetx (1998, as cited by Seu & Heenan, 1998, p. 24) report a case in which a therapist kept away from the use of the terms 'therapist' and 'client' so as to ease the hierarchical dynamics in the connection. Worrell and Remer (2003) opinionated that accepting clients as authors of their experiences

assists in holding them in high esteem. Chaplin (1989, as cited by Seu & Heenan, 1998 p. 148) noted that respecting the clients additionally maintains a fairness between total emphasis on the client's accountability.

Procter (2002) stated that the goal of the therapy is to employ the central state of congruity, unreserved positive regard and sensitivity to motivate women to generate power from within to reach self-awareness and take control. According to Thorne (2007), PCT can be ranked because of its faith in personal self-directedness from a lower to a higher plane. Aims and objectives such as self-realisation, which is generally central to all human's existence, further popularise this belief. However, there remains insufficient recognition of the impacts of gender, status, racial type, and other individual differences on the capacity of individuals to self-actualise (Thorne, 2007).

4.4 Primary Themes from the Review

This section discusses the primary themes that emerged from the literature search. One of the most pertinent papers in this area is by Warshaw et al. (2013), who reviewed the interventions used with domestic violence survivors, focusing on trauma treatment. In their review, nine studies were explored and of these five described modifications of CBT for victims of immediate-partner violence.

The review identified five themes relating to the efficacy of therapeutic approaches used with ethnic minority communities. These themes are discussed in the subsections below. The first theme directly relates to the efficacy of CBT. The others are related to the efficacy of therapeutic approaches in general.

Culture-Specific Treatment and Intervention

One of the studies included in the systematic review of interventions conducted by Warshaw and associates (2013) was a clinical trial conducted by Kaslow et al. (2010), who examined the effectiveness of manualised, culturally-specific, empowerment-focused treatment-content used for African American women to lessen symptoms of suicidal ideation, depression, PTSD and general psychological disorder compared to standard therapy. In this study, 208 suicidal African American women with recent experience of violence perpetrated by an intimate partner and low socio-economic status were randomised into the two groups, and then assessed at baseline, post-intervention and at six-month and 12-month follow up. The treatment was culturally

specific, infusing cultural values and strengths. The results showed that the group of women that received the culturally informed therapy demonstrated more rapid reduction in their symptomology at the initial stage and at follow-up in contrast to the group that received the conventional therapy. Their findings demonstrate the significance of incorporating culturally-specific and empowerment-focused values into therapy.

Kaslow and co-researchers (2010) therefore recommended culturally-informed interventions with elements of empowerment. In addition, other key themes which came out of the systematic review of Warshaw et al. (2013) revolved around portraying ethnic pride, self-worth and risk avoidance. Honouring and preserving one's culture also featured as a theme.

Cultural Influences on Definitions and Meanings

Warshaw et al. (2013) discuss the influences of culture on an individual's definition and experience of mental health and mental illness, stressor type encounters, the decisions made to seek help, their symptomology and issues presented to therapists, along with their coping mechanisms and sources of social support. Due to these unique cultural influences, the way any client from an ethnic minority community views his or her own experience, the manner they define violence, and the decisions they make all become different when compared to clients who belong to English-speaking backgrounds. This view is shared by Leong (2011) who also argues that culture influences people's understanding of the nature, causes, and cures of mental ill-health. According to Warshaw et al. (2013), the culture and community to which the client belongs have a unique impact on what they present to the therapist in terms of their perceptions and views. In the opinion of Leong (2011), sometimes it becomes a challenge for principal mental-health clinicians to confront issues such as stigma, under-utilisation of therapy and pre-term termination of therapy (Leong & Kalibatseva, 2011).

Culture and community also impact the client's responsiveness to interventions, as well as their access to services (Watson-Singleton et al., 2019; Amorin-Woods, 2020; Sawrikar, 2020). These also determine the client's perspectives, especially when it comes to their decision to stay on with or leave their violent partner (Sawrikar, 2019; Sabri et al., 2018; Fa'alau & Wilson 2020). Chapman et al. (2014) opined that culture

influences the victim's perceptions of other people as well. It defines their perception of their social self, expectations about socially-appropriate behaviour, as well as perceptions of what behaviours amount to social threats. Hence, when dealing with domestic violence victims and survivors belonging to CALD communities, therapists and counsellors need to design therapy keeping in mind the influences of culture on the client (Dedeigbo & Cocodia, 2016). Woodcock (2006) says that even though the personalisation of therapy is a generally acceptable guideline, in reality therapists who deal with clients from ethnic minorities need a comprehension of client-related elements that are culturally-grounded, which may affect the way the client senses or responds to therapy (Kohn et al., 2003; Sawrikar, 2019; Sabri et al., 2018; Watson-Singleton et al., 2019). This principle applies to CBT as well.

Community Support

The theme of community support manifested in relation to trauma-focused interventions designed specifically for ethnic minorities. Warshaw et al. (2013) considers the possibility of survivors or victims of domestic violence belonging to ethnic minority communities accessing specific sources of support through their membership in their particular communities. If we draw parallels, a similar approach is possible in designing interventions for domestic violence victims and survivors belonging to CALD communities (Dedeigbo & Cocodia, 2016; Webster et al, 2019, Our Watch et al., 2015). Such interventions could have components that draw upon principles or cultural knowledge from the specific communities to which these victims or survivors belong.

CBT: Assumptions and Techniques

Several studies have assessed the efficacy of CBT for treating ethnic minority clients (Hinton et al., 2012; Kayrouz et al., 2018; Whitmore et al, 2021; Kayrouz et al., 2020). Certain theories and methods that guide CBT may be inappropriate for ethnic minorities, however with adaptation of the therapy to meet the individual need of the client, there has been reports of efficacy of CBT for PTSD, anxiety and depression (Whitmore et al., 2021; Kayrouz et al., 2020; Kayrouz et al., 2018). A large number of such effectiveness studies have not yet been conducted so CBT may possess limited generalisability to clients from ethnic minority communities. In Warshaw et al.'s (2013) review, five of nine studies described modifications of CBT for IPV victims intended at

making CBT more effective for clients from ethnic minority communities, but they are in tension with other opinions (e.g., Crespo & Arinero, 2010; Johnson, et al., 2011; Kaslow, et al., 2010) that traditional therapeutic approaches may have reduced effectiveness if they are adapted too much to suit the cultural requirements of the clients.

Rathod (2010) proposed that culturally-sensitive adaptations of CBT are required for it to be an effective therapeutic approach for clients from ethnic minority communities. According to Rathod (2010), such adaptations should consider the client's culturally-based health beliefs; his/her views on mental disorder, its origination and management; the influences of culture, ethics and attitudes; and the client's perception and response to therapy.

CBT: Gains and Losses

Woodcock (2006) observed that the efficacy of CBT was different with different ethnic minorities. Some visible ethnic groups (such as Hispanic, Asian and Cambodian) experienced more benefits from CBT in contrast to other apparent ethnic communities (such as African American). These results resonate with the presumption that reactions to the utilisation of CBT differs in uniqueness between cultural groups. Hence, CBT for CALD victims and survivors of domestic violence cannot be rejected on the grounds of ineffectiveness of CBT for all clients belonging to these communities. As an example, Woodcock (2006) says that Hispanic ethnic groups effectively respond to CBT when used as a therapeutic approach in contrast to other cultural groups. This finding is consistent with others, such as Latinos being more receptive to counselling and suggestions within CBT compared to insight-oriented therapy like PCT (Warshaw, 2013).

In some cases, CBT may cause harm. For example, Woodcock (2006) discusses an observation that African American clients, especially males, may truly not derive benefits or even be harmed by CBT treatment. This ethnic minority population appear to prefer affective or subjective responses compared to the closed-question research format similarly used in CBT. The exact importance of this finding in reference to CALD domestic violence victims in Australia is yet to be examined.

CBT: Pairing with Other Interventions

Woodcock (2006) writes that it may be more beneficial to ethnic minority clients if CBT is combined with other interventions. These other interventions may be aimed at in-depth outreach and motivation in support of CBT intervention. She also discusses the customisation of CBT for the unique cultural needs of each client. Indeed, a significant number of studies find that empathy may increase the benefits of CBT for all cultural groups (Fowler et al., 2019; Craig et al., 2020; Hwang & Chan, 2019; Naz et al., 2019; Naismith et al., 2021; Consoli et al., 2018).

4.5 Gaps in Therapeutic Services for CALD Communities

Therapist's prejudice towards, and discrimination against, ethnic minorities may be one of the possible inadequacies of mental health services available to clients from these communities (Bowden et al., 2020; Amarin-Woods, 2020; Kayrouz et al, 2018; Saleem & Martin, 2018). This problem may be mitigated if counsellors belong to the same community as that of the victim (Saleem & Martin, 2018; Kim & Kang, 2019; Liao & He, 2020; Cheng et al., 2021). However, some studies have reported no improvement in therapy outcome (Ilagan & Heartgerington, 2021; Steinfeldt et al., 2020; Leung et al., 2021)

Wang and Kim (2010) point out the rarity of instances of health workers matching patients ethnically and linguistically. They cite a report of the American Psychological Association Centre for Workforce Studies (2009) to establish this. According to this report, about 87.5% of psychologists were European Americans, while only 3.6% were Hispanic, 2.7% Black, 1.7% Asians or Pacific Islanders, and less than 1.0% Native American. These figures are significantly lower than the per-capita statistics for these ethnic communities in the overall demographic profile of the US. Clearly, it is rare and difficult for an ethnic minority person in the US to be able to use a therapist from his or her own community. Similar inadequacies may exist in the case of CALD communities in Australia.

Multicultural Barriers to Seeking Help

Evidence suggests that ethnic minority communities underutilise mental health services. Leong (2011) found that people from ethnic and racial minorities face multicultural barriers when seeking therapeutic help. For example, acculturation is the

way through which an immigrant person from an ethnic minority community adapts their behaviours and orientation to conform with that of the host community or ethnic majority group (Leong & Kalibatseva, 2011; Saleem & Martin, 2018). Individuals with lower capacity to acculturate may encounter more barriers in looking for help, while those with higher acculturation capacity have more likelihood of looking for help (Martinez et al., 2020; Amorin-Woods, 2020).

Multicultural Competency During Counselling Training

One of the main themes that appeared frequently was the lacunae that exist in counselling training in relation to the development of therapists' multicultural competencies. According to Patterson (1996) and Saleem & Martin (2018,) many therapists were not able to provide culturally-responsive psycho-therapeutic treatment to ethnic minority clients mainly due to their unfamiliarity with the client's cultural background. Also, therapist training has been developed primarily for the mainstream population.

Wang and Kim (2010) advocate for the teaching of multicultural competence in introductory counselling training. This would include teaching how to build cross-cultural working alliances and empathy quickly. It would also include teaching counselling students that within each ethnic group, each client brings his or her own unique and multidimensional cultural identity (Banuto et al., 2019). According to these authors, multicultural-counselling competencies comprise three attributes: awareness of assumptions, values and biases; acknowledgement of the culturally-different person's perspective; and coming up with a suitable intervention plan and method. Building up these multicultural competencies during counselling training can have a profound significance in increasing the competence of therapists to render culturally-responsive therapy for their clients from CALD communities.

According to Wang and Kim (2010), to be able to build a strong therapeutic connectedness, acknowledgement of the client's cultural values is important. This would include sensitivity to the client's comfort level or even in experience with disclosing personal issues to a therapist. Further, if the therapist discusses culturally sensitive matters such as racism and discrimination, especially earlier on in the relationship, it could potentially lead to a negative judgement of therapy. This could prevent progression of the relationship between client and therapist.

4.6 Genres of Review - Category Classification

The reviews for the purpose of this study can be divided into the following categories:

a. Review of Interventions and Outcome Research: This category includes articles which were predominantly review articles. It includes articles by Warshaw et al. (2013) and Woodcock (2006).

Warshaw et al. (2013) reviewed selected trauma-focused intercessions for survivors of domestic violence. The interventions reviewed in this article had been planned or adjusted specifically for survivors of intimate partner violence. Some of these intercessions focused on intimate partner violence survivors from ethnic minorities. A total of nine articles featuring eight distinct interventions were finally chosen based on the inclusion criteria chosen for this review.

Woodcock (2006) reviewed the outcome research on CBT and ethnic minority groups with the aim of assessing the kind of qualitative and quantitative support that CBT has received for treatment of individuals belonging to ethnic minorities. For this purpose, the methodologies of 22 qualitative and quantitative outcome studies, published from 1999 to 2005, were analysed.

b. Adapting Therapy for Multicultural Needs: This category includes articles which discuss multicultural needs, developing multicultural competence and how therapy could be adapted to these needs. This category includes articles by Wang and Kim (2010), Leong (2011), Rathod (2010), Chapman et al. (2015) and Patterson (1996).

Wang and Kim (2010) address the multicultural competence of therapists and the counselling process which surrounds the cultural values of the Asian-American participants in their study. Considering that the rate of drop-out from mental health treatment is high among Asian Americans, the authors attempted to study therapists' multicultural competences in a bid to eventually reduce the rate of departure. For the study, a video-analogue design featuring 113 Asian-American college students was used.

Leong (2011) and Leong and Kalibatseva (2011) focused on the cross-cultural obstacles to mental-health management that exist for ethnic and racial minorities in the US. They claim that the road to psychiatric management is often obstructed for people from racial and ethnic minority groups by cultural perceptions of mental health

disorder and therapy, absence of insurance, lack of access to suitable service and severely limited study relating to non-white populations.

Rathod (2010) considered how to provide culturally-sensitive CBT for ethnic minorities by examining clients' and professionals' ideas. The aim was to develop supportive treatment for clients with psychosis from selected ethnic minorities in the UK: African Caribbean, Black British, Black African and South Asian Muslim. The authors found that therapists needed to have a thorough understanding of the client's culture so as to understand how the client perceived or responded to the therapy.

Chapman et al. (2015) considered the differences among ethnic minority clients when CBT was used to treat social anxiety. They describe the interaction of culture with the expression of social anxiety disorder (SAD) symptomology in ethnic minorities. Some practical suggestions were also given for professionals for developing multicultural competency while working with clients from ethnic minority backgrounds include integrating cultural variables (ethnic identity and ethnicity/race-based stressors, self-construal, acculturation) into the treatment context.

4.7 Syntactic Analysis

For the purpose of understanding the degree to which CBT has been employed as a treatment option for ethnic minority populations, 22 quantitative and qualitative research studies, published from 1999 to 2021 including their methodologies were analysed. The review found an absence of evidence pertaining to the effectiveness or ineffectiveness of CBT in the management of mental health issues among ethnic minority populations.

Terminology about 'Ethnic Minority'

Since articles selected for this analysis focused on the efficacy of therapeutic approaches for ethnic minorities, the term 'ethnic minority' was used in all selected articles. Some articles used slightly different terms. For example, Woodcock (2006) used the term 'visible ethnic minority' and defined this as 'persons other than Aboriginal peoples, who are not Caucasian in race or white in colour' based on the Canadian Employment Equity Act. Patterson (1996) used the term 'minority client' or 'minority-group client'.

Individualistic Cultures vs Collectivist Cultures

Some of the selected articles used the term 'individualistic cultures' to differentiate between Western cultures and ethnic minority cultures across a perceived East-West binary. The article by Woodcock (2006) used 'individualistic cultures' to denote European and American cultures. Wang and Kim (2010) discussed how sticking to traditional Asian cultural ethics including ranked relationships, 'collectivism', and result in orientations could influence the counselling process which involves members of Asian communities.

The iconic research of Hofstede (2011) is often used to differentiate Western cultures as individualistic against African, South American and Asian cultures as collectivist. Based on his cultural dimension paradigm, Hofstede (2011) placed countries onto a scale along an individualism-collectivism binary, finding most developing countries closer to collectivism and developed countries closed to individualism.

According to Hofstede (2011, p.11), "individualistic cultures have a loosely-knit social framework. Here, individuals take care of only themselves and their immediate circle of family and friends". On the other hand, "collectivistic cultures have a tightly-knit social framework", in which family elders have more authority and a higher duty of care. With respect to domestic violence, victims are expected to be guided by the advice of these elders. If victims seek outside help to solve the problems, this may be seen as a challenge to the authority of the elder. At its very core, counselling itself—that is, a victim searching for help *outside* of the family unit—is therefore a product of the Western, individualist tradition. Also, in collectivist societies, gender equality is usually low (Gao & Li, 2021; Hay et al., 2019). Male dominance can work against the female victims if the unspoken alliance between men leads the elder to find fault with the female victim rather than her intimate partner. In such situations, the perpetrator may escape, and the victim be punished to suffer further violence silently (Ronningstam et al., 2018; Ne'eman, 2021; Femi-Ajao et al., 2020).

However, there is little research that substantiates these perceptions in a formal way. Most work on cultural dimensions deal with family relations and childcare in the contexts of refugee, immigrant and Indigenous communities. Few research papers deal directly with the effects of the individualism-collectivism binary on violence among CALD communities.

As noted by Armstrong (2015), cultural dimensions are also important in family mediations to prevent domestic violence. Both Ojelabi et al. (2012) and Ojelabi (2015) point out that CALD people tend to hesitate to access family dispute-resolution centres as they perceive these to promote divorce rather than dispute settlement. People from individualistic cultures may prefer direct communication, while people from collectivist cultures may prefer indirect communication (Merkin, 2015). Since culture affects the attitudes of each client, it also affects family dispute-resolution processes and their outcomes.

Men belonging to collectivist cultures may believe that Australian laws favour women and treat men badly (Pease, 2019). Women believe they are mostly blamed for family breakups (Sikweyiya et al., 2020; Mshweshwe, 2020). Traditional cultures may not accept the opinion of women (Mshweshwe, 2020; Akangbe, 2020). Marriage is sometimes seen as a religious commitment and above law (Parkin & Nyamyawa; 2018). In some cultures, until women are beaten up and seriously hurt, it is not considered violence (Tonsing & Tonsing, 2019). Among Middle Eastern communities in Australia, it has been found that some Lebanese may consider it the right of a man to hit his wife when she misbehaves, some Iraqi men do not think family violence is a major issue while women do, and some Turkish women think violence is a hidden issue while men are uncertain (Ostapiej-Piatkowski & McGuire, 2008).

However, demonisation of culture may prevent identifying the strengths of culture in dispute resolution, the role of culture in determining the balance of power between partners, and the negative deployment of culture to deprive basic needs and opportunities, discrimination and power imbalance (Lay, 2006; Sokoloff & Dupont, 2005; Ostapiej-Piatkowski & McGuire, 2008). Thus, a senior person within a CALD community cannot be expected to be systemically fair to women if cultural norms perpetuate injustice. Training in culture-specific resolutions may be important in this respect. A norms approach, justice approach and value approach, can all be selectively used for dispute settlement as culture affects all these approaches. Therefore, training in all three approaches would be preferred.

Based on two experimental studies, Vandello and Cohen (2003) concluded that domestic violence may be sanctioned implicitly or explicitly, and even reinforced, in collectivist cultures. These cultures are also 'honour cultures'. In such cultural frameworks, female infidelity damages the man's reputation, and to save his honour,

he needs to use violence against the partner. Women are supposed to remain loyal to their husbands even when violence related to jealousy remains possible or likely.

In their detailed review, Kasturirangan et al. (2004) made several observations regarding the cultural dimensions of domestic violence. They argue that patriarchal values attached to certain collectivist cultures give importance to a woman's duty toward her father, husband and son(s). They also found that women in the African-American community pretend that they are in control when they are with Anglo-Americans (Kasturirangan et al., 2004) and so find it difficult to access help from shelters run by white women. They say that interventions developed within an individualistic context may be inappropriate for people with collectivist mentalities and traditions.

Although collectivist norms may permit domestic violence, other ingredients of collectivist cultures help women cope with adversity (Gopalkrishnan, 2018). They may gain strength from values, beliefs, rituals, religion, celebration, food and art (Prentice et al., 2017; Simon-Kumar et al., 2017). Thus, even if the culture permits and normalises violence to a certain extent, the extended family may mediate this to provide informal support including emotional support, monetary resources, protection and child-minding care (Simon-Kumar et al., 2017). The omnipresence of the family network may reduce the chance of violence and isolation of women (Simon-Kumar et al., 2017; Martz et al., 2020).

Having said this, there can also be contrary instances in which violence is supported by the extended family structures (Mshweshwe, 2020). There could be more than one family member that perpetrates abuse of a woman, and the presence of others may be used for justifying abuse (Nasraddin, 2017; Amadiume, 2015). Mothers-in-law may facilitate a son's wife-abuse and she herself may also abuse the daughter-in-law to generate passivity and social cohesion (Mshweshwe, 2020, Akangbe, 2020). Concerns about finances and children may force a woman to tolerate such violence without complaint (Mshweshwe, 2020, Akangbe, 2020). More abusive men may take advantage of such social dynamics to enact more serious abuse on women (Mshweshwe, 2020, Akangbe, 2020). In cases where women are forced to be the primary financial source for the family, men may use violence to re-establish their dominance out of shame (Myers & Demantas, 2016; Burchardt, 2018).

It may also be the case that available services for help may not be culturally or linguistically compatible (Davison et al., 2021; Sawrinka, 2020). Victims may feel more comfortable to talk to people from their own ethnic origin (Kim & Kang, 2018; Femi-Ajao et al., 2020). Even if a fair degree of acculturation has occurred, it is likely that the more dominant elements of their traditional culture will be passed down through generations of immigrants. Some works (e.g., Sabina et al., 2013; Swan & Snow, 2006) proffer that after acculturation women experience less violence, but others (e.g. Bhuyan, 2012; Caetano et al., 2007; Ghafournia, 2011; Sanders et al., 2004; Segrave, 2017; Thronson, 2012) proffer that after acculturation violence increases. Neither view has been substantiated formally in the context of CALD women in Australia.

In addition, it is possible that acculturation entails women receiving better education and jobs, and thereby increased access to services (Martinez et al., 2020). While intact cultural norms may reassure CALD women who have a more intimate attachment to their traditions, those with a greater degree of acculturation may more actively seek to disempower their partners, such as through divorce, counselling or legal action (Amorin-Woods, 2020; Webster et al., 2019). Sometimes, grass-roots efforts such as women's organisations have generated effective community responses. For example, an anonymous domestic violence service for CALD women which was delivered via collaboration with a settlement service for CALD communities was discovered by child Family Community Australia through stakeholder consultation (AIFS, 2018). This service engages with women who are reluctant to leave their partners but want an end to the violence (El-Murr, 2018). The staff are trained in the use of modified strategies to support these women to have support that empowers them in a confidential manner.

Multicultural Counselling Competence

Wang and Kim (2010) used the term 'multicultural counselling competence' in their study. They conducted video analogue research of 113 Asian American students to investigate the impact of the use of therapy with and without multicultural competence and client's cultural traditions that may impact the counselling process. The results showed preference for therapy sessions that contain multicultural competencies. Their article lists the importance, visibility, understanding and characteristics of multicultural counselling competence, and proposes that there are significant lacunae in the literature available on this. The article also underscored the importance of seven competencies spanning verbal and non-verbal communication ability, language

consultation ability, testing, psycho-education and client advocacy skills under the skills domain of intervention strategies and techniques.

Culture-Specific Interventions

In the systematic review conducted by Warshaw et al. (2013), the term 'culturally-specific' was used to describe specially-designed interventions for IPV survivors from ethnic minority groups. Some of these treatment protocols were initiated in alliance with 'community crusaders' and occasionally with victims as well (Warshaw et al., 2013). The sessions were also intentionally varied to suit the need of the domestic violence survivor.

Another similar term used in this review was 'culturally-focused' intervention. The conclusion of Warshaw et al. (2013) was that there is no one model of treatment that could meet the demands of all CALD women, however culture-specific intervention has the potential to help women recover and successfully move on from the experience of domestic violence. Helpful components of these interventions would include psycho-education on causes and effects of spousal violence and the traumatic impacts, mindfulness of continuing safety, development of emotional and cognitive capacity to deal with symptoms related to trauma and other life goal issues and focusing on survivors' personal and cultural strengths that they can draw on.

4.8 Assessment of Support Services Available for CALD

Victims of Domestic Violence

Various countries have support services that victims and survivors of domestic violence can access. Having reviewed the existing literature on therapy for victims of domestic violence from CALD backgrounds, this section will now explore the application of these therapeutic approaches by some organisations in Australia, as well as the US, UK and Canada. The latter countries were selected because of similar multiculturalism and cultural conditions to Australia. Services in these countries were selected using the following inclusion criteria: services to CALD communities, support services for women, and use of the two selected therapeutic approaches in this study (CBT and PBT). Services that did not meet these criteria were excluded.

4.8.1 Australia

Domestic Violence Victoria (DV Vic) — This organisation is the apex body for services on family violence against women and children in Victoria. Its goal is to direct the community to build safer lives for vulnerable ones suffering or prone to violence (DV Vic, 2013). The organisation has a strong commitment for continuous improvement of their service quality by supporting staff to render outstanding responses to women and children suffering violence or prone to it.

Members of DV Vic aim to interact with women prior to the violence getting out of hand. They serve female Aboriginals, CALD women and women with disabilities, who may find it hard to obtain the needed support. They also support their members to ensure they are accredited in accordance with industry requirements and to offer members occasions to share best practices and innovative service delivery frameworks.

DV Vic projects include:

- The 'Rising to the Case for Change Project' — This relates to the direction of future reform in the community sector. This vision is to be realised by collaboration between key stakeholders and specialist domestic violence service establishments.
- Building Stronger Systems — This is a collaboration between Victorian family violence services, the police force and courts to increase the safety of vulnerable people in the community and hold accountable men who perpetrate violence. DV Vic holds consultations with organisations that are members and with women who are in contact with the support services, police and courts. High-level advice is given by the organisation to government and other stakeholders on the methods of improving the system. DV Vic has its representation in the advisory committees of family violence services at state and national levels.
- Policy Development and Analysis — The organisation responds to policy reform issues and engages itself in serious policy debates in Australia on violence perpetration against women.
- Law Reform — DV Vic advocates for better responses of the justice system to vulnerable people suffering family violence. It also participates in law changing processes and has a leadership role in the Victorian Family Violence Justice Reform Campaign Group.

- **In the Media** — In Australia, DV Vic actively participates in debates on violence against women via media and the press.
- **Representation** — DV Vic advocates for vulnerable people in the community suffering family violence. It also represents the interests of the organisations working with these people on various reference groups at state and national levels and other advisory committees.
- **Building Safer Communities** — DV Vic has strong commitment to support businesses, communities and government to stop violence against women.
- **DV Vic Media Program** — DV Vic's Media Program works with news and social media to support the prevention of violence perpetration on females. Projects under this program ensure that accurate information is received by communities about violence against women through the media. The projects also ensure the empowerment of women to prevent violence and gain support where needed.
- **Innovative work in Victoria** — The organisation used its 'VicHealth Preventing Violence Against Women' framework in many of its early works in preventing violence against the Victorian female population and the 'Right to Refuse: Examining Forced Marriage in Australia'.

InTouch, The Multicultural Centre Against Family Violence — This is a state-wide service organisation in Victoria. It offers services and programs and responds to matters related to CALD community family violence. The organisation develops and implements various culturally sensitive and holistic service models to victims as well as perpetrators of domestic violence. InTouch recognises the rights and multifaceted experiences of their clients. They work on issues of family violence at personal, family, and community levels and try to produce an environment where children and women are safeguarded and have freedom from violence (Women's Legal Services Victoria [WLSV], 2011).

The general practice model that was implemented in the UK was adopted by InTouch. This model involves educating GPs and providing direct referral assistance for early recognition and referral for female patients suffering family violence, to solve the healthcare aspect of domestic violence as the first priority.

InTouch works in collaboration with different stakeholders and the Department of Justice's Family and Sexual Assault unit to provide partner organisations with contact via its Vietnamese Case Manager. Through its family camps, InTouch also gives families whose life has been touched by family violence chance to engage with one another and be together in a safeguarded environment. Recognising the consequences of trauma on families, especially on mothers and their children's attachment, these camps provide an opportunity to empower relationships. Recognising how difficult it could be to plan fun school holidays, InTouch also has a Family Holiday program which gives mothers time to build their social network and strengths as well as focus on some serious issues, while their children get to engage in the same themes through stories, play, and drawing.

InTouch runs women's groups, which are usually ethno-specific and engage bilingual counsellors. In these groups, thematic frameworks are built with relevant cultural sensitivity in mind. Various empowerment therapeutic frameworks are engaged in these groups such as art therapy, drumming therapy, dance therapy, textile art therapy, counselling and parenting support. These programs look into matters such as life in Australia, intergenerational communication, gaining insights into family violence, parenting and motherhood, social seclusion and loneliness, stress management strategies, depression and anxiety, assertiveness discussions and respect in relationships.

Some of the initiatives of InTouch include:

- **Leading the Way to Respectful Relationships** — This is a Victoria's community involvement program intended to stop family violence. This organisation has been working with Indian, Sudanese, Croatian and Vietnamese Task Force Committees on developing and delivering a range of culturally tailored prevention activities. The project specifically addresses the needs of the CALD population who, due to language barriers and differing cultural practices, can be isolated from mainstream prevention activities. By raising consciousness on gender equality and respect in relationships via the implementation of local activities and the use of social and traditional media, InTouch has been seeking to change attitudes and build violence-denouncing cultures.

- ‘Stand Up, Speak Up’ Forum — InTouch works with four culturally-specific communities: Indian, Sudanese, Vietnamese, and Croatian. At the start of the project, Task Force Committees for each of the four ethnic groups, led by community-sourced facilitators, were established. These committees are made up of 4–8 community faith leaders, elders and young people. Each committee is linked with a local, ethnically-aligned ‘partner’ organisation. The facilitators, Task Force Committee members and representatives from the partner organisation were initially provided with culturally-appropriate training in subject areas such as family violence, gender equality, primary prevention theory and practice and community engagement. In consultation with their communities (via community surveys), each Task Force Committee developed a 2-year action plan and implemented eight awareness-raising activities around the theme of ‘respectful relationships’.
- InTouch Legal Centre — The InTouch Legal Centre is innovative and client-centred and makes use of its cultural expertise to establish trust with CALD victims of family violence to enhance their accessibility to justice. Clients access in-house lawyers and social workers. The psychological and civil problems linked to family violence are recognised in the InTouch model and these are responded to while clients access the one-on-one service of the legal centre simultaneously. InTouch supports clients through the entire civil process to ensure that care is continuous starting from the point of an intervention order application to the end of family law proceedings. InTouch was established to fill the deficiencies in needs of its clients including specialised, culturally-appropriate, in-house legal service inside the one organisation. It has been established to offer a safety net to pick up clients which would normally ‘fall through gaps’ as the clients try to navigate the justice system.

InTouch conducts different types of community education sessions, and offers educational units in multiracial issues including:

- Multiracial assessment skills for domestic violence risk assessment;
- Culturally sensitive domestic violence safety strategy;
- Culturally sensitive education for legal practitioners;
- Support for children from CALD backgrounds;
- Research and consultation with CALD communities;

- Culturally sensitive seminars on different ethnicities to promote cultural consciousness and sensitivity;

African Women Advocacy Unit (AWAU) — This group was initially known as the Australian National Committee of Refugee Women (ANCORW) and then the African Women Advocacy Unit. It targets refugee women from African backgrounds and works to represent their interests, and educate and strengthen African Australian females and their communities within social policy at local, national and international levels. Its program includes consultation, research and compilation of data for discussion of matters that impact the lives of African Australian women, their families, and communities.

The matters they cover include family and children, domestic violence, housing and employment. In its representation program, the AWAU offers training in skills of rights and representations through which African women acquire understanding and skills necessary to stand for their communities and themselves at any level in Australian society. The objective is to empower African Australian females and their communities to voice their problems through participation and ensure higher capability-building for African Australian women.

The AWAU uses a collaborative approach, a powerful nexus of educated, experienced female promoters from African communities engaging and influencing decision-making in the interest of the wider Australian community. The AWAU has engaged with Australian government agencies about matters affecting African Australian women and their communities. They collaborate and interact with a nexus of women's advocacy organisations at national and international level. There is a team of experienced community spokespersons to help on matters related to their individual communities. The empowerment of clients is encouraged via participation in discussions, seminars, advocacies and workshops.

Migrant Women's Support Service (MWSS) — This service promotes the fundamental human right of non-English-speaking females from CALD backgrounds to enable them to live domestic violence-free lives. This service provides women culturally sensitive services as allowed in a social justice framework, that enables them to reach their highest capability as members of the multiracial Australian community. The services of MWSS are state-wide based in Victoria. MWSS, together with

Relationships Australia SA (RASA), are state-wide CALD domestic violence services that provide various culturally sensitive supports through capacity building of the workforce in the sector for domestic violence and homelessness services to CALD immigrants, jointly with regional domestic violence services.

MWSS tries to provide support that meets the various requirements of migrant female victims and their children. They work with regional domestic violence services for CALD female victims of domestic violence and children. They provide culturally-oriented assessments, advocacy, safety planning, information support and referral to partner organisations. They also assist immigrant women and mothers who are in unhealthy relationships.

MWSS provide confidential services such as early intervention and case management in collaboration with regional domestic violence services. This service includes advising domestic violence victims of their rights, in addition to support in accessing various services suitable to them, professional interpreter services when needed, assessments of risk and needs either face-to-face or by phone, counselling and support to immigrant women living in remote and rural regions.

Australian Muslim Women's Centre for Human Rights (AMWCHR) — This is a Muslim women's organisation, working for the advancement of the rights and status Australian Muslim women. They aim to intervene with the help of facts and informed analysis, whenever the status of Muslim women is undermined using Islam. Their focus is on challenging the cultural ranking of any monopolisation or exclusion systems that result in a reduction of Muslim women's rights and status. This focus reflects their understanding of the movement for equality and dignity of Muslim women internationally.

The AMWCHR works for Muslim women's rights by empowering the self-determination of women, engaging human rights dimensions to weigh-in on problems of inequality and social disadvantages, and engaging with persons, communities and government to promote gender equality within the Australian perspective. They also work toward "improving women's lives in tangible and measurable ways, by working with individuals, groups and service providers in the areas of case work, referrals, secondary consultation and outreach, advocacy, community-based programs, service

delivery, capacity-building, leadership development, policy development and partnership projects” (2014, p. 5).

The AMWCHR has a research and consultancy arm – The Australian Institute for Minority Women – based on the perception that the experiences of Muslim women as a minority are similar to experiences of women from other racial groups. Hence, this institution was established to utilise the expertise of AMWCHR in engaging with Muslim women towards the betterment of the conditions of other and all minority women.

Muslim Women Support Centre (MWSC) — MWSC is a non-profit service funded by the Department of Family and Community Services (FaCS) under SAAP. It emphasises women’s right of access to information and awareness of women’s rights under Australian and Islamic law alike. Their services include 24-hour crisis/supported accommodation for female victims and children running away from abuse or in crisis.

The MWSC functions under Islamic principles and framework with a philosophy of providing quality services where women and children feel safe, not threatened, and can be motivated to access materials and information that encourages them to be strengthened to make decisions about and thus take authority over their lives.

4.8.2 United States

Institute on Domestic Violence in the African American Community (IDVAAC) — IDVAAC was established in 1993 to address abuse in African American communities, while simultaneously countering the “one-size-fits-all” strategy to end domestic violence. It focuses on issues specifically related to domestic violence among African American communities, including domestic violence, elders’ maltreatment, child abuse and community violence. The program was later expanded, through collaboration, to other CALD communities including First Nations, Asian, Hispanic/Latino and South Asian groups.

IDVAAC works on eradicating domestic violence by enhancing community awareness. It works with individuals, families and organisations, supporting the targeted population, the criminal and legal justice systems, researchers and policy makers from local level, to state, up to national levels, including family and community violence practitioners. The program aims to address the needs of each community to support

them to tackle domestic violence. IDVAAC is involved in many projects aimed at developing evidence-based, culturally appropriate and effective approaches to working with abused women including the families in communities (IDVAAC, 2004). Much of their work involves the creation of innovative strategies tailored to each community. The problems they seek to address include teenage dating-violence and domestic violence recidivism.

IDVAAC strives to enlarge the capability of each organisation and community to render services that conform to the demands of each CALD community. IDVAAC also works to broaden the understanding of domestic violence and its cultural relevance among researchers, advocates, policy makers and the various supporting systems. It creates a community of academics and specialists, and forms partnership among different constituencies, by creating new information about domestic violence, disseminating new research findings to wider audiences and interested constituents through papers presentations, journals, conference proceedings, forums, research reports and training videos. IDVAAC works with women and men, supporting mothers and children and simultaneously increasing the accountability of perpetrators, and educating men. IDVAAC also advocates policy change in legal and political domains.

Arab American Family Services (AAFS) — The mission of the AAFS is to better the life quality of the local community by helping establish more powerful, healthy Arab American generations. It works to empower individuals, training and helping families and organisations to promote and improve the Arab American's financial and social health. AAFS focuses on preventing and intervening in cases of domestic violence; cultural-diversity training; providing assistance to the elderly, those with disability, and those with mental health problems; creating community-healthy and education programs; and supporting immigration services. It aims to develop mutual regards and reasoning among non-Arab Americans and Arab Americans by offering local resources for cultural exchange. They provide translation services through which Arab speakers may access services. AAFS also promotes social reforms by looking for avenues to address the fables and prohibitions that have resulted in limited assistance availability to some Arab Americans. The services AASF render within their Safety Net Program (SNP) are relevant to women and domestic violence victims and survivors.

Safety Net Program — The AAFS' SNP provides services related to advocacy and case management, in a cultural way to communities, specifically to refugees and

immigrants, to help ensure provisioning for daily living and survival in their evolving environment. Caseworkers undertake an intake assessment with their clients to identify their specific needs and eligibility for various public benefit assistance and programs, and communicate with the providers of other services needed by their clients to campaign in the interest of their clients and educate them about guidelines and procedures to avail the benefits under the two eligible programs.

Cultural Diversity Training – AAFS provides training to create more awareness and sensitivity to the needs and diversity of Arab Americans through racial and spiritual awareness symposiums and study groups. They also provide education to immigrants and refugees in the Arab community on the cultural practices and values of the ethnic majority.

Domestic Violence Prevention and Intervention Department – AAFS is a bilingual/bicultural agency and advocates for eradicating domestic violence in Arab communities. It inspires Muslim and Arab women through the provision of services matching their cultural values, and through advocacy on various matters impacting their lives, thus it strives to reinstate and uphold the self-esteem and self-sufficiency of abused women and their families. AAFS offers services and programs including victims and family counselling, case management, victims and family crisis intervention services, safety planning, court advocacy and support program, protection orders, referral services and mental health services.

The Arab-American Family Support Centre (AAFSC) — The AAFSC provides ethnically-, spiritually- and linguistically-sensitive services to Arab immigrant communities members. The AAFSC empowers and strengthens new immigrants from Arab, Middle Eastern, Muslim and South Asian countries (AMENSA) to assist them in successfully adapting to their new environment. The AAFSC works with underserved communities and helps them address various multifaceted problems faced in relation to language difficulties, literacy and the psychological and ethnic-related challenges that come with relocation and immigration. Some of their initiatives relevant to women and domestic violence include:

The Anti-Violence Program — This program offers services that address the necessities of victims and survivors of domestic and sexual abuse, aiming to eradicate violence against women, by creating awareness about domestic violence, dating and

sexual violence and stalking. It also creates a safe place for violence victims and survivors to heal and to facilitate their self-empowerment. This includes the provision of legal services such as assistance with applications, counselling and the direct representation of migrants in the American legal system. Other services include counselling and victims support groups and a preventative services program to protect and nurture children, while stabilising and strengthening families.

Adult Education and Literacy Program — This program provides instructions in English language as a secondary language for those with limited English proficiency. There are literacy classes for women in both Arabic and English, and culture classes to increase their understanding of American culture. The centre encourages women who have limited education and literacy to enrol. They meet and speak with people from other cultural backgrounds and learn about the diversity in America.

Asia-Pacific Islander Institute on Domestic Violence (API Institute) — The API Institute deals with domestic and social violence, human-trafficking and other types of gender-related violence among Asia-Pacific ethnic groups. It works closely on a nationwide platform with community-based organisations, researchers, mental-health care providers, policy promoters and social justice organisation's activists. It analyses and addresses issues through researching, consulting, report-writing, tutoring and promoting policy.

It provides policy advocacy on custody issues, cultural and linguistic services and language services for domestic violence victims. It collects ethnic-specific statistics relating to criminal-justice responses, help-seeking behaviour, domestic violence-related homicides, and it also acts as a resource centre on funding privileges, research reports, glossaries, policy briefs and promising practices, and translated materials provide technical assistance on domestic and sexual violence, human-trafficking and legal and social services.

4.8.3 United Kingdom

National Centre for Domestic Violence (NCDV) — The NCDV was set up to support victims of domestic violence in securing safety from perpetrator, while also rendering services to legal agents, judiciary, police, agency workers, legal profession and probation workers.

Before NCDV was established, police and domestic violence victims had problems in securing non-molestation injunctions because lawyers were only taking clients who could either afford them privately or who were eligible for public funding, thereby leaving unprotected those who lacked access to funds. The service rendered by the NCDV is free, and it targets the swift resolution of domestic violence. This includes the provision of legal aids to victims and survivors of domestic violence, particularly in helping them obtain anti-violence orders from local courts. The NCDV helps clients to secure fast civil court action and also provides advice on other services such as alternative refuge accommodation and protection for children of abused mothers.

Their services are offered irrespective of the socio-economic status of victims, and include:

- Free assistance to victims in obtaining anti-violence orders within 24 hours;
- Access to family lawyers;
- Emergency injunctions;
- Emergency non-molestation and occupation orders;
- Direct connections with refuges, health centres, Women’s Aid Centres, local authorities and other services; and
- A free legal-support service.

As part of initial advice provided by the NCDV, the clients are made familiar with the whole court process. The NCDV also provides practical support with getting to the court if needed. The NCDV has access to qualified lawyers throughout the day and throughout the year in cases that are beyond the knowledge, experience, and expertise of their staff.

Imkaan — Imkaan is a Black feminist organisation that addresses violence perpetration on Black and minority ethnic (BME) females. The name Imkaan is an Urdu word that means possibility, practicability, power and contingent existence. Imkaan’s members include organisations that deliver various services related to outreach, refuge accommodation, advice, women-only spaces, legal, therapeutic and health services and women’s empowerment groups. Imkaan has a strategic-advocacy program through which it ensures that institutional policies and practices to rectify violence against females reflects the actual experience of violence by BME females.

A development-and-support program offers information, capacity-building, and peer support to specialists. The aim of the organisation is to enhance service delivery and promote good practices, improving BME women's pathways to care and support. Imkaan offers training and education on gender-based violence, forced marriage, domestic violence, and 'honour'-based violence. It generates public discourse via presentations and publications on matters related to violence against female BMEs.

Iranian and Kurdish Women's Rights Organisation (IKWRO) — IKWRO renders culture-oriented support services for Middle East and Afghani women. It is continually working to meet the need for advocacy and counselling and protect women from domestic violence such as 'honour-based' violence, child marriage, female genital cutting and forced marriage.

IKWRO provides advocacy, training and counselling directly to women and girls. It also provides counsel and assistance to frontline workers so they comprehend the problems faced by women from ethnic minority communities. They also advocate for more stringent Bills and the effectual execution of suitable resources to sustain women's rights and safeguard them.

It offers advice by phone or in person. They have clinics at local community centres, general practitioner (GP) surgeries and youth clubs. Its services are confidential. They have a referrals and advocacy service, which refers clients to other support organisations such as legal aid, housing and immigration. Their representatives can also go with women and girls for appointments with police, GPs, court, or others. They also offer translation services, including letter-writing or speaking on a client's behalf.

Their services additionally include applications for all forms of court orders including forced-marriage protection order, apprehended violence orders (AVOs) and non-molestation orders. The organisation can also provide specialist evidence in courts. They offer free counselling services and training for women. Service users look into problems that apply to them, including their rights as women under UK law. The organisation also allows women to meet other women with experiences similar to them, and build their confidence and skills. The IKWRO runs a project called Advice for Life, with the Refugee Women's Association, through which it helps domestic violence survivors to attend English language study groups and access workshops,

seminars, training and education sessions, and employment opportunities with the aim of improving their financial independence.

Southall Black Sisters — This organisation provides support in the form of information, advice, advocacy, practical assistance and counselling to women over 25 years old who have experienced gender-related violence, and their children. It provides guidance on legal procedures, immigration advice services and outreach programs. They collaborate with the London Violence against Women and Girls (LVAWG) Consortium, and assist females who have suffered sexual and domestic abuse in the form of honour-related violence, forced marriage and dowry-related violence. Other issues they address include racial discrimination, homelessness, matrimonial issues, access to social security payments, child custody and contact issues, immigration and asylum issues and mental health problems.

Black Association of Women Step Out (BAWSO) — BAWSO delivers specialist services and a Floating Support Program to BME domestic violence victims/survivors, and other types of abuse such as prostitution, female genital cutting, human-trafficking and forced marriage. Their Outreach and Resettlement Program is extensive. In its Refuge program, BME women and children are provided with secure accommodation when they are at the risk of domestic abuse. It supports workers and volunteers, who belong to diverse professional and cultural backgrounds, to provide emotional and practical support to these women. The Floating Support service assists women with accommodation and housing-related issues. It facilitates accessing care and counselling services, and developing skills and training to obtain work and financial independence. It renders support in linking women with other agencies such as social services and voluntary agencies. When leaving the refuge accommodation individuals or families may be vulnerable, hence BAWSO's outreach workers provide tapering support when the family starts its independent life.

SHARAN Project — This service supports vulnerable women, especially of South-Asian origin who have been forced out of their home by domestic violence, honour-based violence, disownment or other forms of cultural conflict through a web-based consultancy program and forum.

While the SHARAN program is similar to the others described above in its provision of services, one facet is unique: the online community forum. This offers its users a

platform on which to present their concerns, post threads, connect with others, offer and receive support and share stories. This forum is available only to SHARAN members, free of cost. Users can create their own profiles and safely access support at their own convenience.

4.8.4 Canada

Native Women’s Association of Canada (NWAC) — NWAC works on developing actions to stop the violence cycle, particularly those leading to death or disappearance of female Aborigines. The activities of the NWAC fall into four themed categories: education, tools for communities, partnerships and community responsiveness. The intention is to empower communities, service providers, educators and government with the capability to respond to violence problems against female Aborigines. NWAC has prepared a toolkit titled: “You Are Not Alone: A Toolkit for Aboriginal Women Escaping Domestic Violence” (Jeffery et al., 2018). This is a community-safety planning resource that aims to address domestic violence against Aboriginal women.

South Asian Women’s Centre — This is an organisation for South Asian females, that works actively and collectively for social change. It gives them an opportunity to work with other women of colour, groups and organisations. As part of its domestic violence services, it provides referrals to transition houses and crisis centres. The service is multilingual, and has telephone information and referral services. It informs women on employment, training and educational opportunities. Its discussion groups and advocacy are directed at political and social issues affecting South Asian women and women of colour. They develop new programs according to the needs of women that utilise their services. Most requested services are resources and referrals for immigration/citizenship information and support, counselling, advocacy, support around family issues, violence in relationships, and assistance in job searches, acquiring job skills and resume writing.

MOSAIC — MOSAIC is a non-profit, multilingual organisation, that works on issues related to the integration of immigrants and refugees into Canadian society. The support and strengthening of refugee and immigrant communities in addressing serious neighbourhoods and workplace problems is the primary mandate of the organisation. Its programs and services are continuously evolving according to

community needs. Many of its programs are targeted at stopping domestic violence and assisting victims and survivors.

MOSAIC provides free and confidential services such as a counselling program called 'Stopping the Violence (STV)'. The service includes advocacy, counselling and support services for women who have suffered violence perpetrated by an intimate partner. The STV Counselling Program provides free counselling to women who have suffered physical, sexual, emotional, social-economic and psychological assaults over the short or long term. It is also meant for women living with domestic violence. MOSAIC offers both one-to-one counselling and group support.

They currently have a project on stopping and reducing honour-based violence against females. This project is working on developing conversation to reduce shame barriers and educate frontline workers about honour-based violence. A multilingual training tool was also created as part of this project. MOSAIC also provides the following services:

Multicultural Clinical Counselling Program (MCCP) — MOSAIC offers counselling for women from multicultural communities going through stress and anxiety and concerns due to migrating to Canada. Counselling is either one-on-one or group-based, and considers issues like stress and coping, abuse and trauma, relationship conflicts, grief and loss, depression and mood swings, divorce, separation, anger management, panic and anxiety. MOSAIC has also initiated a dialogue to increase awareness of forced marriage and enhance the capacity of services to individuals facing forced marriage as they are a form of violence.

'Men in Change' — This program offers education and counselling to migrant males who have perpetrated domestic violence and threats of violence, attempted or real, against their spouses or have a tendency of such conducts. The aim of this program is to stop domestic violence from occurring or recurring within families through comprehension of what constitutes domestic violence, recognition and expression of all forms of emotions apart from anger, recognition of individual triggers and learning stress-management strategies and constructive ways of dealing with conflict.

Multicultural Victim Services Program — This is a specialised MOSAIC program for multicultural males and females in Vancouver who have suffered all forms of crime and trauma. Women are supported to reduce the effects of trauma and crime and recover. The cultural sensitivity of the program is recognisable, and the service is

delivered in the client's native language. The program is client-centred, so they can choose if they want to report the crime to police or the criminal law system. The program offers access to emotional support to fresh migrants, refugees and multicultural people by having a service-worker listen to their story and discuss it with them. They prioritise what can be done and where the client can go to seek extra support. They also provide general advice related to crisis accommodation and housing issues, safety planning, social security payment, information on legal assistance, healthcare, and other resources that clients can access. Specifically, they provide justice-related information like updates on police investigation, whether charges have been filed against the perpetrator, the custodial status of the offender, apprehended violence orders (AVOs), and the result of any court sessions, length of sentence, and parole information.

4.9 Discussion

The organisations identified in this review across the US, UK and Canada share commonalities. For example, they are generally focused on either a specific region or community (e.g., IDVAAC, IMKAAN, IKWRO and NWAC). This specialisation permits greater insight into the issues usually faced by clients of these diverse backgrounds. Some organisations support the family holistically, including perpetrators of domestic violence. For instance, the IDVAAC has programs for reforming perpetrators. Thus, it implements a safe-return program to support perpetrators to deal with issues that could prevent successful reunion with their families with reduced vulnerability to domestic violence.

Australia also has organisations designed to work with women from CALD migrant communities. Many of these work with domestic violence victims as one of several issues they address, but only two (InTouch and MWSS) exclusively support domestic violence victims from CALD communities. Most of the Australian organisations run programs focused on training and capacity-building, skill development, working on settlement issues and empowering women, and some are religion-focused.

Contrary to those overseas, organisations in Australia focusing on ethnic minorities or the immigrant community, may sometimes lack the expertise or technical resources required by the wider variety of clients that approach them. That is, clients may belong to different countries and cultures, speak different languages, and have different belief

systems. Table 4.1 summarises the activities and services of the reviewed organisations.

Country & Organisation	Activity	Psychotherapeutic support
USA		
IDVAAC	Various programs	General
AAFS	Safety net program	General
	Cultural diversity training	General
	Domestic violence prevention and intervention department	CBT, PCT, General
	Youth programmes	General
AAFC	Anti-violence program	PCT, General
API Institute	Domestic violence prevention programmes, data clearing house	General
UNITED KINGDOM		
NCDV	Legal security services	General
IMKAAN	Violence prevention programs BME women	CBT, PCT, General
IKWRO	Violence prevention of women from Middle East and Afghanistan	PCT and General
Southall Black Sisters	Violence against black minority women programs	CBT, PCT, General
BAWSO	Violence prevention programs against BME women, especially genital mutilation	CBT, PCT, General
SHARAN	Web-based	CBT, General
CANADA		
NWAC	Violence prevention programs for native women in Canada	CBT, General
AIWN	Networking for voicing of victims' programs	General
South Asian women's Centre	Violence prevention platforms for South Asian women	CBT, PCT, General
MOSAIC	Stopping of violence (STV) program for both men and women	CBT, PCT, General
AUSTRALIA		
MWSS	Violence prevention among CALD and NESB migrant women programs	CBT, PCT, General
InTouch	Violence prevention of CALD women and men programs	PCT, General

Country & Organisation	Activity	Psychotherapeutic support
AWAU	Violence prevention of African women through empowerment programs	General
AMWCHR	Various programs to prevent domestic violence among Muslim women and fight against their Muslim disadvantages	CBT, PCT, General
MWSC	Muslim women's rights of information	General
DV Vic	Prevention before violence becomes critical, special focus on aboriginal and CALD communities	General

NB: General refers to services other than client counselling by CBT or PCT and aimed at communities as a whole.

Table 4.1: Mapping of various programs and activities of different anti-violence organisations in USA, UK, Canada and Australia.

Findings from this review have revealed no clear demarcation in the psychotherapeutic approaches used by most organisations in supporting their clients. Most of the description of psychotherapeutic supports used in services overlap. The descriptions support both PCT and CBT while some are general. Similarly, information on the effectiveness of services provided by these organisations is not available.

This review also elucidated the concept of trauma-focused therapy (not reported here for brevity); a special type of therapy for people with trauma experiences and people with depression, PTSD and other behavioural and conduct problems. Trauma-focused CBT was developed to address PTSD symptomology linked to sexual abuse (depressive symptomology and behavioural issues) and unhealthy thoughts and emotions about the abuse, but subsequently has been modified to suit the treatment of other forms of abuse and trauma including emotional and physical abuse, domestic violence and traumatic loss (Cary & McMillen, 2012; O'Callaghan et al., 2013).

Trauma-focused CBT follows the principles of re-exposure and cognitive re-organisation strategies specific to the trauma encounters by cautiously introducing the client to memories of the trauma that could be significant or non-significant, thereby reducing distress that comes with these memories and thus reducing trauma-induced reactions (Ramirez de Arellano et al., 2014). The purpose of the gradual re-exposure is to reduce the distress that comes with remembering the trauma experience and reducing trauma-induced reactions. Cognitive re-organisation implies recognising poor and unhelpful thoughts and beliefs associated with the traumatic experience,

such as guilty feelings and self-blame, and establishing an alternative pathway by which victims may come to terms with their experience.

According to Ramirez de Arellano et al (2014), the key elements of trauma-focused therapy are psycho-education, behavioural modelling, gradual exposure, body-safety skill training and coping strategies. Clients are taught how to develop coping mechanisms from practitioners, who may educate them in affective modulation techniques, relaxation skills and cognitive-coping skills. Each of these is modified to suit the management needs of the individual client. There is some evidence in favour of the effectiveness of trauma-focused CBT in the management of trauma and other symptoms (Murray et al., 2015; Murray et al., 2013; Saunders et al., 2003), however there is also a lack of consistency across research studies (Jensen et al., 2014) calling for further rigorous research.

4.10 Literature Review Summary

Chapters 2, 3 and 4 have explored literature to understand and identify the gaps in previous studies and suggest how this study can address them. Chapter 2 highlighted the prevalence of domestic violence across the globe and in Australia, and associated risk and predisposing factors investigated by researchers. Chapter 3 went on to further review CALD communities and the complexities around domestic violence within different cultures. In this chapter, the impact of culture on perception of domestic violence and how these differences across cultures may limit how help is accessed was also reviewed. Furthermore, it was deduced that there is a paucity of research on domestic violence within CALD communities in Australia. There are also limited evidence-based response strategies that can be adopted with victims of domestic violence from this community.

The selected peer-reviewed papers in Chapter 4 also had different views on whether therapeutic approaches such as CBT or PCT are effective for CALD clients. However, cultural adaptations of these interventions may make treatments more effective for ethnic minority clients. For CBT to be more effective for clients from CALD groups, culture-specific adaptations are recommended. At the same time, it is imperative to be conscious that traditional therapeutic approaches may lose their effectiveness if overly modified. Rather, emphasis should be placed on multicultural competencies within the counselling profession.

As mentioned, the papers reviewed in Chapter 4 were not restricted to those that investigated domestic violence victims from ethnic minority groups. Articles included therapeutic approaches for clients from different ethnic minority groups who present with an array of issues including domestic violence, depression and anxiety disorder, PTSD, intimate partner violence, drug addiction and/or a combination of any of these. Culture-specific interventions for recovery as well as adapting CBT approaches using multicultural lenses in counselling was also reviewed.

From this review of the relevant and related literature, it is posited that clients would benefit from therapy where interventions are culturally adapted for CALD communities drawing on multicultural competencies. Therefore, this research will explore and suggest an effective approach that can be adopted in responding to victims of domestic violence within their community.

CHAPTER 5 - Research Design Methodology

5.1. Introduction

An extensive literature review of literatures was conducted in Chapter 2 through to 4. A database search of peer-reviewed papers on domestic violence, CALD communities and psychotherapy was conducted in these Chapters using the relevant keywords for each Chapter. The literature reviews examined available literatures on domestic violence, CALD communities, ethnic minorities and psychotherapy by searching for articles from 1990 through 2021. Major databases searched included Medline, PubMed, Scopus, Scirus, Google scholar, CINAHL, Proquest, Cochrane, published literatures, PsycINFO, Applied Social Science Index and Abstracts, Web of Science, Sociological Abstracts, government reports and grey literature for evidence-based information on domestic violence, CALD communities and psychotherapy.

This chapter presents a summary of the research design and justifications for it, followed by a description of the development of the questionnaire used for the study. Details of the process of participant selection and data analysis are presented in subsequent sections. There is also an outline of the statistical methods employed for analysis of the collected data.

The aim of this research was to explore the perceptions of frontline workers on domestic violence against women from CALD communities with a view to improving the provision of services, advising service providers on multicultural counselling training, and inform funding decisions at the parliamentary level. Key therapeutic interventions were also examined, as well as the perceptions of frontline workers on the current provision of support. This chapter explains how the data was collected to be able to answer these questions and fulfill these aims. Specifically, a brief cross-sectional quantitative survey with open-ended responses (mixed method) was conducted; the details of which are discussed below.

5.2. Research Design

A research design is the overall strategy used to execute the aims of a study and determine a response to the guiding hypotheses (De Vaus, 2001). Thus, the research

questions determine the research design. The research questions that guided this study are described in Section 1.5.

According to Creswell (2013), there are six primary types of research methodology: survey, experiment, action research, case study, grounded theory and ethnography. Some generate quantitative data, some generate qualitative data, and some generate both. Research that generates both types of data is called mixed method (Creswell, 2013; Saunders et al., 2009; Sekaran & Bougie, 2011). Mixed method research offers greater scope to explore issues qualitatively and quantitatively, thereby compensating for the inherent weaknesses of each individual method (Almalki, 2016; Johnson & Onwuegbuzie, 2004). For social science projects, such as this one, a mixed-methods approach enhances the vitality of the project by offering more ways to understand the data compared to if a single approach were used (Creswell & Plano Clark, 2011). Figure 5.1 illustrates the types of studies associated with each method.

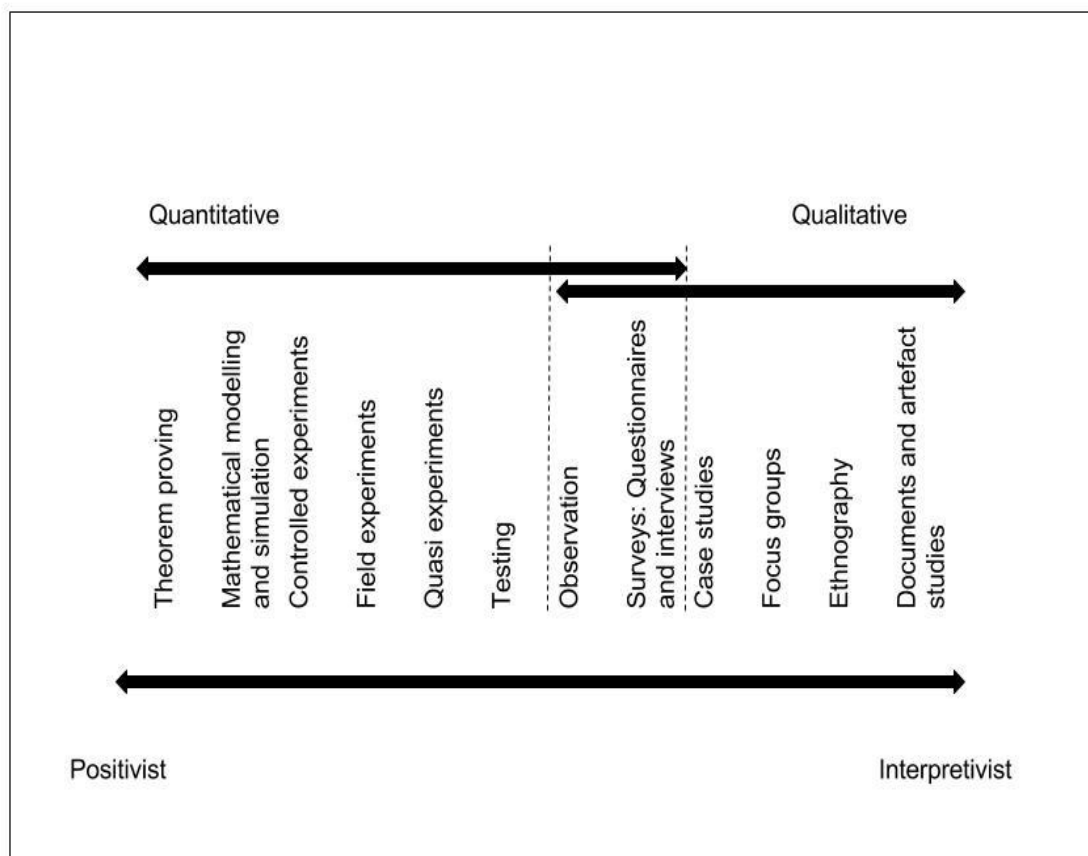


Fig 5.1: Types of Research (De Villiers, 2005)

As it shows, in the social sciences, observation, case studies and focus groups are classified as qualitative methods. However, this study involved the use of a survey questionnaire, a quantitative method. The merits of this strategy are explored below.

Quantitative research methods allow the findings of a research study to be considered with maximum objectivity and explicability (Benz et al., 2008). They can also be used for prediction in subsequent research studies (Creswell, 2013; Kothari, 2004). The researcher ensures the objectivity of the study as well as its conclusions by putting aside any intrinsic biases, perceptions and experiences (Creswell, 2013). Many quantitative studies rely on the employment of tools such as tests or surveys for data collection. They use probability theory to test statistical hypotheses that aligns with the research questions (Creswell, 2013). Usually deductive in nature, quantitative methods involve deriving inferences from statistical hypothesis testing, which lead to the generation of inferences about the characteristics of a population. Rovai et al., (2013) noted that quantitative methods reflect positivist philosophy, implying the existence of a single “truth” independent of human perception.

Some of the major strengths of Quantitative research methods are the fact that that data can be collected and evaluated in a short period. Responses can be analysed within a short time frame. Also, because the collected data is numerical, it allows for comparison between groups or organisation and it also allows for determination of the extent of agreement or disagreement between participants (Choy, 2014). Another strength of a rigorously collected quantitative data, that has employed appropriate tools and critical analytics lies in its reliability (Brief, 2012). Quantitative research will not capture an in-depth description of the experience of the population, for instance in a disaster situation (Brief, 2012)

However, there are weaknesses with quantitative research method. One of them is the fact that the characteristics of the participants including identities, perception and beliefs lose its meaning when reduced to numbers or neither can they be understood adequately when references to the local context in which people live has been excluded (Choy, 2014). Also, for the result of a quantitative research to be meaningful and effective, there is need for a large sample size which may be challenging if there is lack of resources ((Dudwick et al., 2006).

Qualitative methods are used by social scientists for greater understanding of the phenomena under evaluation. A design provides structure for the research to ensure that “the major components of the research project—the samples or groups, measures, treatments or programs, and methods of assignment—collaborate to answer the central research questions” (Creswell, 2013 p. 3).

Creswell (2013) differentiated quantitative, qualitative, and mixed designs based on their “philosophical assumptions”, which include the “basis of knowledge, enquiry strategies and methods” (p. 5). Creswell (2013) described the quantitative method as a research approach in which the researcher utilises “post-positivist claims of knowledge development” (p.7) including finding cause-and-effect relationships, observation and measurement for the purpose of data collection, reduction to specific questions and hypotheses and the testing of variables.

Qualitative research involves either the observation or recording of narrative information without the assignment of numbers or measurements (Creswell, 2013). Qualitative methods are used to explain a phenomenon (Tolley et al., 2016). The researcher uses flexible, iterative and semi-structured instruments, as well as open-ended questions and textual rather than numerical data. When using a qualitative approach, depending on the methodology, many aspects are flexible. For example, the method of questioning can be iterative in that the responses provided to a question may influence the content and nature of the subsequent ones (Creswell, 2013). One key difference between quantitative and qualitative approaches is thus the flexibility of the response.

Qualitative research allows probing and exploration of underlying beliefs, perspective and value of the participants to gain full understanding of what drives their behaviour (Ochieng, 2009). It limits preconceived issues that the researcher may want to explore. It also allows for broad and open-ended inquiry into the subject that is being explored allowing participants to raise issues that is important to them (Yauch & Steudel, 2003).

Some of the weaknesses of Qualitative research

Some of the limitations of qualitative research include the fact that it is time consuming and there is the risk of overlooking important issue or not being notice. Qualitative research is lacks scientific rigour of quantitative research and is subject to researcher bias (Cope, 2014). Qualitative research is subjective and lacks generalisability, it produces large volumes of comprehensive information about a single phenomenon

(Cope, 2014). Qualitative research gives more control to the participant because of its open-endedness. It produces data that may not be objectively verified, the analysis process (categorisation, coding and recoding) can be labour intensive (Choy, 2014). Also, it needs skilled researchers to conduct the primary data collection successfully (Brief, 2012).

Mixed Methods Study

According to Johnson et al. (2007), mixed methods research considers many perspectives, points of view, opinions, frames of reference, standpoints and thoughts. They specifically define mixed methods research as the type of study where the components of qualitative and quantitative designs, (for instance application of qualitative and quantitative frames, collection of data, review and evaluation and conclusion) are combined in one study or in a multiphase program of investigation for the purposes of gaining in-depth knowledge and validation (as cited in Shamu, 2013). Collecting varied types of data through mixed methods provide a more holistic knowledge of the research problem when compared to either quantitative or qualitative data as individual entities (Creswell, 2013).

Johnson et al. (2007) proposed four rationales for conducting mixed methods research:

- **Participant enrichment** — This involves “combining quantitative and qualitative research to optimise the sample” by using tools such as participant recruiting, employing activities like institutional review, board debriefings and making sure each selected participant meets inclusion criteria (p. 123).
- **Instrument fidelity** — This includes evaluating the suitability and/or utilisation of existing tools, developing new tools, and monitoring the performance of humans as tools.
- **Treatment integrity** — This includes evaluating the dependability of interventions.
- **Significance enhancement** — This includes improving the robustness and richness of data, and augmenting the interpretation and usefulness of the results.

Mertens (2014) recognised that a mixed methods approach falls under the research paradigm of pragmatism. A paradigm is a form of viewpoint using certain philosophical

hypotheses that guide thought and action. According to Mertens (2014), the four major paradigms—post-positivism, constructivism, transformative, and pragmatism—are defined by four basic beliefs: “axiology (the nature of ethical behaviour), ontology (the nature of reality), epistemology (the nature of the knowledge relationship between the knower and the would-be-known), and methodology (the research’s approach to systemic inquiry)” (Turner, 2017). Table 5.1 outlines the association between basic beliefs and the pragmatic research paradigm (Fardinpour, 2016).

Basic Beliefs	Pragmatic Paradigm
Axiology	Acquire understanding in pursuit of desirable ends according to the values and politics of the researcher
Ontology	affirms that only one reality exists but every individual has their own peculiar interpretation of reality
Epistemology	Associations in research are influenced by the viewpoints of the researchers as they see as appropriate to the research in question
Methodology	Matching designs to specific questions and objectives of the research; mixed methods are employed as investigator reviews various methods

Table 5.1: Basic Beliefs associated with Pragmatic Paradigm, adapted from Mertens (2014)

Based on the discussion above, a mix of quantitative and qualitative methods was considered apt for the present project. Using a mixed method for this research harnessed the strength of both the qualitative and quantitative methodology and limit the impact of the weakness of both. The researcher administered a questionnaire with frontline workers who engage with domestic violence victims. The questionnaire employed a mix of quantitative survey and open-ended qualitative questions.

The project commenced with the survey to help in generalising findings to a cohort. Then, it shifted to open-ended questions to collect a detailed view from the

respondents so as to better understand the nuances of perception and experience behind the initial quantitative survey.

Cross-Sectional Study

Collection of research data can either be longitudinal or cross-sectional. In longitudinal research, data are collected at multiple point periods while in cross-sectional research, data are collected at a particular time or period (Kothari, 2004).

Cross-sectional data collection for research has its advantages. Katz (2006) noted that cross-sectional studies are easier and faster to execute because the information is collected from respondents at a single point of time. Usually, cross-sectional studies involve descriptive questions. According to Hammond et al. (2014), in a cross-sectional study, an entire research population or significant sample of the population are observed at a given point in time. A cross-sectional study can evaluate the relationship between variables at a set time. It can also measure the prevalence and prove to be relatively lower in cost as compared to other data collection methods. The current research project involved data collection at one point in time, thus making it cross-sectional.

5.3. The Questionnaire

A questionnaire was utilised for data collection for this study (see Appendix 3). This questionnaire allowed the researcher to collect a variety of answers in a relatively short time. It also allowed the participants, in this case frontline workers, time to reflect on their answers. It provided them with anonymity and allowed them to decide to complete the survey on their own time. The questionnaire was developed by taking into consideration inferential variables (CALD communities' psychotherapeutic approaches and the perceptions of frontline workers). These inferential variables were determined based on gaps identified within the existing literature.

The questionnaire consisted of a mix of question types, including open-ended, close-ended, and scale-based. For the scale-based questions, the available options were 'strongly agree', 'agree', 'I don't know', 'disagree' or 'strongly disagree'. There were 22 multiple choice questions and a free-response section comprised of three open-ended questions.

The items for the questionnaire were selected based on the extensive literature review on frontline workers and domestic violence victims from CALD communities. The questionnaire had five sections:

- 1) demographic background of participants;
- 2) type of profession and years of experience of participants;
- 3) domestic violence and CALD-specific questions;
- 4) questions pertaining to perceptions of PCT- and CBT-based therapeutic approaches; and
- 5) open-ended questions gauging the participants' perceptions about the relevance of, and improvements recommended in, existing programs and services for CALD communities.

There were also questions pertaining to whether participants worked with clients from CALD communities and whether they had received any specific training to aid their work with CALD clients. The questionnaire asked about the kinds of organisations the participants worked for and whether these organisations had specific guidelines on how to work with clients from CALD communities.

This questionnaire was accompanied by a research-participant information sheet, which contained a summary of the study and instructions for the participants (see Appendix 2). It also contained information for participants regarding where the results and further information will be made available. The survey questionnaire was sent via email to the participants with a link to the online survey.

5.4. Data Collection Tool

The survey for this research was conducted using an online survey tool (Survey Monkey). Prior to now, designing and creating an online survey was exerting, and required the user to be familiar with web authoring and scripting programs, as well as HTML or another similar coding language. With advances in information technology, various tools have made creating and carrying out online surveys much easier and faster (Wright, 2005).

5.5 Categorisation of research questions

The research questions for this study were categorised into five sections. The first segment involved questions on respondents' demographic backgrounds. Participants were asked about their work experience and gender to determine if these characteristics had a bearing on their choice of therapeutic approach.

The questionnaire also contained questions related to respondents' perceptions and preference regarding CBT and PCT. The respondents were asked to rate their responses on a Likert scale (strongly disagree, disagree, agree or strongly agree). The questions were specifically framed to illustrate the frontline worker's perceptions stemming from their belief systems, as well as their approaches to supporting clients from CALD backgrounds. There were nine questions that measured respondents' perception of CBT interventions. These included:

1. I respect the client's racial/ethnic identity.
2. I believe that all CALD clients understand themselves.
3. I believe that all CALD clients are inherently trustworthy.
4. I believe in the client's ability to solve difficult problems.
5. I believe that CALD clients can solve their own problems without direct interference.
6. My approach to helping CALD clients who have experienced domestic violence is direct with a focus on thoughts and feelings that influence behaviours.
7. I always maintain a non-judgmental stance with the client.
8. I always listen respectfully to the client and always remain congruent (or genuine).
9. I believe trust is the foundation of any counselling relationship.

The following five questions evaluated respondents' perception of PCT interventions:

1. The client's actions, whether negative or positive, will not determine or diminish my regard for that client.
2. In general, how will you rate the level of co-operation of clients from CALD backgrounds?

3. In general, how will you rate the utilization of your service by clients from CALD backgrounds?
4. In general, how will you rate the impact of your service on the lives of the clients from CALD communities?
5. How well will you rate the impact of current government policy on the reduction of domestic violence in general (across all communities)?

5.6 Validity and Reliability

According to Burns and Grove (2004), the validity of an instrument is determined by the extent to which it considers the abstract concepts being investigated. Grove (2004) also mentions that there are different approaches for assessing validity including face validity, criterion-related validity, content validity and construct validity (Kleib, 2012). These validity tests are classified into two broad groups: internal validity and external validity. Internal validity refers to how accurately the result of the research quantifies what it was designed to measure while external validity measures how accurately the result of the research obtained from the study sample describes the reference population from which the sample was drawn (Wong et al. 2012). In the case of this project, only its content validity was ensured by asking research experts to evaluate the contents of the data collection instrument. Content validity refers to the degree to which a data collection instrument reflects the content universe to which the research collection instrument will be generalised (Straub et al., 2004). Content validity was applied while developing the research questionnaire. The survey questionnaire was evaluated by research experts in order to ensure it includes all the essential items to be able to answer all the research questions and to eliminate undesirable items that could derail from the research aims and objectives. To establish content validity, an extensive literature review was conducted to extract relevant items followed by evaluation by expert judges from senior researchers and experienced domestic violence frontline workers. The content validity survey was sent to the panels through email with a four-week deadline, a lack of response after the deadline lapsed was taken as an indication of non-willingness to participate. A total of ten responses was received from the survey as the ten subject matter experts in the field that is being researched. A content validity ratio (CVR) was then calculated for each item using the Lawshe's (1975) method.

Lawshe's CVR method is a linear transformation of proportional agreement level of the number of subject matter experts within the panel that rate the survey item as essential using the formula below:

$$CVR = \frac{n_e - \left(\frac{N}{2}\right)}{\frac{N}{2}}$$

Where CVR represent validity ration, n_e represents panel member that mark a survey question as essential, and N represents the total number of subject matter experts on the panel. The decision to retain a survey question as determined by the CVR is based on the number of panel members. Research items that were not marked as essential were eliminated. All of this was done to establish that the intended items really do measure the underlying construct and that the construct has been fully measured but not any more than is required to balance against participant fatigue.

Reliability refers to repeatability, that is the extent to which the outcome of a research can be replicated, the ability of a measurement to provide stable and consistent result overtime or across observers (Bolarinwa, 2015; Taherdoost, 2016). Reliability contributes to validity of a survey questionnaire, however, on its own, it is not a sufficient measure of the validity or research questionnaire (Bolarinwa, 2015). Reliability has three attributes: equivalence, stability and internal consistency (homogeneity) (Wong et al., 2012). To establish reliability, there must be concordance between observers, data collection instruments and consistency of the attribute that is being measured (Wong et al., 2012). The Cronbach's alpha was measured across all survey questions to assess the reliability of this study.

5.7 Ethical Consideration

Ethics approval (Appendix 1) was granted by The University of Notre Dame Human Research Ethics Committee (HREC). This research was conducted in full conformity with the National Statement on Ethical Conduct in Human Research (2007), the Australian Code for the Responsible Conduct of Research (2007) and all applicable local laws and regulations. All potential participants were recruited through their membership body or the organisations they work for. They were invited to participate in the survey via an email that was sent to their membership body or organisations. The email contained the research statement and a link to the online consent form and

survey. The research statement provides a detailed description of the study to ensure full understanding of what the research entails and what participation involves. The survey ensured that the identities of participants were strictly confidential. No identifiable information was collected. There was no foreseeable or unforeseeable risk identified during the preparation of ethics application and data collection. All data was saved in password-protected files in secure folders on the principal investigator's personal computer.

5.8 Sampling

According to Burns and Grove (2004), sampling is the process of selecting participants for a study from the population. Hence, "a sample is a subset of the population selected to represent the population" (Brink, 2010, p. 124). One of the most common sampling techniques is convenience sampling. It is a form of non-probability sampling that depends on the collection of data from samples of the population readily available to take part in the study (Grove, 2004). Convenience sampling is a statistical method that draws representative data where the people are selected based on ease of access. In this kind of sampling, the first available primary data source is being utilised for the study without seeking further data sources. In other words, the participants are procured wherever they can be found and wherever it is convenient. Convenience sampling was used for this study.

A sample of 60 respondents agreed to take part in the study, and were included from the following organisations:

1. Australian Association of Social Workers, NSW branch;
2. Mary's Place (a branch of the St Vincent de Paul Society);
3. South West Sydney Women's Domestic Violence Court Advocacy Service;
4. Bankstown Women's Health Centre;
5. Cumberland Women's Centre, Harris Park;
6. Muslim Women Support Centre, Lakemba;
7. Counselling and Psychotherapist Association, NSW;
8. Domestic Violence Liaison Officers, NSW; and

9. Australian Psychological Society, NSW branch.

Research invitations and two reminders were sent to staff across six months with the number of final respondents being 60 during the period of data collection (June 2014 to January 2015). This response was considered to be moderately representative because it was drawn from nine premier organisations in NSW working with domestic violence victims.

5.9 Sample selection

According to Creswell (2008), a quantitative approach allows the researcher to collect data in a short time from participants who are generally representative of the broader population of interest; in this case, frontline workers who may also see clients who are domestic violence victims and survivors from CALD communities. Thus, the sample of participants approached and included were frontline workers such as psychologists, counsellors, therapists, case workers, legal aides/court support, social workers and advocacy professionals who may also see CALD clients.

5.10 Study Participants

Of the total sample, they were predominantly comprised of female participants (n=51) and the majority (n=49) were professional counsellors. More detail about the sample is provided in Chapter 6.

One of the methodological limitations of research on domestic violence is the great variation that exists in the cohorts used for research. For example, a lot of research includes women from a specified age group to try and address this. Other studies include only married women or women who have been married at some point in time.

5.11 Data Analysis

The following chapter presents the demographic characteristics of the research participants and insights into their perception of CBT- and PCT-based therapeutic approaches for use with women domestic violence victims of CALD backgrounds. It also establishes any statistically significant differences between their perceived effectiveness and preference for either therapeutic approach. Here, the following data analysis techniques were used for these quantitative analyses and are described:

Frequency Counts and Descriptive Statistics — All questions in the questionnaire which had categorical responses (nominal and ordinal) had their frequency distributions (percentages and counts) calculated. All questions that have a continuous response had their descriptive statistics (mean, median, standard deviation and interquartile range, where required) calculated. Questions which had responses where participants agreed or disagreed with an item had their trends summarised according to whether the majority of the respondents (more than 50%) 'agree' or 'disagree' with the items. The skewness of the distributions across either points were also recorded where necessary (Alsharari, 2013).

Variable Scoring — Using the responses from the survey, two scores were computed. These were the CBT perception score and PCT perception score. The CBT perception score was calculated as the average of the nine questions in the questionnaire related to the perception of respondents to the use of CBT-based therapeutic approaches. Similarly, the PCT perception score was calculated as the average of the five questions relating to perceptions of PCT-based therapeutic approaches. The CBT perception score has a range of 1 to 5, where 1 corresponds to strongly agree and 5 corresponds to strongly disagree. The PCT perception score has a range of 1 to 5, where 1 corresponds to very good and 5 corresponds to very bad. Computation of the PCT perception score where the response choice is 'I don't know' was assigned a value of 0.

Test of Normality — The assumptions of parametric statistics were inspected, and the data were examined for statistical skewness and kurtosis. The Kolmogorov-Smirnov (K-S) test was utilised to check the statistical significance of normal distribution of the variables at $\alpha = .001$.

Paired Sample T-Test — A paired sample t-test is employed to compare two population means in the case of two sets of variables with equal numbers of observations (Shier, 2004), or when there are two samples and the observations in both samples can be paired (Lau, 2006). This study utilised a paired sample t-test to test if the CBT perception score and PCT perception score were significantly different from each other. This study compared preferences for PCT or CBT, therefore, a paired samples t-test was used. According to Kim (2015), a paired sample t-test is used when a relationship exists between variables. In this study, the PCT and CBT are related

because they are both psychotherapeutic interventions. An alpha = .05 was used to test for statistical significance.

MANOVA — MANOVA is a useful instrument for testing the effects of factors and covariates on more than one dependent variable considered at one time. According to French et al. (2007), multivariate analysis of variance (MANOVA) is an ANOVA with many dependent variables. This implies that the difference in means between two or more groups is determined by ANOVA, while MANOVA determines the difference in two or more vectors of means. In this study, MANOVA was employed to determine the relationship between the demographic characteristics of the respondents and their preference for CBT or PCT in dealing with domestic violence clients from CALD communities.

5.12 Free Response Thematic Analysis

The aim of this section of the research analysis was to explore frontline workers' perceptions of the efficacy of CBT and PCT in supporting women from CALD communities in Australia. A thematic analysis of the open-ended section of the research survey was conducted and the results of the thematic analysis was triangulated with the themes identified in the literature review thereby strengthening the results of the research data analysis. A content analysis methodology was used in categorising the responses to the open-ended question section of the research survey to reveal themes. To ensure confirmability, there was outlined procedure of checking and double-checking of the data throughout the period of conducting this study. A secondary coder was not employed due to resource constraints.

5.13 Methodological Strengths and Limitations

Limitations to this study should be considered when the findings of this research are applied to other contexts. These limitations are:

- 1) This research is constrained by the availability of data on selected CALD communities. In particular, the data is unlikely to reflect the true breadth of the burden of domestic violence by both perpetrators and victims.
- 2) The estimates of the psychological and emotional effect of domestic violence are limited, particularly as this is not a longitudinal study.

- 3) This research did not involve direct communication with victims and survivors of domestic violence. Rather, it relies on the reports of the frontline workers. This research must therefore be considered in light of victims' views regarding the current provision of service, and the proposed changes thereto.
- 4) Survey instrument may present limitation. To minimize this limitation, two types of data analysis (descriptive and multivariate tests) were carried out.
- 5) Sampling design may present limitation as convenience sampling was adopted. Sample. This study was not intended to develop generalisability but to explore how to best support frontline workers that support CALD women who have experienced domestic violence.

CHAPTER 6 - Research Results

6.1 Introduction

This chapter presents the results of the questionnaire section of the research, followed by an analysis of the findings of the free-response section. The demographic profile of the respondents will also be discussed, which includes factors such as gender, profession, years of experience, training and awareness of guidelines when working with CALD communities.

6.2 Results

To assess the validity and reliability, the Cronbach's alpha was measured across all survey questions. The reliability coefficient of Cronbach's alpha values greater than 0.7 represents fitness (reliable) of the scales used. Results are given in Appendix 5.

The total number of respondents was sixty (n=60). The majority identified as female (n=51, 85%), as presented in Table 6.1. Counsellors formed the largest group of people surveyed by profession (n=49, 81.7%), as presented in Table 6.2. Only 13.3% of participants had less than five years' experience (Table 6.3), the remaining (87%) had five or more years of experience. Of this percentage, 69% had 5–14 years of experience. About 85% (n=51) were aware of their organisations' guidelines on working with cases of domestic violence (Table 6.4). Organisations having additional guidelines for working with CALD communities specifically were almost evenly divided according to the responses of participants (Table 6.5). Of the respondents, 53% said their organisations had additional guidelines for supporting women from CALD communities, while 47% said their organisations did not have such guidelines. About 57% of respondents had received training on working with CALD victims of domestic violence either before or after qualification and the remaining 43% had not received any such training (Table 6.6), while 83% had worked with clients who had experienced domestic violence and 93% worked with CALD clients (Tables 6.7 and 6.8).

Table 6.4: Are you aware of your organisation's guidelines on dealing with cases of domestic violence?

		Frequency	Percent	Valid Percent	Cumulative Percent
	Yes	51	85.0	85.0	85.0
Valid	No	9	15.0	15.0	100.0
	Total	60	100.0	100.0	

Table 6.5: Does your organisation have any additional guidelines for working with people from Culturally and Linguistically Diverse (CALD) communities?

		Frequency	Percent	Valid Percent	Cumulative Percent
	Yes	32	53.3	53.3	53.3
Valid	No	28	46.7	46.7	100.0
	Total	60	100.0	100.0	

Table 6.6: Have you received any training on working with victims/survivors of domestic violence specifically from Culturally and Linguistically Diverse (CALD) communities?

		Frequency	Percent	Valid Percent	Cumulative Percent
	Yes, pre-qualification	10	16.7	16.7	16.7
	Yes, post-qualification	24	40.0	40.0	56.7
Valid	No	26	43.3	43.3	100.0
	Total	60	100.0	100.0	

Table 6.7: Do you work with clients who have experienced domestic violence?

	Frequency	Percent	Valid Percent	Cumulative Percent
Yes	50	83.3	83.3	83.3
Valid No	10	16.7	16.7	100.0
Total	60	100.0	100.0	

Table 6.8: Do you work with clients from Culturally and Linguistically Diverse (CALD) communities?

	Frequency	Percent	Valid Percent	Cumulative Percent
Yes	56	93.3	93.3	93.3
Valid No	4	6.7	6.7	100.0
Total	60	100.0	100.0	

6.2.1 Responses to CBT and PCT

This section addresses the first aim of the research, which was to gain insights into the use of CBT and PCT interventions when working with victims of DV from CALD communities. The responses are presented in Table 6.9.

All respondents reported that they respect the racial or ethnic identity of the clients. When asked whether they believe CALD clients understand themselves, 42% leaned 'yes', 30% claimed not to know, and 28% leaned 'no'. Of the respondents, 53% believed that CALD clients were inherently trustworthy, 30% did not know, and 17% said they were inherently untrustworthy (contradicting self reports that they respect CALD clients). Of the respondents, 85% believed that CALD clients were capable of solving difficult problems, but only 47% believed that CALD clients can solve their own problems without direct interference, and approximately 32% did not know, while the remaining 22% said CALD clients needed direct interference. Of the respondents, 55% preferred a direct approach focused on thoughts and feelings, while the remaining 45% were either unsure or did not use this approach. Of the respondents, 93% believed that a non-judgmental standpoint was ideal. All respondents declared

they carefully listened to clients and remained congruent, and 98% believed that trust is the basis of any counselling relationship.

If clients can understand themselves and solve their own problems without direct interference, this aligns with PCT. Only 22% of respondents did not support this therapeutic approach, with characteristics of CBT appearing favoured by the remaining participants. This result is identified as one of the most significant of this study.

Table 6.9: Survey responses on the perception of CBT- or PCT-based therapeutic approach for domestic violence among CALD women

Item	Strongly agree	Agree	I don't know	Disagree	Strongly disagree
I respect the client's racial/ethnic identity.	50 83.33%	10 16.67%	0 0.00%	0 0.00%	0 0.00%
I believe that all CALD clients understand themselves.	9 15.00%	16 26.67%	18 30.00%	16 26.67%	1 1.67%
I believe that all CALD clients are inherently trustworthy.	12 20.00%	20 33.33%	18 30.00%	8 13.33%	2 3.33%
I believe in the client's ability to solve difficult problems.	17 28.33%	34 56.67%	5 8.33%	4 6.67%	0 0.00%
I believe that CALD clients can solve their own problems without direct interference.	8 13.33%	20 33.33%	19 31.67%	13 21.67%	0 0.00%
My approach to helping CALD clients who have experienced domestic violence is direct with a focus on thoughts and feelings that influence behaviours.	4 6.67%	29 48.33%	12 20.00%	15 25.00%	0 0.00%

Item	Strongly agree	Agree	I don't know	Disagree	Strongly disagree
I always maintain a non-judgmental stance with the client.	35 58.33%	21 35.00%	4 6.67%	0 0.00%	0 0.00%
I always listen respectfully to the client and always remain congruent (or genuine).	43 71.67%	17 28.33%	0 0.00%	0 0.00%	0 0.00%
Do you believe trust is the foundation of any counselling relationship?	48 80.00%	11 18.33%	1 1.67%	0 0.00%	0 0.00%

6.2.2 Frontline Workers' Perceptions of Domestic Violence among CALD Women

This section also addresses the first research aim, which was to gain insight into the perception of frontline workers regarding domestic violence among CALD women. The results to the relevant questions are presented in Table 6.10.

It was found that 65% (n=39) of respondents reported that the negative or positive actions of CALD clients who had experienced domestic violence did not diminish their regard for that client, while 18% reported that they don't know. The level of co-operation by CALD clients was rated positively (including moderate) by 87% (n=52) of respondents, while 12% (n=7) reported that they did not know. Regarding whether their services were utilised well by CALD clients, 63% (n=38) agreed and 28% (n=17) responded that there was a moderate utilisation, making a total of 91% (n=55) positive answers. Of the respondents, 75% (n=45) rated the impact of their services on the lives of CALD clients to be good to very good while 18% (n=11) rated it as moderate. Finally, the impact of current government policies on reducing domestic violence was rated as good to moderate by 55% (n=33) of respondents, while 38% (n=23) perceived them as bad or very bad.

Table 6.10: Survey responses on the perception of domestic violence among CALD women

Item	Very good	Good	Moderate	Bad	Very bad	I don't know
The client's actions whether negative or positive will not determine or diminish my regard for that client	22 36.67%	17 28.33%	10 16.67%	0 0.00%	0 0.00%	11 18.33%
In general, how will you rate the level of cooperation of clients from Culturally and Linguistically Diverse (CALD) backgrounds?	15 25.00%	22 36.67%	15 25.00%	1 1.67%	0 0.00%	7 11.67%
In general, how will you rate utilization of your service by clients from CALD backgrounds?	12 20.00%	26 43.33%	17 28.33%	2 3.33%	0 0.00%	3 5.00%
In general, how will you rate the impact of your service on the lives of the clients from CALD communities?	17 28.33%	28 46.67%	11 18.33%	0 0.00%	0 0.00%	4 6.67%
How well will you rate the impact of current government policy on reduction of domestic violence in general (all communities)?	0 0.00%	7 11.67%	26 43.33%	11 18.33%	12 20.00%	4 6.67%

6.3 Test of Normality and Summary Statistics

A Kolmogorov-Smirnov test of normality was conducted on the two CBT-Perception and PCT-Perception scores derived from the survey. The results are summarised in Table 6.11. They indicate that both scores can be assumed to be from a normally distributed population as the significance value is greater than .001. Therefore, the subsequent use of parametric techniques is justified.

Table 6.11: Tests of Normality

	Kolmogorov-Smirnov		
	Statistic	df	Sig.
CBT Perception Score	.102	60	.194
PCT Perception Score	.120	60	.030

Table 6.12 presents the summary statistics for both scores regarding respondents' relative preference for CBT or PCT. The mean scores for the two therapeutic approaches indicate that respondents appear to favour PCT, as it had a higher mean score ($M=2.06$, $SD=0.55$) compared to CBT ($M=1.95$, $SD=0.45$). A test of whether the difference is statistically significant is presented in the subsequent section.

Table 6.12: Descriptive Statistics

	N	Minimum	Maximum	Mean	SD
CBT Perception Score	60	1.00	3.11	1.95	0.45
PCT Perception Score	60	0.60	3.40	2.06	0.55

6.4 Effectiveness of CBT- and PCT-Based Therapeutic Approaches (Paired Samples T-Test)

This section establishes whether there is a statistically significant difference between the perceived effectiveness and preference for CBT or PCT, using a Paired samples T-test (Table 6.13). The results show that there was no statistically significant difference. Thus, the perceived effectiveness and preference for the two therapeutic approaches are similar among frontline workers.

Table 6.13: Paired Samples Test

	Paired Differences					T	df	Sig. (2-tailed)
	Mean	SD	SE of Mean	95% CI of the Difference				
				Lower	Upper			
CBT Perception Score - PCT Perception Score	-.11519	.61182	.07899	-.27324	.04287	-1.458	59	.150

6.5 Association between Respondent Demographics and Preference for CBT- and PCT-Based Therapeutic Approaches

This section examines the association between respondents' demographic characteristics and their preference for either CBT- or PCT-based therapeutic approaches in supporting domestic violence clients from CALD communities. A MANOVA was used to examine the effects of gender, profession, experience, awareness of organisation's guidelines, additional guidelines for CALD, training for working with domestic violence victims from CALD communities, work with domestic violence victims and work with CALD clients. Descriptive cross-tabulated data is presented across Tables 6.16 to 6.24.

The results of the multivariate tests, given in Tables 6.14 and 6.15, did not find any of these factors to be significantly related with a preference for CBT or PCT. However, follow-up tests indicated that the PCT perception score was significantly different based on the respondent's gender ($F(1, 43)=4.278, p<.05$). The mean PCT perception score for females was 1.735 and for males 1.221, indicating that females in this sample prefer PCT more than males. However, the statistically significant difference could be due to the vast majority of participants being female ($n=51$).

The CBT Perception Score was also significantly different by length of work experience ($F(4, 43)=3.559, p<.05$). The mean CBT perception score was highest for respondents with the greatest amount of experience, 20 or more years (2.204). This was followed by respondents with between 5–9 and 10–14 years of experience (1.790, and 1.768, respectively) and then by people with 15–19 years of experience (1.595). The groups with the least preference for CBT were respondents with 0–4 years of experience (1.558). This result implies that there is preference for CBT as a therapeutic approach and the length of work experience of the respondent increases.

Multivariate Test Results

Table 6.14: Multivariate Tests^a

Effect		Value	F	Hypothesis df	Error df	Sig.	Partial Eta Squared	Noncent. Parameter	Observed Power ^d
Intercept	Pillai's Trace	.712	51.968 ^b	2	42.000	.000	.712	103.937	1.000
	Wilks' Lambda	.288	51.968 ^b	2	42.000	.000	.712	103.937	1.000
	Hotelling's Trace	2.475	51.968 ^b	2	42.000	.000	.712	103.937	1.000
	Roy's Largest Root	2.475	51.968 ^b	2	42.000	.000	.712	103.937	1.000
Gender	Pillai's Trace	.124	2.975 ^b	2	42.000	.062	.124	5.950	.548
	Wilks' Lambda	.876	2.975 ^b	2	42.000	.062	.124	5.950	.548
	Hotelling's Trace	.142	2.975 ^b	2	42.000	.062	.124	5.950	.548
	Roy's Largest Root	.142	2.975 ^b	2	42.000	.062	.124	5.950	.548
Profession	Pillai's Trace	.248	1.217	10	86.000	.292	.124	12.171	.592
	Wilks' Lambda	.767	1.194 ^b	10	84.000	.307	.124	11.941	.580
	Hotelling's Trace	.286	1.171	10	82.000	.322	.125	11.709	.569
	Roy's Largest Root	.181	1.555 ^c	5	43.000	.193	.153	7.776	.491
Experience	Pillai's Trace	.285	1.786	8	86.000	.091	.143	14.292	.731
	Wilks' Lambda	.724	1.844 ^b	8	84.000	.080	.149	14.754	.746
	Hotelling's Trace	.370	1.898	8	82.000	.071	.156	15.184	.760

Table 6.14: Multivariate Tests^a

Effect		Value	F	Hypothesis df	Error df	Sig.	Partial Eta Squared	Noncent. Parameter	Observed Power ^d
	Roy's Largest Root	.335	3.603 ^c	4	43.000	.013	.251	14.413	.834
Awareness Organisations Guidelines	Pillai's Trace	.004	.090 ^b	2	42.000	.914	.004	.180	.063
	Wilks' Lambda	.996	.090 ^b	2	42.000	.914	.004	.180	.063
	Hotelling's Trace	.004	.090 ^b	2	42.000	.914	.004	.180	.063
	Roy's Largest Root	.004	.090 ^b	2	42.000	.914	.004	.180	.063
Additional Guidelines CALD	Pillai's Trace	.052	1.142 ^b	2	42.000	.329	.052	2.284	.238
	Wilks' Lambda	.948	1.142 ^b	2	42.000	.329	.052	2.284	.238
	Hotelling's Trace	.054	1.142 ^b	2	42.000	.329	.052	2.284	.238
	Roy's Largest Root	.054	1.142 ^b	2	42.000	.329	.052	2.284	.238
Training Domestic Violence CALD	Pillai's Trace	.064	.706	4	86.000	.590	.032	2.824	.220
	Wilks' Lambda	.936	.701 ^b	4	84.000	.593	.032	2.805	.218
	Hotelling's Trace	.068	.696	4	82.000	.597	.033	2.783	.217
	Roy's Largest Root	.068	1.456 ^c	2	43.000	.244	.063	2.913	.294
Work With Domestic Violence Clients	Pillai's Trace	.010	.204 ^b	2	42.000	.817	.010	.407	.080
	Wilks' Lambda	.990	.204 ^b	2	42.000	.817	.010	.407	.080
	Hotelling's Trace	.010	.204 ^b	2	42.000	.817	.010	.407	.080

Table 6.14: Multivariate Tests^a

Effect		Value	F	Hypothesis df	Error df	Sig.	Partial Eta Squared	Noncent. Parameter	Observed Power ^d
	Roy's Largest Root	.010	.204 ^b	2	42.000	.817	.010	.407	.080
	Pillai's Trace	.023	.494 ^b	2	42.000	.613	.023	.989	.126
	Wilks' Lambda	.977	.494 ^b	2	42.000	.613	.023	.989	.126
Work With CALD Clients	Hotelling's Trace	.024	.494 ^b	2	42.000	.613	.023	.989	.126
	Roy's Largest Root	.024	.494 ^b	2	42.000	.613	.023	.989	.126

a. Design: Intercept + Gender + Profession + Experience + Awareness Organisations Guidelines + Additional Guidelines CALD + Training Domestic Violence CALD + Work With Domestic Violence Clients + Work With CALD Clients

b. Exact statistic

c. The statistic is an upper bound on F that yields a lower bound on the significance level.

d. Computed using alpha = .05

Table 6.15: Tests of Between-Subjects Effects

Source		Type III Sum of Squares	df	Mean Square	F	Sig.	Partial Eta Squared	Noncent. Parameter	Observed Power ^c
Corrected Model	CBT Perception Score	5.694 ^a	16	.356	2.349	.013	.466	37.584	.950
	PCT Perception Score	4.096 ^b	16	.256	.818	.659	.233	13.084	.446
Intercept	CBT Perception Score	14.234	1	14.234	93.948	.000	.686	93.948	1.000
	PCT Perception Score	9.779	1	9.779	31.234	.000	.421	31.234	1.000
Gender	CBT Perception Score	.111	1	.111	.732	.397	.017	.732	.133
	PCT Perception Score	1.340	1	1.340	4.278	.045	.090	4.278	.525
Profession	CBT Perception Score	1.178	5	.236	1.555	.193	.153	7.776	.491
	PCT Perception Score	1.465	5	.293	.936	.467	.098	4.679	.301
Experience	CBT Perception Score	2.157	4	.539	3.559	.014	.249	14.237	.829
	PCT Perception Score	.923	4	.231	.737	.572	.064	2.948	.218
Awareness Organisations Guidelines	CBT Perception Score	.009	1	.009	.061	.806	.001	.061	.057
	PCT Perception Score	.026	1	.026	.082	.776	.002	.082	.059
Additional Guidelines CALD	CBT Perception Score	.311	1	.311	2.054	.159	.046	2.054	.289
	PCT Perception Score	.219	1	.219	.700	.407	.016	.700	.130
Training Domestic Violence CALD	CBT Perception Score	.008	2	.004	.028	.973	.001	.055	.054
	PCT Perception Score	.904	2	.452	1.444	.247	.063	2.888	.292
Work With Domestic Violence Clients	CBT Perception Score	.042	1	.042	.279	.600	.006	.279	.081
	PCT Perception Score	.019	1	.019	.060	.808	.001	.060	.057
Work With CALD Clients	CBT Perception Score	.095	1	.095	.625	.434	.014	.625	.121
	PCT Perception Score	.191	1	.191	.611	.439	.014	.611	.119
Error	CBT Perception Score	6.515	43	.152					
	PCT Perception Score	13.463	43	.313					
Total	CBT Perception Score	239.926	60						
	PCT Perception Score	273.000	60						
Corrected Total	CBT Perception Score	12.209	59						
	PCT Perception Score	17.559	59						

a. R Squared = .466 (Adjusted R Squared = .268)

b. R Squared = .233 (Adjusted R Squared = -.052)

c. Computed using alpha = .05

Estimated Marginal Means

Tables 6.16 to 6.24 present the overall or cross-tabulated means on CBT and PCT perception scores. These are by the various demographic variables explored in this study.

Table 6.16: Grand Mean

Dependent Variable	Mean	Std. Error	95% CI	
			LB	UB
CBT Perception Score	1.783	.184	1.412	2.154
PCT Perception Score	1.478	.264	.945	2.011

Table 6.17: What is your gender?

Dependent Variable		Mean	Std. Error	95% CI	
				LB	UB
CBT Perception Score	Female	1.709	.169	1.368	2.051
	Male	1.857	.232	1.389	2.325
PCT Perception Score	Female	1.735	.243	1.244	2.226
	Male	1.221	.334	.548	1.894

Table 6.18: What is your profession?

Dependent Variable		Mean	Std. Error	95% CI	
				LB	UB
CBT Perception Score	Counsellor	1.919	.153	1.610	2.227
	Social worker	1.654	.327	.995	2.313
	Case worker	1.194	.346	.496	1.892
	Psychologist	1.676	.456	.757	2.596
	Psychotherapist	2.121	.281	1.553	2.688
	Court support/ advocacy	2.135	.276	1.578	2.691
PCT Perception Score	Counsellor	1.826	.220	1.383	2.269
	Social worker	1.151	.470	.204	2.098
	Case worker	1.530	.497	.527	2.532
	Psychologist	1.349	.655	.028	2.671
	Psychotherapist	1.585	.405	.769	2.401
	Court support/ advocacy	1.427	.397	.627	2.226

Table 6.19: How long have you been a member of the profession?

Dependent Variable		Mean	Std. Error	95% CI	
				LB	UB
CBT Perception Score	0-4 years	1.558	.230	1.095	2.021
	5-9 years	1.790	.217	1.352	2.227
	10-14 years	1.768	.182	1.402	2.134
	15-19 years	1.595	.249	1.094	2.097
	20 or more years	2.204	.227	1.746	2.662
PCT Perception Score	0-4 years	1.481	.330	.815	2.147
	5-9 years	1.382	.312	.752	2.011
	10-14 years	1.585	.261	1.059	2.112
	15-19 years	1.263	.357	.542	1.984
	20 or more years	1.679	.326	1.020	2.337

Table 6.20: Are you aware of your organisations' guidelines on dealing with cases of domestic violence?

Dependent Variable		Mean	Std. Error	95% CI	
				LB	UB
CBT Perception Score	Yes	1.803	.186	1.429	2.178
	No	1.763	.216	1.328	2.198
PCT Perception Score	Yes	1.444	.267	.906	1.982
	No	1.512	.310	.886	2.137

Table 6.21: Does your organisation have any additional guidelines for working with people from Culturally and Linguistically Diverse (CALD) communities?

Dependent Variable		Mean	Std. Error	95% CI	
				LB	UB
CBT Perception Score	Yes	1.874	.196	1.479	2.269
	No	1.692	.193	1.302	2.082
PCT Perception Score	Yes	1.554	.282	.986	2.122
	No	1.401	.278	.841	1.962

Table 6.22: Have you received any training on working with victims/survivors of domestic violence specifically from Culturally and Linguistically Diverse (CALD) communities?

Dependent Variable		Mean	Std. Error	95% CI	
				LB	UB
CBT Perception Score	Yes, pre- qualification	1.791	.231	1.324	2.257
	Yes, post –qualification	1.764	.207	1.346	2.183
	No	1.794	.180	1.431	2.158
PCT Perception Score	Yes, pre- qualification	1.470	.332	.800	2.141
	Yes, post –qualification	1.309	.298	.707	1.910
	No	1.655	.259	1.133	2.178

Table 6.23: Do you work with clients who have experienced domestic violence?

Dependent Variable		Mean	Std. Error	95% CI	
				LB	UB
CBT Perception Score	Yes	1.743	.184	1.372	2.114
	No	1.823	.213	1.394	2.252
PCT Perception Score	Yes	1.505	.265	.971	2.038
	No	1.451	.306	.835	2.068

Table 6.24: Do you work with clients from Culturally and Linguistically Diverse (CALD) communities?

Dependent Variable		Mean	Std. Error	95% CI	
				LB	UB
CBT Perception Score	Yes	1.881	.157	1.565	2.197
	No	1.685	.272	1.137	2.233
PCT Perception Score	Yes	1.617	.225	1.163	2.072
	No	1.339	.391	.551	2.126

6.6 Free Response Thematic Analysis

The frontline workers were asked three free-response questions as part of this survey. They were in relation to their programmes and services relevant to CALD communities. They were also asked for suggestions for improvements to these programs, and given opportunity to share additional information.

General responses formed one theme, the responses that mention involvement of a CALD person in any manner (as trainer, interpreter or specialist) was coded into a

second theme, and responses that could be clearly categorised as PCT-related were coded as the third theme. Other client-related responses were coded as CBT because as they contain items related to CBT. All other responses were coded separately and grouped as a last theme. The results are summarised in Table 6.25 with some explanation added as remarks for each item, but a lengthier analysis follows thereafter.

Themes	Number of responses	Remarks
General comments without any mention of CALD community or culture	26	These are relevant to CALD contexts. Participant wrote about the support that they provide to all their client irrespective of the cultural background.
Involvement of a CALD trainer, staff, interpreter, specialist in any manner	14	Each of these respondents belong to an organization which has designated specific roles for their employees belonging to CALD communities.
PCT approach	28	Some of these responses have attributes specific to PCT including attentive listening, non-judgement, and the notion that the women in question have self-actualising tendencies since, as described by Rogers (1959), they only need to be supported to make their own decisions.
CBT approach	17	All responses were not specifically identifiable as CBT-related. Hence, those client-related responses that could not be classified as PCT were categorised as CBT element of CBT exists within these responses (e.g “clients need to be told what to do”).

Themes	Number of responses	Remarks
Others	15	These responses do not fall under any of the above themes. For example, one of the comments which has been classified under this category is “I can't answer that specifically as I don't really have a specific program.”

(Total of PCT + CBT + Others = 60)

Table 6.25: Thematic analysis of free responses to open-ended questions.

Programs and Services within Organisations

Participants were asked to describe aspects of their programs and services they perceived as relevant (or useful) to clients from CALD communities. Three participants did not provide a response. The responses were used to identify the therapeutic approaches used by their organisations to support CALD women. Most responses explored PCT in a variety of ways. There were 28 responses where elements of PCT intervention were evident. Some of the responses that align with PCT include the following themes:

Ownership, Trust and Support

Some responses represented clients as the experts on issues relating to their own lives as they were the ones in best position to know what they wanted. Such as stance gives the option of control of their own lives:

“...we take a supportive approach in working with clients, we give them ownership of their own life as we still know they are the best to know what they really need, even though it might be confusing sometimes for them due to what they are going through, it is still very important to give that option of control over their life at every point in time, we work with them by giving them options”(Response ID: 3515598680).

Other participants mentioned trust and support. They identified the need for clients to be able to identify their own needs and to trust the frontline worker to believe in their capacity:

“Supporting them and the needs that they feel are important to them and doing this either directly or by referring out to other support services and networks and offering resources” (Response ID: 339092900).

One participant focused on supporting the client to be able to plan for their own safety and future:

“... supporting the client to plan for physical and emotional safety and support. Supporting the client to plan and hope for a safe and fulfilling future” (Response ID: 3382048683).

Active Listening and Cultural Respect

Some participants shared the importance of listening to clients, as this helps to understanding them as they talk about their culture and beliefs:

“Respectful listening...Time spent is understanding the client's cultural beliefs re - family violence. Belief in a client's capacity to make good decisions, given appropriate information and support. Awareness of the impact of previous trauma in a current situation of family violence. Education re emotional impact of family violence” (Response ID: 3382048683).

In addition, other participants highlighted the importance of respecting cultural differences and the willingness to learn about their client's culture:

“we respect cultural differences & invite clients to educate us not only of their cultural prospective but also their personal view of their cultural needs, work from a feminist framework, maintain a referral data base for all appropriate CALD organisations & respect an individual's judgement if a cultural referral is appropriate for them or not” (Response ID: 3381853722).

A respondent talked about exploring factors that could have contributed to the client experiencing domestic violence and sensitivity to cultural issues:

“If I am working with a client from another cultural background I take extra care to explore with them the factors affecting them that are cultural in nature. For example, there may be cultural factors influencing certain women in Domestic Violence NOT to leave her husband. My position is to be sensitive to the cultural issues” (Response ID: 3380055168).

One participant mentioned respecting individual differences. They also understood differences in their needs and not taking clients at face value or making assumptions:

“Many of my longer term clients come from CALD communities...I find it best to not make assumptions and work with the individual and/or couple or family and go from there. Every family/couple/individual is different and requires something different from me and I find if I remain curious and stay in the moment with them, (whether from different culture or not) I develop rapport and trust” (Response ID: 3381881516).

Another participant mentioned showing respect for client autonomy and understanding of living across different culture:

“...Respecting the client's autonomy (excepting where mandatory reporting exists) Understanding of living cross culturally Understanding of the migrant experience...”(Response ID: 3380026037).

Based on the responses of participants, themes that support CBT were also analysed. Seventeen responses could be categorised as supportive of CBT, but some overlapped in characteristics of both PCT and CBT and many long responses contained different themes. Some of the themes that support CBT included:

Frontline Workers Claiming to be the Expert

One participant claimed that frontline workers know the cause of the client's issues:

“helping them to understand that many of the issues they are confronting are a result of the different social constructs between their "new" culture in Australia and those of the culture that they "left" (Response ID: 3381943107).

One participant wrote about helping the client to understand their problems and their options:

“... Help them understand their situation and options available to them”
(Response ID: 3366611600).

Another participant identified that it is not simply a case of cultural difference alone but an interplay of other factors:

“I come from a perspective of deep democracy so that within all our cultural or ethnic identities there are a range of collective and individual perspectives. Some individuals have more centrality or are more marginalised than others within their own communities as well as in mainstream culture. Whilst I feel it's important for me to have some prior knowledge of cultural history, I am also conscious of the range of power and privilege differences based on other cultural layers: education, socio-economic status, gender, age, migratory status, mental and physical health, ability/disability” (Response ID: 3381627174).

Two participants stated the importance of trauma-informed therapy by their organisation in supporting CALD victim of domestic violence:

“Effective TRAUMA INFORMED THERAPIES: EMDR, Brainspotting, Somatic Experiencing AND the MATES Resourcing Program” (Response ID: 3383614866).

“...trauma informed generalist counselling, CSA counselling; health promotion addressing the specific needs and interests of local CaLD communities” (Response ID: 3380095409).

No participants identified any challenge in supporting clients from CALD communities. Eight mentioned the employment of CALD frontline workers by their organisations. As examples:

“We are fortunate enough to have staff who are also from culturally diverse backgrounds, who speak a range of different languages...” (Response ID: 3384104237)

“Being a CALD person myself is definitely useful! Our service is also very CALD friendly as we employ lots of counsellors and receptionists from CALD background!” (Response ID: 3381234178).

Frontline workers are sometimes specialists who provide staff education and create staff awareness of CALD cultures:

“We have a CALD specialist worker whose responsibilities include educating us and raising our awareness of the needs of people from CALD backgrounds and informing us about relevant specialist services and agencies” (Response ID: 3626244492).

Some participants mentioned having CALD-specific protocols in their organisation to support their CALD clients:

“...I worked in a CALD specific organisation and we had specific protocol to ensure good service was given to CALD clients” Response ID: 3381881516).

However, one respondent stated CALD-specific services are diminishing:

“Some programs are specifically targeted towards CALD groups however these services are diminishing” (Response ID: 3381793815).

Participants also wrote about using staff that could speak other languages (bilingual or multilingual) in their services to support CALD women:

“We have 2 bilingual [sic] workers one who speaks Cantonese [sic] and Mandarin the other Serbian. This makes a big difference as so many clients are limited in accessing services due to the language barriers” (Response ID: 3380101918).

Some participants mentioned the provision of training for their staff. Others mentioned providing group activities:

“... We have groups and activities that help break the social isolation and other issues that might have come due to their DV experience, we offer counselling and other relevant DV services” (Response ID: 3515598680).

Some activities aim to teach practitioners about the client's culture and to gain their trust:

“My programs are around finding out more about the client & their background using preparing of food, art, bush walks... Ability to gain trust, so we can start the journey of healing & client's ability to find confidence to start again” (Response ID: 3381422480).

Some participants reported that their organisations recognised their limits and sometimes refer clients to other organisations that could support them better based on their specific needs:

“Supporting them and the needs that they feel are important to them and doing this either directly or by referring out to other support services and networks and offering resources” (Response ID: 3390932900).

“Networks with other agencies and cross referrals to other agencies to best meet clients [sic] needs” (Response ID: 3385280788).

It is not possible to categorise some of the responses into distinct themes. However, most respondents clearly preferred PCT over CBT.

Suggestions for Improvement in Programs and Services within Organisations

The second question explored the kinds of improvements participants would recommend within their existing programs and services for CALD communities. Six respondents did not provide any response to this question, four reported that it did not apply to their practice, two wrote they were not sure, and eleven said no improvements were needed.

For the remaining participants, the key emerging themes after coding the responses were training and education, as it was the response of most participants. Some participants proposed other suggestions for improvement too (n=13). Nine respondents mentioned the need for more time with clients and training. One respondent suggested improvement through workshops:

“Training and assistance in when to organise translators/interpreters. Many community workers do not know when to do that. Training on not

making assumptions and stereotypes and more training about how to spot racism” (Response ID: 3381881516).

Four participants suggested that CALD-literacy training be a part of professional development for frontline workers.

“annual staff development days on CALD communities needs” (Response ID: 3381587779).

“Training and supervision for individuals who work in these communities” (Response ID: 3381793815).

“training update on cultural sensitivity promotion in CALD communities” (Response ID: 3381561792).

“further staff training, stronger connections with each local CaLD community and with individuals and families within each community” (Response ID: 3380095409).

Suggestions included drawing from CALD communities for trainers, staff, interpreters or specialists. Two participants proposed training by someone from a CALD background:

“Reviewing conducted by people from a CALD background. Having CALD community members provide training” (Response ID: 3380026037).

Advice and training from CALD workers themselves on appropriate policy and interventions for particular (sic) communities” (Response ID: 3382175839).

One respondent stated they used CALD clients to explain the cultural differences.

“we respect cultural differences & invite clients to educate us not only of re (sic) their cultural prospective (sic) but also their personal view of their cultural needs...” (Response ID: 3381853722).

Participants also mentioned professional development workshops to update frontline workers of current issues on domestic violence and changes in laws and policies on domestic violence:

"...Improvements in my organization perhaps a workshop updating counsellors on the issue at hand and informing us (counsellor) on the legal assistance or legislation that has recently changed for the worse?!"
(Response ID: 3381422480).

One respondent highlighted the importance of training managers and empowering their clients:

"Better training of Managers to help them to be more observant and proactive with staff members who experience this issue. Points of referral and follow up. How to empower those who have suffered DV, educate across all levels of an organisation" (Response ID: 3381048810).

One of the respondents emphasised the importance of trauma-informed care for supporting victims of domestic violence:

"Currently we are doing what needs to be done, and we have recently ensured all staff members get trained in TRAUMA INFORMED CARE [sic], as this is a huge aspect of DV" (Response ID: 3515598680).

Another theme that emerged from the analysis of the free-response question was quality of assessment:

"Increase assessment phase to understand perspectives wholistically as often we are bound by service policies and procedures without incorporating the big picture and impact on outcomes" (Response ID: 3384284716).

One participant expressed the opinion that programs designed to support victims of domestic violence must vary because of different cultural values:

"I can't see how a set 'program' can apply to any and all CALD community individuals? So a blanket fix would be a recipe for failure. Individual

assessment based on past history, genetics, personality, social construct - etc. must be taken into consideration” (Response ID: 3381542047).

Participants also mentioned increasing the workforce by employment of more staff from CALD backgrounds:

“I think that maybe having a list of people who speak languages other than English would be useful for helping people in our community” (Response ID: 3384104237).

“Having information there in many languages especially the dominant languages in the area... Bi-Lingual workers are essential and that is another barrier in itself” (Response ID: 3380101918).

Awareness of Client’s Needs and Available Services to CALD Clients

One participant mentioned being aware of the client’s needs:

“Be mindful of special needs of CALD clients such as restricted visa” (Response ID: 3382188963).

Other participants suggested creating awareness in CALD communities about the support services that are available:

“More awareness within the community for our service. Direct input about improved delivery from these communities” (Response ID: 3381412251).

“Increased advertising within these communities” (Response ID: 3383915848).

Community Support and Preventative Strategy

One participant mentioned preventing domestic violence by educating CALD communities:

“More education in the CALD community on how to prevent domestic violence” (Response ID: 3366611600).

Another respondent mentioned having support of elders within the community to resolve clash between cultural groups in CALD communities:

"...With refugees where there is a cultural clash it is important to be able to understand issues and get the support of elders within community where possible" (Response ID: 3381048810).

There were 26 responses which were more general in nature, however some of these contained CALD-related themes in an implied manner. For instance, one of the comments was:

"We need certainty in funding to continue the work we do" (Response ID: 3380377370).

The need for funding was mentioned as necessary for both CALD and non-CALD victims of domestic violence:

"...We need funding - not just for CALD clients - but for all women in DV" (Response ID: 3380055168).

One of the participants mentioned a need for more workers and employment of more staff:

"more workers better funding..." (Response ID: 3380022827).

One participant mentioned reviewing other approaches that have proved effective in the past:

"It would be good to have available other approaches that have been found to help" (Response ID: 3381961119).

Another respondent mentioned raising cultural awareness of frontline workers:

"...it is important to raise awareness of our own cultural lens our own values as practitioners" (Response ID 3381627174).

The last open-ended question asked participants to provide any additional comments. Some of the responses identified challenges in supporting CALD victims of domestic violence:

"Sometimes it has been difficult to put a safety plan in place for women with D.V as they don't utilise it for many reasons so you can feel powerless and frustrated as a counsellor to make effective change" (Response ID: 3384284716).

"CALD Clients take long to open up due to their cultural boundaries and taboos..." (Response ID: 3383831045).

*"I work with very difficult clients who have experienced domestic violence. I stick with them no matter what their behaviours may be, I stick with them which helps them but I also let them know when they cross the line. Educate clients on how to communicate in better ways. This is hard for clients who have experienced domestic violence as they need to learn how to trust themselves again, due to being so Mind F****d. Sorry for the swearing but this term really covers it for the clients I work with". (Response ID: 3380101918).*

One response identifies the need for programs for offenders:

"...I would like to see a more concerted campaign to make domestic violence an unacceptable behaviour in Australian society with a focus on male offending behaviours. I would also like to see more treatment options for men who wish to change their behaviours, or at the very least some campaign that encourages men to seek professional help" (Response ID: 3383693492).

Other responses reinforced the responses to the other open-ended questions and so are not discussed further (See Appendix 6).

6.7 Summary

Many useful suggestions were made by respondents. They asserted a need for increased time for the assessment phase. This was highlighted as important to ensuring a holistic understanding of CALD perspectives of the problem presented. Other respondents mentioned the possibility of a list of multilingual service providers. Advertisements among CALD communities about organisations and services on offer

could reduce rates of perpetration while educating women about the organisations they could approach for help. Husbands would not be able to withhold this information from victims as it would be public. Respondents also suggested greater availability of information on support services and bilingual workers, reducing problems of confidentiality, the restoration of interpreter services by the government (linked to funding cuts), and the provision of information to communities through letterboxes. Respondents also proposed a preventative strategy by educating CALD communities.

One respondent highlighted the need to address the problems associated with some CALD migrants' visa restrictions. One respondent suggested using CALD workers as a resource for advice and training. This is a useful suggestion. Another important suggestion concerned creating a greater understanding of cultural norms that determine the nature and extent of violence, and the defences available to victims. One respondent proposed that evidence-based guidelines be created. This will require further research into different CALD contexts in Australia. One respondent mentioned a specific policy, but did not elaborate, thus making it difficult to identify the policy that was intended. Some respondents suggested that increasing the availability of publications in different languages may help clients access them without an interpreter. One respondent suggested an existential-phenomenological approach, but the respondent did not elaborate.

Respondents made additional remarks of a broad nature. These concerned the need to reduce the time taken by victims to open up, the need for campaigns to eliminate domestic violence, the creation of more treatment options for men with violent behaviour, the need to listen to CALD clients properly, the possibility that CALD clients do not want to be referred to CALD organisations, the need to ensure that CALD organisations spend the money given to them for the intended purposes only and not to fund religious organisations:

“Currently their (sic) is uncertainty for finding (sic) with a fear that funding will go to religious organisations...” (Response ID: 3380095409).

Implementing these suggestions would improve the effectiveness of support for CALD victims of domestic violence and minimise the harmful effects on victims. Many of these suggestions form part of the recommendations in Chapter 8.

CHAPTER 7 - Discussion

7.1 Introduction

This chapter discusses the findings and interpretations of the results of this study. The extent to which the findings meet the questions, aims and objectives of this research is also examined. To ensure validity, alternative explanations are examined and grounds for selecting explanations are justified.

This research sought to explore the perceptions of frontline workers about domestic violence in CALD communities and their preference for either CBT or PCT therapeutic approaches in their practices. The literature review explored the effect of culture on domestic violence and the deterrents that women from CALD communities encounter in accessing support. The research also investigated the challenges faced by frontline workers while working with diverse cultures and the perceived limitations to level of support offered. Existing programs for domestic violence victims and survivors in other Western countries in comparison to programs in Australia were also explored. How the current studies' findings fare contextualised against this review backdrop is discussed below.

7.2 Domestic Violence against CALD Women, Frontline Workers' Perceptions and Therapeutic Choices

Questions were asked to determine frontline workers' beliefs, and approaches when supporting domestic violence victims from CALD backgrounds. In this study, 93% of respondents (n=56) work with clients from CALD communities. Thus, a significant number are involved in providing assistance for survivors of domestic violence from CALD communities. These services are complex due to the interplay of factors such as community, society and culture.

From the review of the literature, culture, most importantly, was identified as having a predominant influence in the perpetration of domestic violence, and according to WHO (2012) culture and customs are often used to justify the perpetuation of violence toward women. In the same vein, participants in our study were cognisant of the cultural backgrounds of their clients, with 83.33% (n=50) affirming they respect the

client's racial/ethnic identity. The significance of culture was also highlighted in the thematic analysis where respondents indicated that time is taken to understand the client's cultural beliefs of family violence.

Boas (2009) notes that culture has a powerful role in defining the way a woman experiences domestic violence. Every culture has its own unique role from the perspective of family, community and legal frameworks that may affect a woman's ability or determination to end an abusive relationship. In addition, these factors also impact help-seeking behaviour and protection under the law. As women's experience of domestic violence differs by culture, so too does their ability and willingness to seek help which depends on the kinds of challenges they encounter in their bid to leave the abusive relationship.

Challenges may manifest in the form of families and communities, as well as the legal system and services and support availability. There is an increasing effect of cultural diversity of refugees in Australia, including in regard to their cultural beliefs and immigration status on issues usually associated with domestic violence (Pease & Rees, 2008). Living in the Western world presents a set of hurdles for CALD communities, making the women more vulnerable to physical and sexual violence. These issues include seclusion, limited support and social networks, social and economic disadvantage, societal pressure and limited understanding of the rights of victims (Allimant, 2005; Taylor & Putt, 2007).

A significant number of the frontline workers surveyed (55%, n=33) agreed that their approach to helping CALD women who had lived in a domestic violent relationship was to focus on clients' thoughts and feelings that influence their behaviours. Respondents indicated they provide support to domestic violence victims and survivors by giving them ownership of and control over their own lives. Clients are usually presented with options and are encouraged to rectify any social isolation through introduction to groups and activities. This approach supports the underlying philosophy of PCT (Rogers, 1986).

Rogers (1986) focused on promoting each individual's self-actualising tendencies. The foundational belief of PCT is that each of us is able to reach our full potential. The therapist acts as a facilitator, remaining non-directive. Hence, majority of the frontline workers 53.33% (n=32) indicated they respected their clients and also believed in their

capacity to make good decisions thus demonstrating their trust toward clients. This result indicates that they believe all CALD clients are inherently trustworthy. As almost half of the respondent's responses indicated that they do not trust their clients, this could show a bias or racism on the side of the therapist.

According to Seligman (2006), PCT originates from the concept of humanistic psychology, which sees people as competent and independent, possessing the capability to resolve their problems and recognising their capacity to transform their lives positively. Hence, this approach encourages the client to realise his or her own inner resources that can be drawn upon. It is a non-directive method that assumes the person who is seeking therapy will find their own solutions to their problems (Twigg, 2011). PCT begins with the assumption that both therapist and client are reliable, that the capacity to trust resides in everyone, and that everyone has a fundamental and intuitive drive in the direction of useful achievement of their intrinsic potential (Thorne, 1984). PCT-based approaches view clients as being masters of their own experience who have the capacity to fulfil their own growth potential (Mulhauser, 2011). Similarly, responses to questions related to their capacity to make sound decisions indicated that the majority of frontline workers (85%, n=51) viewed their clients as being fully capable of making decisions that would lead to their own growth.

According to Rogers (1986), human beings have a natural tendency to self-actualise. Thorne (2007) states that clients whose lives have been impacted by domestic violence need their therapist to trust this self-actualisation determination. Therapists must help such clients to find solutions to fulfil this goal. Significantly, many domestic violence victims come to the therapist in conditions where their sense of self may have been badly damaged. The problem of domestic violence in CALD society is complex. Hence, the therapist might be more motivated to use PCT with victims from CALD communities. The aim is to restore and develop the victims' sense of self and give them an opportunity to realise the violence experience has negatively impacted their attitudes and behaviour.

During this time, the therapist's positive attitude and respect for the client is critical. Frontline workers benefit from empathy to help them understand the client's perspective (Motschnig-Pitrik & Mallich, 2004). Here, active listening is a useful tool. Another important facet of PCT-based therapeutic approaches is the therapist's

genuineness towards the client, and they may increase this by drawing on their own experiences. There is also a greater degree of emotional involvement for therapists who use PCT compared to those who use CBT.

Regarding the responses to questions relating to respect for clients' ethnic identities and their capacity to make sound decisions, the majority of frontline workers believed their clients are fully capable of making decisions that would lead to their growth. A vast majority (65%, n=39) indicated that client's reactions, whether positive or negative, did not diminish their regard for the client. Mulhauser (2011) writes that when someone is denied acknowledgement and respect, or the acknowledgement is tied to them behaving in a certain way, it may hinder their ability to reach their potential, or they may lose a hold of the meaning of their experience and their potential to blossom in line with that meaning.

Some respondents mentioned modification of their programs and activities for domestic violence victims and survivors. This modification was socio-ecological in terms of influence in order to impact an individual's thoughts, feelings, and behaviours. For example, some programs were specifically designed to get the client to move away from the shame and blame linked with domestic violence victimisation, and some respondents reported it was important for domestic violence clients from CALD communities to contemplate the needs particular to them. This aligns with the finding of Allimant and Ostapiej-Patkowski (2011) who said that domestic violence clients from CALD communities may have insufficient understanding of their rights and needs. Hence, frontline workers may refer their clients to other support services and networks to help them obtain the support they need.

Respondents indicated that while working with CALD domestic violence clients, it is essential for practitioners to respect their autonomy, except wherever mandatory-reporting conditions existed. The client's autonomy and confidentiality were considered key to greater disclosures on the part of the client and of fostering greater mutual trust. Women from CALD communities often may not seek help for domestic violence outside of their own community (WHO, 2013), so the fact that some had sought therapy and were attending follow-up appointments showed that they trusted their therapists over and above the help available within their communities, regardless of barriers such as cultural taboos, financial dependence and immigration issues

facing them (National Plan to Reduce Violence against Women and their children [NCRVWC], 2008, Webster et al., 2019). However, sometimes laws and organisational policies make it mandatory for the therapist or the case manager to report incidents, such as those that could endanger the lives of clients and/or children in their care (Carlson et al., 2020; Child Protection Regulation, 2013; Children and Young Persons Act, 1998). This could constitute an ethical dilemma for frontline workers as reporting incidences of domestic violence may make their clients more vulnerable to domestic violence and discouraging victims from accessing services if they are aware that it could trigger mandatory reporting thereby damaging victim/therapist relationship, disempowering the client and increasing reluctance to seek further help (Carlson et al., 2020)

Frontline workers shared that their regard for their client did not depend on how they conducted themselves, meaning they gave their clients acknowledgement and respect without the enforcement of rigid rules upon them. This gives clients the freedom to flourish to their maximum potential. Respondents stated that their positive regard for their clients would remain constant, regardless of the client's behaviour and attitude. However, this response could have been influenced by the effects of social desirability in which study participants answer survey questions in line with what is considered to be more socially acceptable than what their 'true' response would have been thus projecting a favourable image of themselves (Gaia, 2020).

Mulhauser (2011) states that having the client trust their therapist is not judging them and willing to regard them with respect despite their attitudes and convictions, encourages them to face their problems and continue with therapy in order to achieve an outcome. This relates to the respondents' claim that the utilisation and impact of their services on CALD clients was moderate to very good. It also relates to the claim by some respondents that their CALD clients were long term. This could mean that CALD domestic violence victims were satisfied with the impact of counselling services on their lives and hence were not only utilising the service fully but were also returning to the service for continued support.

Respondents highlighted that they support their clients by trying to understand their perspective and listening respectfully. Respectful listening promotes the feeling of mutual trust (Ragavan et al., 2020; Motschnig-Pitrik & Mallich, 2004) and aids in the

structuring of therapy to meet the client's needs. Respondents also stated that they try to generate awareness and educate clients regarding the emotional impact of trauma. Some CALD clients may not be aware that institutional support is available (Allimant & Ostapiej-Patkowski, 2011). Educating clients about the impact of trauma would increase comprehension of the complexity level and of the matter, which would encourage them to work positively with the therapist toward a solution (Motschnig-Pitrik & Mallich, 2004). They can also be made aware of Australian law and the services available to them.

Overall, the responses indicate that the behavioural approaches frontline workers employ in supporting CALD women commence with an understanding of the clients, including their culture and inhibitions. The approach then moves to addressing the issues identified through the discussion with clients. Clients are offered strategies to deal with domestic violence, suggestions about general aspects of their lives and where to seek additional support. The approach used by frontline workers seems to be effective with respect to victims from CALD communities, as a large proportion of such victims, according to the respondents, continued to seek their support.

7.3 The Relationship between Culture and Domestic Violence in CALD Communities

Providing support for domestic violence victims of CALD background is complex because of the various associated components and risk factors, including community, societal and cultural factors. Henderson and Horne (2018) emphasised the importance of cultural competence to enable clarity of operation.

Consistent with this, 85% (n=51) of respondents in this study signified awareness of their organisation's guidelines on handling domestic violence, while 15% (n=9) were not aware of such guidelines. However, 50% (n=30) of frontline workers stated that their organisation had additional guidelines on supporting domestic violence victims from CALD backgrounds, while the other half were not aware of such guidelines. Almost half the organisations lacked guidelines about supporting domestic violence victims from CALD communities. This could mean either of two things: that no specific guidelines exist, or that the study participants were not made aware of the existence of such guidelines. This could also indicate a lack of sufficient knowledge of CALD

cultures, which limit the ability of frontline workers to support CALD domestic violence victims in their organisations. Of the respondents, 57% (n=34) claimed they had received training, before and/or after qualification, on working with CALD victims. Of these, 17% (n=10) received pre-qualification training and 40% (n=24) received post-qualification training. Of the respondents, 43% (n=26) did not receive any training on working with CALD communities; it may be that such frontline workers are not adequately prepared to handle domestic violence problems in CALD communities.

Respondents who support CALD domestic violence victims/survivors indicated they respected their client's cultural and ethnic identities, and believed in their clients' capacity to make sound decisions toward solving difficult problems. Respecting their client's ethnic or cultural identity, and respecting the client as an individual, helps foster trust and rapport between the counsellor and client. Culture adds complexity to the already complicated issues relating to domestic violence. Culture and ethnicity has prominent significance in the perpetration of domestic violence as they are frequently used as justification for custom that allows perpetuation of violence toward women (Akangbe, 2020; Msheswwe, 2020; Sikweyiya et al., 2020; WHO, 2002). Boas (2009) noted that culture has a powerful role in defining the way a woman experiences domestic violence, and every culture has its own unique stumbling blocks formed by family, community and legal systems that could hamper a woman's capacity and inclination to end a relationship full of abuse and reach out for help and protection under the law.

The existence of economic imbalances between males and females is also a major factor behind the power dynamics that perpetuate domestic violence. Cantalupo et al. (2006) identified four ways by which female's financial dependence on males contributed to domestic violence: (i) a man can be violent to a woman by robbing her money, refusing food, and denying other resources, (ii) Lack of financial resources affects the woman's ability to access paid services, such as lawyers, (iii) these may also discourage women from leaving an abusive relationship, and (iv) factors that predispose to domestic violence, such as family history of violence, personality disorders, substance abuse, individual factors and relationship factors, must also be considered.

A frontline worker who respects the client's culture would take the time and effort to explore the various facets of the client's situation. A good frontline worker customises the support the client requires. This ensures the client can determine the best possible way to remediate their issues. Frontline workers also depend on understanding the background to the client's trauma, as well as her personality and culture (Rees, 2008).

Having bilingual and bi-cultural case managers ensures that clients requiring translation services get the help they need. Eliminating the language barrier makes it easier for people from CALD communities to develop trusting relationships with their case managers. Communicating in the same language facilitates the perception that both the counsellor and client are from the same in-group and have the same aim of healing. One respondent suggested that some activities would be acceptable to people from all cultural backgrounds, however they did not elaborate on the types of such activities.

Some respondents thought that activities designed for clients from all cultural backgrounds would rely on cultural stereotypes. Each client is unique, regardless of whether they belong to a CALD community. One respondent mentioned the tension between treating members of CALD communities in a specific way because there is diversity between and within CALD communities.

In some instances, a domestic violence victim or survivor from a CALD community may not want their culture or community to be taken into account (Ragavan et al., 2020). Some clients from these communities are looking to break free from their cultural backgrounds. According to one respondent, it is essential to listen to the needs of clients especially if they are trying to escape a situation where their culture is not supporting their best interests and the client wishes to take on a new culture, or in small communities where gossip can endanger or create ongoing issues for clients (Beaini & Shepherd, 2022; Ragavan et al., 2020). While culture affects domestic violence, it is essential other factors be considered in each situation, such as power, privilege, education, socio-economic status, migratory status and physical and mental health.

A vast majority of frontline workers indicated that they rated the level of co-operation of clients from CALD communities to be moderate to very good. This co-operation is necessary for the provision of appropriate support. Bonar and Roberts (2006) and

Beaini & Shepherd (2022) point out that CALD women are usually reluctant to disclose domestic violence to authorities or use services. Given that respondents perceived their clients from CALD communities to be co-operative, it would appear that CALD domestic violence victims/survivors who approach counselling services are disclosing sufficient information to counsellors to permit them to design appropriate support plans.

Some noteworthy trends can be seen when revisiting the research questions about the relationship between culture and domestic violence in CALD communities. The results indicate that frontline workers take extra efforts to understand the culture of CALD clients. These findings suggest the need for cultural sensitivity training for frontline workers. Since 93% of respondents support women from CALD communities, offering cultural-awareness training and culture-specific guidelines may improve the therapeutic process. Several studies have emerged in support of culturally competent training for frontline workers (Anita et al., 2010; Caperchione et al., 2013; Chipps et al., 2008; Henderson et al., 2011). Other studies have suggested incorporating cultural-competence training into academic curricula (Merrell et al., 2014; Oh & Kim, 2013; Goddard et al., 2012). Although the effect of culturally competent training on client outcomes has yet to be fully accounted for (Horvat et al., 2014), the lack of data in these papers could be a result of deficiencies in their data collection approach.

CALD domestic violence victims/survivors require culturally sensitive supports that cater to their specific needs. Majumdar et al. (2004) conducted a randomised control trial to examine the effectiveness of culturally sensitive training on service providers' attitudes and the satisfaction of clients from ethnic minority backgrounds. The study showed that cultural sensitivity training improved cultural awareness and communication with ethnic minority clients, leading to increase open-mindedness and better therapeutic outcomes.

Furthermore, McElfish et al. (2017) carried out a cultural competency training program in some CALD communities in the US to evaluate the value of culturally-sensitive training. The researchers administered 1,250 units of in-person training at 25 organisations between 2015 and 2016. Of the participants, 91.2% reported significant increases in knowledge, 86.6% reported improvements in competence and 87.2% reported improvements to their performance. Based on their findings, it is a reasonable

assumption that cultural competence training improves therapeutic outcomes for CALD clients (Alhejji et al., 2015; Canenguez & Nunes, 2016; Govere & Govere, 2016; Henderson & Horne, 2018; Kim & Lee, 2016). Training programs can be developed in consultation with community representatives, to help ensure that cultural-sensitivity training is efficient and specific to each culture.

7.4 The Effectiveness of PCT- and CBT-Based Therapeutic Approaches and Associated Interventions

The responses to the questions on the effectiveness of CBT and PCT showed that frontline workers favoured PCT for CALD domestic violence victims. However, the results did not show sufficient evidence to believe there is a statistically significant difference between the perceived effectiveness and preference for either PCT- or CBT-based therapeutic approaches.

Years of Experience

It was found that frontline workers with 20 or more years of experience had the highest CBT-perception score, whereas respondents with 0–4 years and 15–19 years had the lowest. The relationship between years of experience and therapeutic preference was not well-defined in the results. While the mean CBT-perception score was the highest for respondents with experience of 20 or more years, respondents with 0–4 years had the least preference for CBT and those with 15–19 years closely followed.

Similarly, the PCT-perception score was highest among those with over 20 years of experience, and closely followed by respondents with 10–14 years. The PCT-perception score was lowest among respondents with 15–19 years of experience. Again, there is no clear link between the preference for PCT and experience of the respondent. This suggests that preferences for therapeutic approaches may depend on other factors, and not on years of experience.

Working with Clients with Domestic Violence Experience

According to the data, the PCT-perception score for respondents who worked with clients from CALD communities was higher than those who did not. When the perception scores for PCT and CBT were compared according to whether the respondents provide support for clients from CALD communities or not, the result was

that the use of both CBT and PCT are prevalent among frontline workers, however the PCT-perception score was higher for those who work with CALD clients compared to those who do not. The CBT-perception score was highest for those who had not worked with domestic violence victims.

While comparing perception scores for CBT and PCT, it emerged that respondents who had previously provided support for or were currently supporting clients who had suffered domestic violence preferred PCT. The explanation might be that regardless of emphasising any specific approach in the design of counsellor education, those with hands-on experience may favour the use of PCT more frequently. In other words, CBT may not be a first choice approach in supporting CALD domestic violence victims compared to PCT.

Organisational Guidelines on Domestic Violence

The data shows that the CBT-perception score was highest for participants who had awareness of their organisation's guidelines on handling cases of domestic violence. This indicates that frontline workers conversant with their organisation's guidelines on handling cases of domestic violence prefer to use CBT. Conversely, PCT-perception scores were lowest for respondents who knew of their organisation's guidelines on dealing with domestic violence cases. This could tell that workers who use PCT are not using their organisational guidelines because these guidelines may be considered not appropriate for CALD victims. They are using their practice wisdom instead.

On the other hand, the PCT-perception score was highest for respondents who did not know whether their organisation had specific guidelines for handling cases of domestic violence. This implies that PCT is a preferred therapeutic approach among frontline workers who reported not knowing about their organisation's guidelines for handling cases of domestic than those who were aware of organisational guidelines.

When the perception scores for CBT and PCT were compared, the finding was that the respondents' awareness of their organisation's guidelines on domestic violence determined their preferred therapeutic approach. Those who have an awareness of their organisation's specific guidelines on how to handle domestic violence cases preferred CBT and those frontline workers who were unaware of the same preferred PCT. This raises the question as to whether organisational guidelines for dealing with

domestic violence victims influence the type of therapeutic technique favoured by the frontline worker. Perhaps the content of the organisations' guidelines encourages the frontline workers to follow CBT, while a lack of organisational guidelines encourages the frontline workers to select a PCT-based approach. It is possible that in an unconstrained environment (one that lacks guidelines), frontline workers prefer PCT.

There is also the possibility that context informs whether frontline workers perceive CBT or PCT as the better approach in each situation. Thus, the guidelines may be tools for applying either of these approaches in specific cases. This could mask the effect of organisational guidelines on the selection of approach, which could be strictly context specific.

Guidelines for Working with CALD Communities

The CBT-perception score was highest for respondents who worked for organisations that had additional guidelines for working with CALD people. This indicates that amongst the sample of frontline workers surveyed, those who worked for organisations that had specific guidelines on working with clients from CALD communities preferred CBT.

Similar findings were observed for the PCT-perception scores. The PCT-perception scores were highest for respondents who worked in organisations that had additional guidelines for working with CALD people. These scores were the lowest for respondents who worked in organisations that did not have additional guidelines for working with CALD people.

When CBT- and PCT-perception scores were compared, the findings were mixed. Perception-scores for both CBT and PCT were highest for respondents who worked in organisations that had additional guidelines for working with CALD people. These findings are inconsistent when compared with the findings mentioned in the previous section, which compared the CBT- and PCT-perception scores for respondents whose organisation did or did not have guidelines for supporting CALD domestic violence victims. The results indicate that having organisational guidelines for working with CALD victims is not relevant to the frontline workers' choice of therapeutic approach. The inconsistencies between the results from this and the previous section could be investigated further by way of conducting a dedicated study.

Another possibility is that if the organisational guidelines do not specify the approach to be used for specific needs, the workers are free to choose what they think to be most appropriate or what suits them. For instance, for a given situation for a CALD client, if the guidelines specify the use of PCT, the workers need to use this approach only, even if they prefer CBT. If no such specifications exist, workers could choose what they think is the best depending on their expertise and experience.

Training

The CBT-perception score was highest for frontline workers who received no training on working with CALD domestic violence victims. This implies that although frontline workers had the highest preference for CBT, however, amongst trained workers, those who received pre-qualification training on how to support CALD preferred CBT compared to those who received post-qualification training. The latter group had the lowest CBT-perception score. Those who received post-qualification training on how to support CALD clients had the opportunity to work with domestic violence victims in CALD communities before they received training. Thus, most of them would have had the chance to engage with victims of domestic violence belonging to CALD communities. This also represents a form of 'on-the-job' training. These frontline workers were in a position to explore first-hand the various facets of culture, community, family, and individual experience that make such cases complex. Thus, they may have been in a better situation to decide for themselves that an approach such as CBT would be inadequate to support CALD victims. As discussed above, CALD cultures are often collectivist. Hence, a therapeutic approach that focuses entirely on the individual may not be effective since such clients may require different support needs.

According to the results, the PCT-perception score was highest for respondents who had not received any kind of training on providing support for CALD domestic violence victims. Therefore, these frontline workers preferred PCT. Of the lower perception scores, the lowest were from respondents who had received post-qualification training on providing support for CALD domestic violence victims. This was followed by respondents who had received pre-qualification training. This means that PCT was favoured most by frontline workers who had no training on providing support for CALD domestic violence victims.

Mixed findings result from a comparison of perception scores for CBT and PCT against whether the participants had received training on working providing support for CALD domestic violence victims. The perception scores for CBT and PCT were the highest for frontline workers who had no such training. Perception scores for both CBT and PCT were the lowest for those who had had post-qualification training.

Thus, the question as to whether CBT or PCT ought to be used for victims of domestic violence, either among the general population or CALD communities, does not depend upon whether the worker is trained or not. The question of preference arises only if the training concerns CBT or PCT rather than how to provide client support. This brings the content of training modules into focus. If the training modules do not contain information about CBT and PCT, it may be desirable to include them, including information about their application in different situations, with supporting case studies. However, such training and/or organisational guidelines on the use of CBT or PCT for different contexts attenuates the freedom of workers to adapt different approaches for specific situations. The workers could be tied down to methodologies rather than outcomes.

Overall, respondents reported a preference for an approach that leans toward PCT when working with domestic violence victims belonging to CALD communities. The effectiveness of this approach can be deduced from the fact that the clients' needs are being met enough for them to continue using the services being provided by the frontline workers. The evidence for this can also be found in the responses to the open-ended questions. A majority of participants reported using a therapeutic approach underpinned by the principles of a PCT based therapeutic approach even though the findings were not statistically significant. Further research with a larger sample size is warranted.

7.5 Dimensions of PCT

The questionnaire raised five dimensions to PCT, which have been represented in Figure 7.1. Each of these dimensions is discussed below.

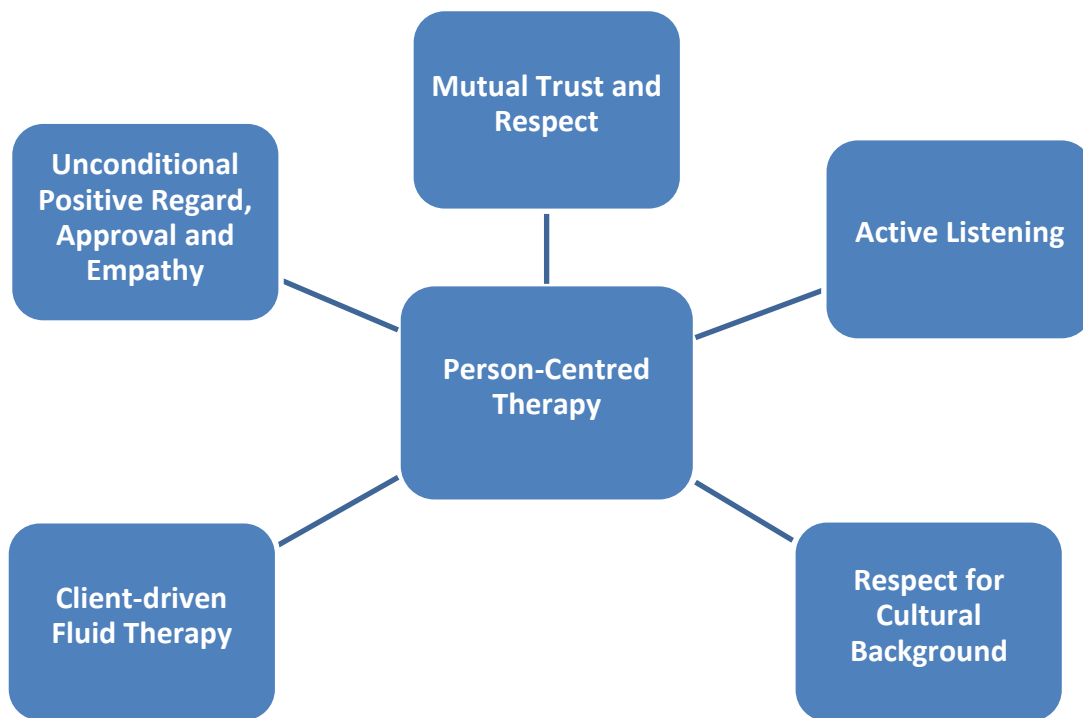


Fig 7.1 Dimensions of PCT

Mutual Trust and Respect

As discussed earlier in this chapter, the responses to the open-ended questions indicate that the majority of respondents respect their clients and believed in their capacity to make sound decisions. Since the respondents felt their clients were utilising their services well, these clients from CALD communities trusted their counsellors enough to remain regular and long-term clients.

PCT is credited to Carl Rogers (1989) who proposed that people possess resources such as self-knowledge and self-learning. Rogers (1956) believed that personalities are adaptive, and that development is possible if the subject is placed in a facilitative environment. The assumption here is that certain environments foster growth and development while others inhibit it (Witty, 2007).

According to Witty (2007), the confidence reposed in the client as the one who determines the process outcome ensures the therapist does not engage in activities such as goal setting or seeking to drive the client-therapist relationship. Furthermore, respecting the client also involves valuing their autonomy and privacy. From our study,

respondents were cognisant of the importance of client confidentiality and client autonomy. They were also aware of mandatory reporting rules.

Respect for Clients' Cultures

According to Woodcock (2006), the emphasis that Canadian and European Americans place on individualism and independence is the remarkable forking in belief and perspectives between many apparent ethnic minority communities and the Western world. This perspective contrasts to the value system (collectivist or interdependent) that is common in CALD communities. Respondents reported that they respected the cultural backgrounds their clients belonged to, and that before commencing therapy they took the effort to understand and explore their client's background.

Warshaw et al. (2013) discuss the cultural dimensions of the individual's experience, including their decision to seek help, and their choices regarding what symptoms and concerns they present to therapists. These factors influence clients from ethnic minority communities' views of their experiences, their decisions, and the manner in which they define violence and how they seek help. Culture influences people's perceptions of the causes and remedies of their situation (Amorin-Woods, 2020; Beaini & Shepherd, 2022; Leong, 2011). It also impacts the client's responsiveness to interventions as well as their access to services. Cultural background and community also have an impact on what clients present to the therapist (Amorin-Woods, 2020; Warshaw et al., 2013). Addressing issues the client is undergoing could sometimes be a challenge to the frontline worker (Amorin-Woods, 2020; Beaini & Shepherd, 2022; Leong, 2011).

According to Kenning et al. (2017), accurate assessment and access to suitable support need is challenging for CALD clients oftentimes as a result of their low English proficiency and the few therapists with clinical skills. In their study, which involved a meta-analysis of the barriers and facilitators to ethnic minorities' access to care, they identified lack of understanding, familiarity and recognition of the available supports as some of the issues. According to the authors, these inadequacies were further complicated by language barriers, which was mentioned as a significant deterrent to acquiring necessary information. They also mentioned other inadequacies of mental health care services for ethnic minorities, including the lack of cultural sensitivity and multiplicity for interacting with multiracial communities.

Many respondents in the present study reported that translation services were available in their organisations. Some reported that their organisations had bilingual, multilingual, and multicultural case managers for those clients who felt more comfortable with them. Some organisations employed counsellors and receptionists from CALD backgrounds. Many of the respondents' organisations offered cultural-sensitivity training that embed CALD perspectives.

CALD is diverse and has several cultures, customs, and distinct spoken languages, each with its own systems of thinking, values, and cosmogeny, there is no single CALD culture (Heine & Nurse, 2000). Also, CALD cultures are neither rigid nor constant; they are ever changing; for instance, compared to older generations, young people from CALD backgrounds generally favour traditional cultural values to a lesser extent (Kpanake, 2018). In addition, everyone has their own specific ways of engaging with the normative values, thought patterns, and social habits as supported by their culture (Kpanake, 2018). Factors that influence how individual engage with his or her one's culture include religion, level of education, beliefs, sexuality, gender, age and environment (Kpanake et al., 2016). Also, many CALD cultures encourage an interpersonal-oriented personhood, whereby a person displays his or her personhood via relationship with different forms of agencies including spiritual (God, ancestors, spirits) that influence the individual; social (family, kinsman, community), with extension to humanity; and self, which accounts for individual's inner experience (Hallen, 2009). This unique kind of self or personhood underpins the concepts of person in some CALD cultures, and affects the perceptions of illness, help-seeking behaviour, and needs and expectations of clients, and has implications for cultural concept of the person for psychotherapy with CALD clients (Kpanake, 2018).

Unconditional Positive Regard, Approval, and Empathy

Unconditional positive regard implies accepting and respecting the client, with insistence on valuing the client as an individual person whose thoughts, affections and beliefs are openly and unconditionally accepted (Amorin-woods, 2020; Gatongi, 2007; Ragavanet al., 2020; Sommers-Flanagan & Sommers-Flanagan, 2004). The theory purports that if the therapist accepts the clients completely, the client can honestly express themselves, develop trust with the therapist and begin to explore their own self-actualisation.

According to the responses to the open-ended questions, most respondents believed in continuing to support their clients from CALD communities regardless of the perceived quality of their behaviour. According to Hudson (2014), people belonging to CALD communities, especially immigrant refugees experiencing conflict-related trauma, are often adversely affected by the new settlement experience (Dow, 2011, as cited in Hudson, 2014). Factors relating to migration impact not only the mental health of immigrants of CALD backgrounds, but also their access to mental health services (Hudson, 2014).

Clients' traumatic experiences can detach them from the truth of realising who they are now (Blackburn, 2005, p. 99). Respondents believed it was important to continue to support victims without the therapist judging them or altering their positive regard for them. The attitude of the frontline worker is central to PCT. They ought to experience and express the three central states of agreement, unreserved positive regard and empathy (Sommers-Flanagan & Sommers-Flanagan, 2004). Frontline workers must genuinely empathise with their clients and show them that their approval of them is unchanging, and independent of their behaviour or background. Most respondents claimed they were empathetic and fixed in their approval for their clients from CALD communities. The acceptance of the clients should stretch out to moment-to-moment changes and inconsistencies demonstrated by the clients even at the therapy sessions (Sommers-Flanagan & Sommers-Flanagan, 2004).

Respectful Listening

Active listening is a valuable skill for therapists. It involves using specific techniques and strategies—body posture, eye contact, verbal tracking and vocal qualities—to effectively listen (Amorin-Woods, 2020; Ragaver et al., 2020; Sommers-Flanagan & Sommers-Flanagan, 2003). Active, empathetic, or respectful listening demonstrates unconditional acceptance of the client and unbiased reflection on the client's experience by the frontline worker (Weger Jr et al., 2010). Through active and respectful listening, the listener tries to comprehend the communicator's cognition of their own experience without the listener's interpretive structures distorting their understanding of the speaker (Weger Jr et al., 2010). Non-judgemental listening allows therapists to decide how best to help the client. Also, when the client observes that the therapist is practicing respectful listening, they are in a better frame of mind to

fully confide in the therapist. The clients might be confused about their feelings and attitudes initially due to the trauma they have gone through, but respectful listening encourages the clients to organise their thoughts about their experiences. This could lead to effective self-realisation as the client is able to identify the problem and then work toward a solution (Lester, 2002). The respondents in the present study believed in the importance of respectful listening.

Client-Driven Fluidity in Therapy

In the present study, respondents who provide support to CALD clients have awareness of the importance of keeping their cultural backgrounds in mind while designing therapeutic programs for these clients. They were aware that most CALD communities had collectivist or communal cultures. This awareness made a significant difference in the way therapy goals could be met. The therapy that would best suit such clients ought to be more fluid in nature, with reduced emphasis on structure and process, and increased emphasis on flexibility and customisation. There is a considerable degree of fluidity and coalescing between Western traditions and CALD cultures that results in intricate and dynamic blend of culture (Mbembe, 2002). An awareness of such a cultural type of personhood or self allows deeper knowledge of the meaning illness, symptom, help-seeking behaviour, and recovery expectations of CALD women (Kirmayer, 2007; Moodley & West, 2005). Fluidity in PCT is characterised by openness to clients accepting their feelings, experiencing things spontaneously and having a free-flowing internal conversation with themselves in addition to the external conversation with the therapist (Tudor et al., 2004). The therapist's openness to the client's experience allows the meaning or significance of each new experience to emerge for clients from within, rather than via a clouded, shrouded or pre-shaped sense that the therapist has made about the client's experience based on their own perceptual biases (Tudor et al., 2004). Open-mindedness is conducive to empathic client-understanding, thus allowing meaning to emerge. Open-minded therapists acknowledge their limits and question the relevance of their own worldview and prior experiences (Tudor et al., 2004).

Respondents to the present study leaned towards PCT more than CBT, the latter being more focused on individualistic goal-setting and decision-making. Although CBT is more structured and organised, it has limited flexibility, which is required to

successfully support CALD domestic violence victims. Limited flexibility reduces the practicality of CBT in many contexts (Bryant et al., 2008; Mendes et al., 2008; Olff et al., 2010; Schottenbauer et al., 2008). Hence, clients from CALD communities are not likely to respond well to CBT (Kar, 2011). Also, it may be illogical to preach behavioural modification to clients from CALD communities when many other factors in their lives may not be modifiable (Otto et al., 2003). However, incorporation of CBT aspects of trauma-focused therapy may be beneficial as they do challenge beliefs about self and others (Seidler & Wagner, 2006).

Trauma-focused therapy is a therapeutic approach that resist re-traumatisation for someone who has experienced trauma by promoting autonomy while minimising distress as they re-live their experience (Doncliff, 2020; Townsend et al., 2020). Trauma informed therapy is bases on the key principles of safety, trustworthiness and transparency, peer support collaboration and mutuality, empowerment, voice and choice, cultural, hisotirical and gender issues (Doncliff, 2020). This therapeutic approach recognises the core value of safety that ensures for safe elaboration of trauma experience as someone describes it in their own autobiographical context (Neelakantan et al., 2019). Some trauma-informed therapeutic approaches incorporate CBT such as REMD (rapid eye movement desensitisation) and Dialectical Behaviour Therapy.

Frontline workers who support CALD domestic violence victims claimed they usually design therapy sessions for their clients in which the client is given the opportunity to identify their issues and the kinds of support they believe they require. A structured, CBT-based therapeutic approach where the therapist tells the client how to map out their thinking processes so as to bring about changes in their lives may not be suitable for these types of clients. The aim of their therapy is to allow clients to self-realise and structure their therapy sessions so as to find answers for their situations.

According to the responses to the open-ended questions, frontline workers believed that if the client was given ownership over her own life, the assumption is that they would become able to identify their own needs. Respondents felt that this approach would be successful. They felt it was essential to give clients the option to take control over their own lives. The respondents perceived that by giving clients the opportunity

to think about their own selves, their families and the cultural influences on their well-being, clients would progress towards self-actualisation.

7.6 Thematic Analysis

As described in Chapters 3 and 5, the themes selected for the purpose of this study were coded and primary themes identified. A total of ten themes were generated:

1. Culture-specific treatment and intervention;
2. Cultural influences on definitions and meanings;
3. Community support;
4. Cognitive Behavioural Therapy: Assumptions and techniques;
5. Cognitive Behavioural Therapy: Gains and losses;
6. Cognitive Behavioural Therapy: Pairing with other interventions;
7. Culturally-sensitive adaptation of CBT;
8. Inadequacies of mental health services for ethnic minority groups;
9. Multicultural barriers to seeking help; and
10. Multicultural competency during counselling training.

The literature review identified that the reviewed articles had divergent views on whether therapeutic approaches such as CBT are effective for clients belonging to CALD backgrounds. Culturally-adapted interventions were perceived to be more effective for clients from these communities; that is, if culture-specific adaptations were made to a traditional therapeutic approach such as CBT, it could become more effective for clients from ethnic-minority communities. Hwang (2009) was of the opinion that traditional therapeutic approaches may have reduced effectiveness if adapted too much to suit the cultural requirements of the clients. Some scholars (Kaslow, 2010; Townsend et al., 2020; Wang & Kim, 2010, Warshaw et al., 2013; Webster et al, 2019) proposed inserting multicultural competencies into counsellor training.

The reviewed articles were not restricted to domestic violence victims from ethnic minority groups. They included studies on clients from different ethnic minority groups

who presented with an array of problems including domestic violence, depression, PTSD, anxiety, intimate partner violence, drug addiction and/or a combination of these. The review ranged widely. It considered the effectiveness of culture-specific treatment and interventions for ethnic-minority clients, such as cultural adaptations to traditional therapeutic approaches. It also considered debates about the connections between multiculturalism and therapy.

The analysis of the relevant articles provided insight about some direct and indirect trends in domestic violence research associated with CALD communities. The direct insights are summarised in Chapter 4. One indirect insight is that there is insufficient research in this area. Some research focused on the efficacy of CBT when applied in the context of CALD domestic violence victimisation. There is deficiency of studies on the efficacy or other kinds of therapeutic techniques. Also, most of the research on ethnic minorities has been conducted on communities in North America; there are limited studies from other parts of the world.

The results revealed diverse findings on the efficacy of therapy when supporting domestic violence victims from ethnic minority communities. The fact that some cultural variations of CBT have translated to better outcomes for some victim groups could be sufficient reason to invest in further research in this area. In the context of Australia's CALD domestic violence victimisation, more research is required into the efficacy of selected cultural adaptations to therapy in Australia.

Adapting US studies to the Australian context suggests that interventions should be culturally adapted and that counsellors should be trained in multicultural competencies. Since clients belonging to CALD communities can present with culture-driven problems, multicultural-competency training would entail improved outcomes for clients. According to Wang and Kim (2010), if the therapist discusses a culturally-sensitive subject such as racial discrimination, especially early in the relationship, it could potentially lead to a negative outlook of therapy, which could stump the relationship between the client and therapist. Multicultural-competency training could reduce the likelihood of this. Another theme that emerged from the present research is that culture has a significant role in how the victims perceive their situation and choose to handle it. Therefore, the efficacy of any therapeutic technique is reliant on the therapists' understanding of the cultural context. There are, however, a variety of

caveats and pragmatic concerns. Mandating multicultural-competency training in tertiary counselling courses would add costs, including financial, temporal and opportunity costs.

Two additional themes emerged from the thematic analysis. The first is that support from the CALD community can encourage the uptake of counselling services for domestic violence victims from CALD communities and also enhance the efficacy of the therapy. The second is that there could be an under-representation of therapists from minority communities. Initiatives can be designed which encourage or incentivise the participation and training of people from ethnic minority communities to work as therapists. This would reduce the need for mandatory multicultural-competency training. This could translate to more effective therapies for CALD domestic violence victims (Dedeigbo & Cocodia, 2016).

Overall, it could be said that the effectiveness of any therapeutic approach in supporting CALD domestic violence victims cannot be evaluated in silos as some of these therapeutic approaches stemmed from Western culture and their development and effectiveness were tested by Researchers and therapist from major ethnics. The results of this study show that various frontline workers involved in the victims' recovery journey including the psychotherapists, educators, service providers, researcher, government agencies and other government bodies need to work together to improve the efficacy of therapy for domestic violence victims from CALD communities.

7.7 How Support Services in Australia for CALD Communities Compare with Services in Other Developed Countries

Chapter 4 reviewed various organisations working with domestic violence victims from ethnic minority communities in the US, UK, Canada and Australia. The purpose of the comparison was to identify gaps, if any, in the services available in Australia and to learn of strategies from these organisations by which to improve the efficacy of support provided by Australian organisations.

Organisations in the US, UK and Canada were usually focused on a specific region such as South Asia, the Middle East, or a specific community such as Arab Americans, African Americans, Iranians or Kurds. Cultural nuances tended to make already-complex domestic violence issues even more complex.

Australia has organisations that work with women from CALD communities and organisations that work with women who have suffered domestic violence. Most of the Australian organisations under examination ran programs focused on training and capacity-building, skill development and settlement issues. They consider a broad range of issues, including domestic violence. Some focused solely on remediating domestic violence, and some had programs for CALD women. There are also organisations that work solely for domestic violence victims from CALD communities (such as InTouch, MWSS). However, these are comparatively few.

Another characteristic of Australian organisations was that some of them (e.g., AMWCHR, MWSC) were religion-focused. Also, Australia has organisations focused on ethnic minorities, immigrants, or CALD communities in general. Although the works of these organisations are important, these broad focuses could limit the specificity of practitioners' expertise, thus adversely affecting the provision of service to their wide variety of clients. These clients belong to different countries and cultures, speak different languages and have different belief systems. Broadly-focused organisations may not have all resources required for every unique case that comes their way, thereby limiting their efficacy.

There are commonalities between organisations on the basis of the kinds of services they offer. Organisations that support domestic violence victims from ethnic minority and refugee communities all offer services such as skills-training and capacity-building, advocacy, counselling, legal advice, refuges or safe houses, access to support services, and sometimes, housing advice and support.

In summary, there are both similarities and differences between support services of Australia and other Western countries. Australian support services focused more on curative and preventative aspects. There are many religion-based support services in Australia, unlike in other countries.

7.8 Frontline Workers' Perceived Challenges in Supporting CALD Women

Although the respondents did not directly mention any challenges in supporting female CALD domestic violence victims, Boas (2009) observed that frontline workers in NSW, and in Australia generally, are confronted with the difficult task of comprehending the multicultural views of domestic violence victims from various CALD backgrounds. This is significant because it helps improve service delivery and be able to increase and expand service delivery to these different immigrant population groups to encourage abuse disclosure, search for protection within the law, and accept emotional support through counselling service (Boas, 2009). Many times, women from migrant and CALD communities belong to cultures and societies in which, if they disclose domestic violence to authorities, they are held responsible for the violence and are insulted, they are also frequently asked to return home and 'be a good wife' (Cantalupo et al., 2006). Such experiences can colour the minds of many CALD victims of domestic violence, making them hesitant to seek counselling, open up during counselling or access other parts of the safety net offered to them.

Domestic violence varies in in different culture, and culture is often used problematically to justify domestic violence in CALD culture. For instance, forced marriage where one or both persons are pressured into a marriage unwillingly and under pressure (physical and emotional) which falls under a form of coercive control (Foreign and Commonwealth Office et al., 2006) is an issue across a wide range of culture however there is no policy that criminalise forced marriage (Chantler et al., 2009). Also, when it comes to domestic violence, physical and sexual violence are often favoured over emotional pressure and coercive control (Chantler et al., 2009). Similarly, honour killing or honour related violence, a form of violence targeting women who are believed to have sinned against a religious-cultural ethos, especially in matter pertaining to sexuality is practiced and justified by some culture and goes unreported to police (Idriss et al., 2011).

The respondents reported that another barrier is the time taken by CALD community clients to open up to their counsellors due to cultural inhibitions, boundaries and taboos. Krung et al. (2002) report that frontline workers had to improvise and make

use of different techniques to get their clients to open up. One respondent in the present study indicated that her way around this problem was to conduct her counselling sessions in a variety of different languages and dialects to facilitate trust and rapport-building with the hesitant client. This strategy is only possible in so far as the client and the therapist are able to speak multiple languages or dialects.

Opinion was divided amongst the respondents to the present study as to whether CALD workers should be used with victims of CALD backgrounds. Some felt that using CALD workers would make it easier for these victims to understand their situations and explore the options available to them. Others felt that though bilingual workers were an asset to any service providing support to domestic violence victims from CALD communities, some clients may hesitate to ask for help if they find workers of their community in the service. The prime insecurity is that someone from their community would find out that they were getting help.

Most respondents suggested that in order to improve the service provided to CALD communities, staff needed more training. Training suggestions included general cultural-sensitivity training and workplace-specific training programs integrating CALD perspectives. Another suggestion was organisation-wide training for staff on CALD communities and their possible needs. Some respondents mentioned having received advice and training from CALD workers themselves on appropriate policies and interventions for particular communities. Another suggestion was having CALD community members provide training. Respondents also discussed the possibility of training more bilingual workers for employment in counselling and case work; none of the respondents acknowledged the opportunity costs and long runway for any such policy response, nor did the respondents detail how such a policy might work in practice. Respondents also advised that training and assistance should be given regarding when to organise translators and interpreters for CALD clients, as according to the respondents, many do not know when to do so. Also, respondents mentioned it was essential that training be given as to the importance of not making assumptions or acting on stereotypes, and on how to spot racism. One organisation had a CALD-specialist trainer on site to train all staff. One respondent suggested that training in multicultural competencies ought to be given to managers and beginner frontline-workers.

Some respondents highlighted that a lack of awareness on the part of CALD victims was also a challenge. These respondents advocated educating these communities about domestic violence prevention and remediation, including information about available support services including welfare payments, housing benefits and legal protections.

One respondent suggested that the assessment phase be increased so that a holistic picture can be derived regarding the client. The participant opined that service policies and procedures that shorten the assessment phase prevented the frontline worker from focusing on the big picture, and that this impacted client outcomes. The respondent did not acknowledge the resourcing issues and opportunity costs associated with such a policy change.

Respondents were sceptical about the applicability of a 'fixed program' for all CALD victims. Sometimes taking only the cultural background of clients into account blinds the therapist to the other factors involved. One of the frontline workers thought that a set program would be a failure without individual assessment and history.

Many of the respondents stated that decreased funding has acted as a barrier to the availability of support services to CALD victims. One respondent felt that the reduction of funding by the government was diminishing services targeted specifically towards women from CALD communities.

According to one respondent, a possible reason for the uptake of drop-in services is uncertainty for funding, with a fear that funding will go to religious organisations as opposed to secular ones. Hence, this respondent was afraid that funds could be channelled into religious fundamentalism and possibly terrorism. This respondent felt that this issue could be mitigated if the government increased the funding to secular organisations.

Most respondents rated the impact of current government policy on the reduction of domestic violence (for all communities) to be moderate, bad or very bad. Most respondents believed current government policies were inadequate.

Overall, frontline workers faced many challenges in supporting domestic violence victims from CALD communities. One challenge is multilingual support. Victims may actively seek CALD therapists, actively avoid them or remain neutral. Avoidance may

stem from the fear of judgement or breaches in confidentiality. Further research could be conducted into this phenomenon, and organisational guidelines and training could be formulated on the outcomes of such research. The other major problem is lack of funding. Lack of funding places limitations on the scope of services that frontline workers can offer to victims of domestic violence from CALD communities. Inadequate collaboration and co-ordination between agencies also reduces frontline workers' ability to work closely together and offer a holistic solution to the victims of domestic violence.

7.10 Summary

In summary, frontline workers continue to draw upon PCT. The data analysis revealed that preference for PCT was dependent on whether frontline workers support domestic violence victims from CALD communities. CBT had limited success with clients from ethnic minority communities. However, PCT may be used in conjunction with other interventions for healing and recovery. The results of the survey and free-response questions point towards the collectivist nature of CALD cultures in general. The transition of CALD clients into individualistic Western cultures may affect their accessing and utilisation of services. Respondents believed that a combination of therapeutic styles, such as trauma-focused therapy, adapting CBT to clients' cultural requirements or designing culturally-sensitive interventions, was more effective for CALD clients. Respondents believed that multicultural-competency training would be beneficial.

Domestic violence victims of CALD heritage may not disclose domestic violence to government officials because of various cultural, familial, economic and migration matters (Dedeigbo & Cocodia, 2016). Hence, only victims already in therapy with service providers were ready to receive help, meaning that the present study is inevitably subject to a degree of reporting bias. In order for therapy to be successful and practicable for such victims, many service providers customise their therapy to the victim's needs (Dedeigbo & Cocodia, 2016). The presumption therein is that the victim has the best understanding of her issues and is therefore best placed to resolve it. In some instances, case managers of a similar background were allocated to make the client feel comfortable. Respondents reported that active listening was

imperative to remediation. Australian support services were similar to those of other countries; however the focus was broad and more on preventative and curative approach. There are also many religion-based support services in Australia.

CHAPTER 8 - Conclusion and Recommendations

8.1 Introduction

This thesis explored CALD women's experience of domestic violence from the perspective of frontline workers and the preferred therapeutic approach in supporting CALD female victims of domestic violence. This chapter discusses the strengths and limitations of the research and the benefits that could be derived from the findings of this research. It also explores current deficiencies in knowledge and possibilities for future study.

From the research survey, data was collected which explored not only the perception and therapeutic supports for CALD domestic violence victims but also the subjective 'voices' of the frontline workers, which included observations, practices, opinions, comments and suggestions concerning the domestic violence. To improve service provision for CALD migrants, some of the recommended areas for consideration by relevant stakeholders are presented in the following section.

8.2 Recommendations

Recommendations for Policy-Makers

Although the Council of Australian Governments endorsed the National Plan to Reduce Violence Against Women and their Children in 2009 (ALRC, 2010), no nationwide strategy to tackle domestic violence for CALD and refugee communities was identified during this research. Policymakers need to keep in mind socio-cultural factors with regard to ethnic minority communities when designing policies and strategies for service-delivery in CALD communities. In their study on obsessive-compulsive disorder (OCD) amongst ethnic minority communities, Kolvenbach et al. (2016) stated that both clinicians and decision-makers must be conscious of the additional barriers CALD clients face in accessing treatment. They also counselled that support interventions must be designed to overcome these socio-cultural factors to encourage help-seeking behaviours among CALD populations.

Logan et al. (2016) studied mental health service access by CALD patients compared to their Australian-born counterparts. They observed a remarkable difference in mental

health service access, use and treatment by CALD communities compared to their Australian-born counterparts. In their study on CALD populations in Canada, Thomson et al. (2015) found that barriers to access and use of services included factors connected to the utilisation of available healthcare services and information resources. These factors are linked to migrant settlement exercise and hurdles of availability of suitable support systems. According to a study conducted in the UK by Memon et al. (2016), people of Black and Minority Ethnicity (BME) require enlightenment and practicable support to increase their cognition of psychological and mental health issues and thus be empowered to resist stigma. Memon et al. (2016) recommended a strong need to boost services accessibility information availability.

According to Green (2017), low socio-economic status is often linked to lack of insurance, transportation, and general access to treatment; these, according to the author, are barriers to ethnic communities accessing services. According to Richman et al. (2007), limitations to accessing services were not the only explanation for ethnic minorities' underutilisation of services (as cited in Green, 2017). According to this study, other barriers such as experiences of discrimination, racial identity and stigma help explain the underutilisation of services. Green (2017) writes that there were other additional factors, such as perceptions and attitudes towards mental health treatment. The above discussion points to the fact that it is vital to comprehend the influence of ethnicity on service use.

To reduce the spread of domestic violence among Australian CALD communities, there is need for a national strategy that addresses the issues above. Such strategies must take into consideration cultural competence. Cultural competence includes a set of compatible conducts, perspectives and policies that converge into a professional network that encourages frontline workers to carry out their duties efficaciously in transcultural situations (NHMRC, 2005; NATSILS, 2017). To be culturally competent, strategies will need to develop frontline workers' capacity to self-assess, value diversity, attain cultural knowledge, be sensitive to inter-cultural dynamics and modify service delivery in such a way that it shows a recognition of cultural multiplicity among and inside cultures (NHMRC, 2005).

Also, in the course of this study, it was identified that the plan adopted by organisations providing support for CALD communities and domestic violence victims in Australia

differs significantly to organisations in other Western countries such as the US, UK, and Canada. It is vital for organisations that provide victim support services to use a holistic approach combining formal and informal activities around cultural integration and supportive counselling, for efficient and successful service provision to CALD communities. Brar-Josan and Yohani (2017) studied refugee youth in Canada and found that a holistic approach improved the wellbeing of clients. This comprises formal and informal activities that facilitated cultural integration and improved sense of belonging, such as linking to relocation services, culture-oriented counselling, support in obtaining mental health referrals, mental health education, provision of circumstantial information and multicultural education.

Along with a holistic approach, it is also essential to customise services to best suit the needs of CALD communities. This would encourage prevention in addition to early intervention, which could lead to more successful service delivery. According to Holloway et al. (2018), holistic, integrated services that incorporate mental health and vocational services are vital for prevention, early intervention and therapies. Holloway et al. (2018) also stated that support for mental health must be customised to individual needs. According to Eliacin et al. (2016), patients from CALD backgrounds could enjoy greater success if they are invited to be actively involved in their treatment.

Many organisations in Australia are fully dependent on government funding. For instance, in NSW, the women's refuge system was impacted by funding cuts in 2014 as part of a radical reform to the homelessness sector. Women's shelters could not re-apply for funding and had to demonstrate that they could provide services to every homeless person in their area. This resulted in services being no longer exclusively available for domestic violence victims. Many shelter workers lost their jobs and many shelters were shut down, changed their names, relocated, or merged with other services. This policy shift resulted in many domestic violence victims having nowhere to turn, and resulted in some homicides (Hill & Cohen, 2015). Reduced funding limits the geographical scope of service provision for domestic violence victims from CALD communities. Alternate avenues of funding, such as sponsorship from companies, are recommended to reduce dependence on the government, which would reduce the adverse effects of budget cuts. Also, a policy must be created that safeguards such organisations from the disconnect between state and federal planning.

According to Hudson (2014), some of the barriers to accessing services for immigrants from CALD community include lack of knowledge, cultural beliefs and stigmatisation from psychological and mental ailments that could arise from domestic violence. These could affect CALD women's willingness to access services. Many researchers agree with the idea that cultural bias, beliefs and values could impact a person's choice to accept mental health support and the way by which their illness is viewed and conceptualised (Dow, 2011; Ham et al., 2011, as cited in Hudson, 2014). Hudson (2014) also pointed to the stigma of domestic violence to those who suffer from psychological or mental health issues which, according to Corrigan and Kristin (2014, as cited in Hudson, 2014), may be more distressing to individuals with these mental illnesses than the illness itself. Hudson (2014) stated that the 'racial' identity of the migrant belonging to a CALD community is immediately obvious through their skin colour, language, and ethnicity; along with this, the mental ill-health manifests itself as the reprehensible or indefensible dilemma.

Community Health Workers (CHWs) could be an avenue for improving CALD victims' access to effective services. According to Gustafson (2017), using CHWs to disseminate interventions among ethnic minorities offers some advantages. It could be a potential means of mitigating the barriers to mental health services, as argued by Hudson (2014). According to Alegria et al. (2018), there have been many creative solutions offered by scholars in the hope of increasing access to services. These include integrating behavioural health services into either community-based or primary care, supplementing the roles of workers through task-shifting (utilising CHWs or peer navigators to offer some services), using technology and e-learning tools to train and monitor newly enlisted providers via the Internet and implementing service delivery at the points of need using mobile clinics, medical vans, or tele-mental health services, rather than having clients travel long distances to access services. These strategies could be explored to increase service delivery and utilisation by CALD women.

Another recommendation to policymakers would be to take the voices of CALD communities into account when designing policies that relate to domestic violence and minority ethnic groups. In recent years, there has been criticism that this was not being done. In 2014, the Australian government came under fire for failing to directly consult the peak body for CALD communities, the Federation of Ethnic Communities' Councils

of Australia (FECCA), in the creation of a national strategy for the reduction of violence in ethnic communities (FECCA, 2015). Policies need to be in place that ensure that people from CALD backgrounds have opportunity to contribute to decisions on policy changes that affect them.

The Australian government developed initiatives to provide more support for domestic violence victims in 2015 by announcing a \$100-million package of measures for the provision of support for women and children prone to domestic violence. This included \$21 million for specific measures directed towards helping Indigenous women and communities. Also, the government reaffirmed its commitment toward developing culturally-effective responses to help address domestic violence. In 2015, the Australian government announced the creation of a family-safety package for newly arrived immigrants to Australia; currently, there is limited available data to assess its effectiveness and utilisation.

In 2016, the Minister for Social Services released a report titled "A Platform for Action". The report highlighted that there was no one-strategy approach for addressing domestic violence. The government has been funding specialist services such as InTouch Multicultural Centre to increase victims' understanding of domestic violence by working with communities and assisting them in accessing support services. According to this report, since many of the new arrivals to Australia had limited understanding of Australian laws, especially pertaining to issues such as family violence, the government is dedicated to providing improved information to orient these immigrants to Australian laws on domestic violence, women's rights, and all available support. As part of its efforts, the government also committed to developing new training for settlement workers so they can better recognise, react and refer people that are experiencing family, domestic and/or sexual assault. These initiatives form part of the above-mentioned \$100million Package announced in 2015. The report also recommends other priority actions such as:

1. Addressing gender inequality in CALD communities;
2. Creating safe and supportive workplace environments for women experiencing violence;

3. Improving data, research and information-sharing in order to generate effective strategies to address violence; and
4. Enabling better integration of community services to ensure victims do not have a sense of loneliness when navigating the complex support systems.

The purpose of this package is to improve frontline support and services, utilise innovative technology to improve women's safety and provide educational resources to change community attitudes towards violence. It may take some time for the effects of the package to be made evident.

This has since progressed to the fourth action plan of the national plan to reduce violence against women and their children 2010 to 2022 which builds on the work that has been done so far by the previous action plan. This action plan is addressed to governments, policy makers, specialist organisations and community sectors and it provides an overview of the national policy's response to reduce violence against women and their children for support services workers and individual that have been affected by one form of domestic violence or the other. The action areas of this plan include primary prevention and early intervention, making reduction of violence everyone's business, trauma-focused support including listening to lived experience and respecting cultural knowledge, gender equality, learning from previous plans and flexibility around approaches to support women and their children. However, there is need for evaluation of the effectiveness of these plans in preventing/reducing domestic violence in CALD communities.

Recommendations for Frontline Workers

It is essential that healthcare professionals and frontline workers provide support for domestic violence victims from CALD communities. Practitioners need to be appropriately educated to empower them to provide effective support to meet their clients' needs.

Addressing domestic violence in CALD communities has three broad elements underpinning it. The first element focuses on altering the moral principle and perspective of the broader society and practitioners who engage with CALD domestic violence victims; the second element focuses on diminishing the elevated risks of exposure to violence for women belonging to CALD communities; the third element is

oriented toward increasing CALD communities' awareness of the issues facing domestic violence victims, which can be financial, legal, psychological and so on.

A major point in international publications relates to the multifarious and multicultural personality of domestic violence among ethnic minorities and the resulting requirement for interdisciplinary and multi-institutional reaction. Hence, in Australia, there is a need to develop fully multidisciplinary and multi-agency responses nationwide to help victims belonging to CALD ethnicities. Unfortunately, there is limited nationwide strategy to tackle domestic violence in CALD communities, and the scope of strategic plans and policies also differ across Australia states and territories.

Evidence confirms the importance of education and training of frontline workers when it comes to effectively supporting domestic violence victims from CALD communities. Multimodal training is recommended for counsellors and psychologists. In their study on Japanese Americans in the US, Teo et al. (2016) found that brief, multimodal gatekeeper education was effective in boosting positive gatekeeper behaviours for prevention of suicidality in suicide-prone ethnic minority Japanese Americans. The authors emphasise that service providers would benefit from applicable education and assistance in initiating effectual communication plan to provide personalised and culture-oriented care (Memon et al., 2016). This could also improve participation of CALD people, improve the establishment and provision of culture-oriented mental health care, boost knowledge of psychological and mental health disorders that could develop from trauma experience and improve the utilisation of services (Memon et al., 2016; The Black, African and Asian Therapy Network, n.d.).

Tan and Denson (2018) also suggest that significant changes are required in psychology training in order to improve mental health service-delivery to CALD communities. Such psychology training in Australia could include bilingual and multilingual psychologists, and enhanced training and competency standards. The authors emphasised that psychologists should support practice in community languages. Tan and Denson (2018) also state that the Psychology Board of Australia and universities need to examine policies and strategies to increasing the admission of CALD people to the psychology profession in Australia.

When exploring therapeutic techniques that work with CALD clients, consideration should be given to the concept of personhood or self from the perspective of the CALD

culture by frontline workers in selecting therapeutic techniques. The notion of self may affect important issues such as mental health, including the meanings given to mental illness, help-seeking behaviours, and recovery outcome expectations. Psychotherapy involves discussion on how to live a normal life, thus its objectives and approaches are bound to specific cultural beliefs of the person (Kirmayer, 2007). If consideration is not given to the specific personhood of the client, the therapists' may be limited in his or her ability to assess and treat patients from culturally diverse backgrounds (Dwairy, 2009; Tseng & Streltzer, 2004). The relationship between the patient's conception of the person and the idea of the person inherent in a therapy practise may be a factor in psychological change (Dwairy, 2009; Kirmayer, 2007). Consideration should be given to awareness of the way that people perceive themselves and employing this perception to formulate psychotherapeutic treatment plan. Such therapy would stress the whole person's reformation, instead of seeking to create an internal reformation of one of the person's components as stated by Kirmayer (2007), Psychotherapy that disregards the patient's internalised concept of themselves runs the risk of leaving them unable to maintain either the social interaction that keeps them alive in society or the cohesive development of their own private experience of themselves.. To ignore how an individual conceptualise the "normal" person is tantamount to misunderstanding CALD patients' needs and expectations (Kpanake, 2018).

Frontline worker should be cognisance of acculturation in their approach and be gentle in their approach. A person can become a culturally significant entity known as a person or an actor in a social domain through the process of acculturation (Hammack, 2015; Kpanake, 2018; Sedikides & Brewer, 2002). Individuals do not exist in isolation; each person exists and thrive in some specific social and cultural backgrounds which shapes individual's ideas about one's and others' personhood, (Martin & Bickhard, 2013). Culture also affects individual actions by its effects on a person's way of being-in-the-world (Kpanake, 2018). A person does not exist by himself or herself but only in relation to a social world (Sedikides & Brewer, 2002). Thus, trying to shape a person construct through dense relationships into an isolated individual is likely to destabilise and weaken the person rather than helping them (Kpanake, 2018). Acknowledging and comprehending the concept of person creates an opportunity opens for ground-

breaking interventions and collaborative care in conjunction with other significant people in the patients' families and communities on their journey to recovering (Kimayer, 2004; Kpanake, 2018).

Summary of Recommendations

In summary, practitioners and policymakers must recognise the experiences and needs of CALD domestic violence victims with reference to their cultural backgrounds, levels of acculturation and integration in the host society. If therapy is to be effective, consideration should be given to factors such as their vulnerabilities, cultural norms, and any cultural barriers to seeking help.

In addressing domestic violence and the therapeutic approaches by frontline workers, the recommendations arising from this study include:

1. Stakeholders should increase their efforts to improve training for frontline workers on understanding the cultural context of CALD communities with respect to domestic violence, since members of CALD communities experience the violence differently to members of Western communities.
2. Proactive outreach services should be developed to address the requirements of vulnerable CALD members. No single agency should have a co-ordination role.
3. A national strategy with increased collaboration and resources should be created to support consistency and best-practice principles.
4. Improved coordination of agencies needs to be achieved to deliver more assistance to CALD domestic violence victims.
5. Using an evidence-based strategy in establishing and implementing government plans and procedures related to domestic violence should be implemented in key agencies across Australia.
6. Stakeholders should aim to improve community awareness regarding different communities that make up Australian society. Also, there should be improved awareness among CALD community members concerning their rights and available support services.

7. Stakeholders should create guidelines, procedures and pathways for staff, while implementing regular case reviews for complex clients. Staff should receive education targeted at their roles and responsibilities within an organisation.
8. Domestic violence victims from CALD communities should receive free services such as legal and financial advice, such that they are not forced to return to the cycle of abuse that may endanger their lives.
9. Australia needs to improve its data collection processes on domestic violence in CALD communities by ensuring that more frequent updating occurs. This may help strengthen strategic planning for services for domestic violence victims.
10. There is need for the development of strategies to monitor and evaluate the effectiveness of programs that have been developed to support domestic violence, especially in CALD community in Australia. This will help to assess the effectiveness of such program and identify gaps in such program as well as opportunity for improvement.

8.3 Strengths of the Study

As discussed in Chapters 2 and 3, this study comes at a time when Australia is experiencing a demographic shift in relation to its population make-up. Australian society is made up of a significant percentage of people from CALD communities. There is the possibility that as the population of CALD communities in Australia increases, the cultural complexity would increase, thus making the problem of domestic violence in these communities increasingly visible. At such a time, this study has pointed toward the current need for training and educating frontline workers to bridge the cultural gap that may exist when supporting domestic violence victims from these communities. If the identified gaps are rectified sooner rather than later, this would ensure that healthcare staff and frontline workers are better equipped to handle the requirements of clients from CALD communities in the future.

Another strength of this study has been the voices of frontline workers who participated in this research, who are already working with domestic violence victims from CALD

communities. By exploring these voices, this research has been able to tap into the opinions, comments, needs and requirements of the people who currently help and support clients from CALD communities. As this information is a direct insight into the requirements of the communities concerned, it is a valuable tool and resource for planning services and policy concerning domestic violence and CALD communities.

This study has focused on the effectiveness of CBT- and PCT-based therapeutic approaches used by frontline workers when supporting clients from CALD communities. Another strength of this study was that some findings reaffirmed those of similar research carried out in other parts of the world. One is that a traditional therapeutic approach, such as CBT, may not be effective for CALD clients. This study found that CBT is not commonly used by frontline workers in Australia for domestic violence victims from CALD communities.

8.4 Lessons Learnt

This research acknowledges that while domestic violence in CALD communities is not a new phenomenon, the demographic shift in Australian population could lead to higher number of people from CALD communities making up the Australian society in the future. In order to make sure that these communities continue to receive suitable support and effective care, it is imperative that systemic changes be brought about at the policy and procedure levels. This requires that voices of frontline workers and CALD clients be taken into consideration.

To be prepared for future population shift, Australian stakeholders should plan on developing stronger and more effective services for domestic violence victims from CALD communities. There is need to focus on the evolution of currently available services for CALD domestic violence victims and survivors.

8.5 Limitations of the Study

This study has explored attitudes to two therapeutic approaches (CBT and PCT) in isolation. Findings revealed that, in practice, there is an overlap between the therapeutic approaches and no clear demarcation exists between them. This thesis did not investigate frontline workers' attitudes to other therapeutic approaches, or combinations thereof. Therapists tend to use an integrative approach when working

with clients in counselling practice. Whilst CBT and PCT are used in conjunction with other approaches, therapists who still use either of these in isolation will find relevance of this research to their practice.

Another limitation to this study has been its inability to explore and address all dimensions of domestic violence that impacts CALD communities in Australia as CALD communities are diverse. The study was focused specifically on the prevalent approaches to therapy that frontline workers use in Australia. Therefore, the conclusions drawn from this research are limited to the suitability of the therapeutic approaches used with clients from CALD communities and the training needs of frontline workers in meeting the peculiar needs and support requirements of CALD domestic violence victims.

Another limitation is that the research did not engage directly with victims of domestic violence. This study relies on third-party opinion to understand the complexities of domestic violence among CALD ethnicities in Australia. Further study may examine the narratives of the domestic violence victims themselves. Such a study could enhance policy development and training, and also provide a comprehension of the peculiar needs and requirements of CALD victims.

Another limitation of the study was the sample size. A sample size of 60 limits the generalisability of the findings. Scales and items selected for the survey served only the limited purpose of measuring the perceptions of frontline workers. Their comparative assessment of CBT and PCT could have been added in the questionnaire, as this was the primary focus.

Also, most of the study participants were female even though convenience and snowballing sampling were used. This could have skewed the results towards a preference for a certain therapeutic approach. Subsequent studies may seek to survey equal numbers of females and males with a larger sample size to determine if gender guided the choice of therapy.

Because the design of the first part of the survey was multiple choice, it was not possible to explore further the answers to these questions as to the variance in the responses to clear confusion and ambiguity in the survey questions. This could have

been responsible for “I don’t know /neutral’ responses to some of the survey questions. There were also ethical constraints due to the sensitive nature of the study.

8.6 Future Research

This research has highlighted the complexities relating to domestic violence among CALD ethnicities and identified a requirement for a co-ordinated national approach to the issue. To progress and evolve from the current situation, it is essential that gaps in research and current policy responses be identified and reduced. This would also act toward identifying the needs of CALD domestic violence victims and survivors and the professionals who encounter them.

Future research should consider the true prevalence of domestic violence among CALD communities in Australia, and the rates of and barriers to help-seeking behaviour from members of these communities. This would assist the formulation of informed policy, and the prevention and management of domestic violence cases. Future researchers may consider individually studying the communities grouped under the term ‘CALD’. Knowledge derived from such research would also help in the future training of frontline workers.

Further research could also examine domestic violence policies and laws pertaining to ethnic minority communities in other countries such as USA, UK, and Canada. This comparison could elucidate areas where policies and laws in Australia could be strengthened.

8.7 Conclusion

In conclusion, the research methodology employed for this study has been successful in generating the findings that the research set out to explore. The study also identified the therapeutic preferences of a sample of frontline workers when supporting CALD domestic violence victims. Furthermore, the study identified the gaps in the current support services available in Australia. It is apparent that an update of strategies is required by organisations providing support to CALD domestic violence victims in Australia. Improved strategies may strengthen available translation services, legal aid and shelters to better support CALD women. This will ensure that CALD domestic violence victims receive appropriate support to lessen the risk of them returning to the

abusive environment, which can endanger their life. As mentioned earlier, domestic violence in CALD communities is an issue which could become more evident in the future as the Australian societal demographic changes. Hence, the mandate at all levels of governance and law enforcement would be to make sure that effective and acceptable resources are available to respond to the evolving situation.

From a policy perspective, as the respondents raised, diminishing resources is posing a problem for the availability and sustainability of services for domestic violence victims from CALD communities. Some respondents reported that funding cuts had reduced the availability of support services.

This study supports the arguments that there is limited knowledge and research at present to inform domestic violence policy for CALD communities in Australia. CALD communities in Australia have limited appropriate identification, intervention and prevention strategies in place with respect to domestic violence. It is hoped that the results of this research will inform policy as well as practice targeting domestic violence among CALD ethnic groups in Australia.

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APPENDICES

Appendix 1



5 June 2014

Dr Ebinepre Cocodia & Ms Oluwatoyin Abiola Dedeigbo
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Dear Ebi and Oluwatoyin,

Reference Number: 014077S

Project Title: "Responding to domestic violence (DV) in culturally and linguistically diverse communities (CALD)."

Your response to the conditions imposed by a sub-committee of the university's Human Research Ethics Committee, has been reviewed and based on the information provided has been assessed as meeting all the requirements as mentioned in *National Statement on Ethical Conduct in Human Research (2007)*. Therefore, I am pleased to advise that ethical clearance has been granted for this proposed study.

All research projects are approved subject to standard conditions of approval. Please read the attached document for details of these conditions.

On behalf of the Human Research Ethics Committee, I wish you well with your study.

Yours sincerely,

A handwritten signature in black ink, appearing to read 'N. Giles'.

Dr Natalie Giles
 Research Ethics Officer
 Research Office

cc: A/Prof Steven Lovell-Jones, Dean, School of Arts & Sciences Sydney

Appendix 2



PARTICIPANT INFORMATION SHEET

PROJECT TITLE: RESPONDING TO DOMESTIC VIOLENCE (DV) IN CULTURALLY AND LINGUISTICALLY DIVERSE COMMUNITIES (CALD): A PERSON CENTRED APPROACH WITH FRONTLINE WORKERS

CHIEF INVESTIGATOR: Dr E. Cocodia

STUDENT RESEARCHER: Oluwatoyin Dedeigbo

STUDENT'S DEGREE: PhD

Dear Participant,

You are invited to participate in the research project described below only if you work with members of cultural and linguistically diverse communities in the area of Domestic Violence.

This project will examine behavioral approaches and perceptions of frontline workers who work with CALD (Culturally and Linguistically Diverse) communities. The aim is to assess whether a Person-Centered approach may impact levels of service and the clients' willingness to seek assistance or safety. A survey of your existing program is also sought within the free response section.

Who is undertaking the project?

This project is being conducted by Dr Ebi Cocodia and will form the basis for the degree of Ms Dedeigbo at The University of Notre Dame Australia, under the supervision of Ebi.

What will I be asked to do?

- Complete a short anonymous online survey.

How much time will the project take?

Approximately 20 minutes

Are there any risks associated with participating in this project?

There are no foreseeable risks as each of the professionals surveyed receive professional supervision in line with professional registration requirements. You may participate by completing the anonymous email survey which protects your identity.

What are the benefits of the research project?

General benefits of this project include assessing what works and what doesn't in our practice and programs for those who have experienced domestic violence in CALD communities.

Can I withdraw from the study?

Withdrawal is not possible after the submission of the completed survey because participants will not be identifiable.

PARTICIPANT INFORMATION SHEET

Will anyone else know the results of the project?

Information collected for this survey will be completely anonymous.

However the study will be published in a relevant counselling journal yet to be decided.

Will I be able to find out the results of the project?

Results of the project will be made available to the membership coordinator at each association and will be published in a relevant counselling journal yet to be decided.

Who do I contact if I have questions about the project?

Dr E Cocodia- Ebinepre.cocodia@nd.edu.au

What if I have a complaint or any concerns?

The study has been approved by the Human Research Ethics Committee at The University of Notre Dame Australia (approval number 014077S). If you wish to make a complaint regarding the manner in which this research project is conducted, it should be directed to the Executive Officer of the Human Research Ethics Committee, Research Office, The University of Notre Dame Australia, PO Box 1225 Fremantle WA 6959, phone (08) 9433 0943, research@nd.edu.au

Any complaint or concern will be treated in confidence and fully investigated. You will be informed of the outcome.

I want to participate! How do I sign up?

You may participate by clicking on the link to the anonymous online survey sent to you.

Yours sincerely,

RESEARCHER NAME/S AND SIGNATURE/S

Dr. E. Cocodia

Ms. O. Dedeigbo

Appendix 3

QUESTIONNAIRE

1. What is your gender?
 - a. Male
 - b. Female

2. What is your profession?
 - a. Counsellor
 - b. Social worker
 - c. Case worker
 - d. Health care worker
 - e. Psychologist
 - f. Other frontline worker (specify)

3. How long have you been a member of the profession?
.....

4. Are you aware of your organisation's guidelines on dealing with cases of domestic violence?
 - a. Yes
 - b. No

5. Does your organisation have any additional guidelines for working with people from CALD communities?
 - a. Yes
 - b. No

Comments

.....
.

6. Have you received any training on working with victims/survivors of domestic violence specifically from CALD communities?

- a. Yes, pre-qualification
 - b. Yes, post qualification
 - c. No
7. Do you work with clients who have experienced domestic violence?
- a. Yes
 - b. No
8. Do you work with clients from culturally and linguistically diverse (CALD) communities?
- a. Yes
 - b. No
9. I respect the client's racial/ethnic identity.
- a. Strongly agree
 - b. Agree
 - c. I don't know
 - d. Disagree
 - e. Strongly disagree
10. I believe that all CALD clients understand themselves.
- a. Strongly agree
 - b. Agree
 - c. I don't know
 - d. Disagree
 - e. Strongly disagree
11. I believe that all CALD clients are inherently trustworthy.
- a. Strongly agree
 - b. Agree
 - c. I don't know
 - d. Disagree
 - e. Strongly disagree

12. I believe in the client's ability to solve difficult problems.

- a. Strongly agree
- b. Agree
- c. I don't know
- d. Disagree
- e. Strongly disagree

13. I believe that CALD clients can solve their own problems without direct interference.

- a. Strongly agree
- b. Agree
- c. I don't know
- d. Disagree
- e. Strongly disagree

14. My approach to helping CALD clients who have experienced domestic violence is direct with a focus on thoughts and feelings that influence behaviours.

- a. Strongly agree
- b. Agree
- c. I don't know
- d. Disagree
- e. Strongly disagree

15. I always maintain a non-judgmental stance with the client.

- a. Strongly agree
- b. Agree
- c. I don't know
- d. Disagree
- e. Strongly disagree

16. I always listen respectfully to the client and always remain congruent (or genuine).

- a. Strongly agree

- b. Agree
- c. I don't know
- d. Disagree
- e. Strongly disagree

17. Do you believe trust is the foundation of any counselling relationship?

- a. Strongly agree
- b. Agree
- c. I don't know
- d. Disagree
- e. Strongly disagree

18. The client's actions whether negative or positive will not determine or diminish my regard for that client

- a. Very good
- b. Good
- c. Moderate
- d. Bad
- e. Very bad
- f. I don't know

19. In general, how will you rate the level of cooperation of clients from CALD backgrounds?

- a. Very good
- b. Good
- c. Moderate
- d. Bad
- e. Very bad
- f. I don't know

20. In general, how will you rate utilization of your service by clients from CALD backgrounds?

- a. Very good
- b. Good
- c. Moderate
- d. Bad
- e. Very bad
- f. I don't know

21. In general, how will you rate the impact of your service on the lives of the clients from CALD communities?

- a. Very good
- b. Good
- c. Moderate
- d. Bad
- e. Very bad
- f. I don't know

22. How well will you rate the impact of current government policy on reduction of DV in general (all communities)?

- a. Very good
- b. Good
- c. Moderate
- d. Bad
- e. Very bad
- f. I don't know

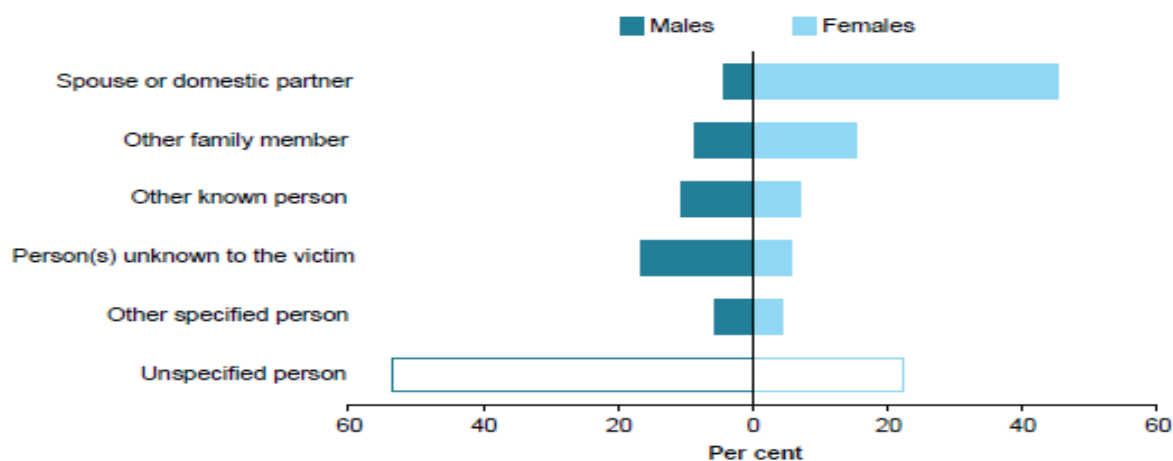
Free Response Section

A. Please tell us what aspects of your programs and services you perceive as relevant (or useful) to clients from CALD communities:

.....
.....
.....
.....
.....

Appendix 4

Figure 1 highlights violence-related hospitalisation in 2014-15.



*Fig1: Violence-related Hospitalisation by reported perpetrator and sex 2014-15
Analysis of National Hospital Morbidity Database by AIHW (Source: AIHW, 2017).*

Figure 2 displays the proportion of women, compared to men, who had been through one form of domestic violence in the 12 months preceding the Personal Safety Survey in 2005, 2012 and 2016.

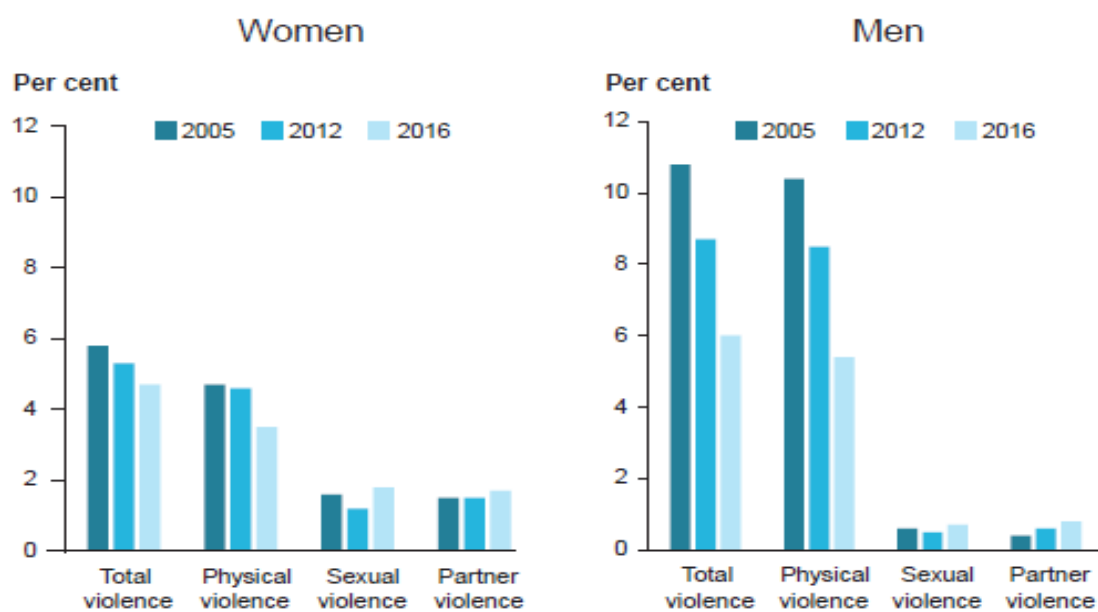


Fig 2: Proportion of women and men who had experience violence in the 12 months before 2005, 2012 and 2016 survey (Source ABS, 2006, ABS, 2017).

Figure 3 displays the sexual violence victimisation rate for women compared to men for all ages between 2010-2016.

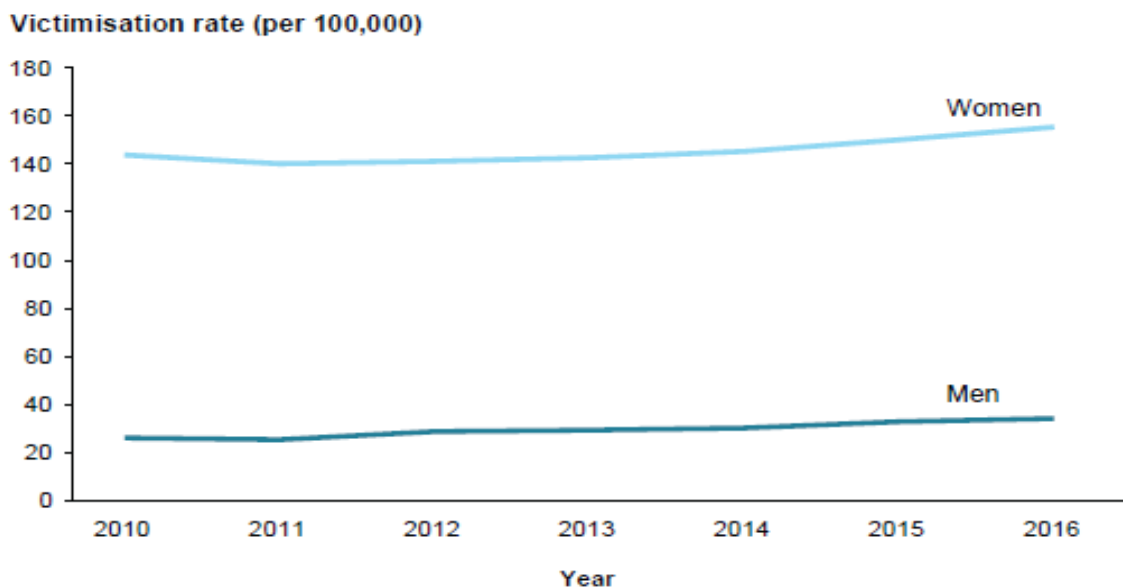


Fig 3: Sexual violence victimisation rate between 2010-2016 (Source: ABS, 2017).

Figure 4 display the prevalence of domestic violence among females across all states and territories in Australia in 2015 according to the ABS.

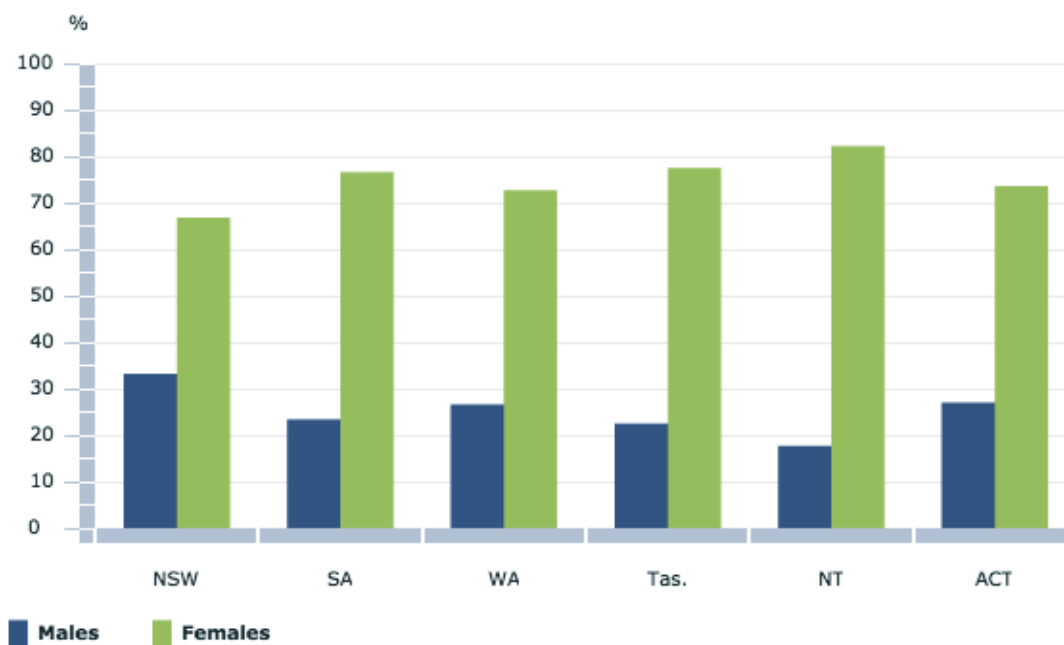


Fig 4: Proportion of victims of domestic violence by sex, selected states and territories (Source ABS 2017)

Figure 5 displays incidents of domestic violence-related homicides between 2012-13 and 2013-14 by location of the homicide.



Fig 5: Domestic homicides incidents by location 2012-13 to 2013-14 (Source: Australian Institute of Criminology NHMP, 2012-14).

Figure 6 displays 2016 reporting of domestic violence to police for support compared to other support networks.

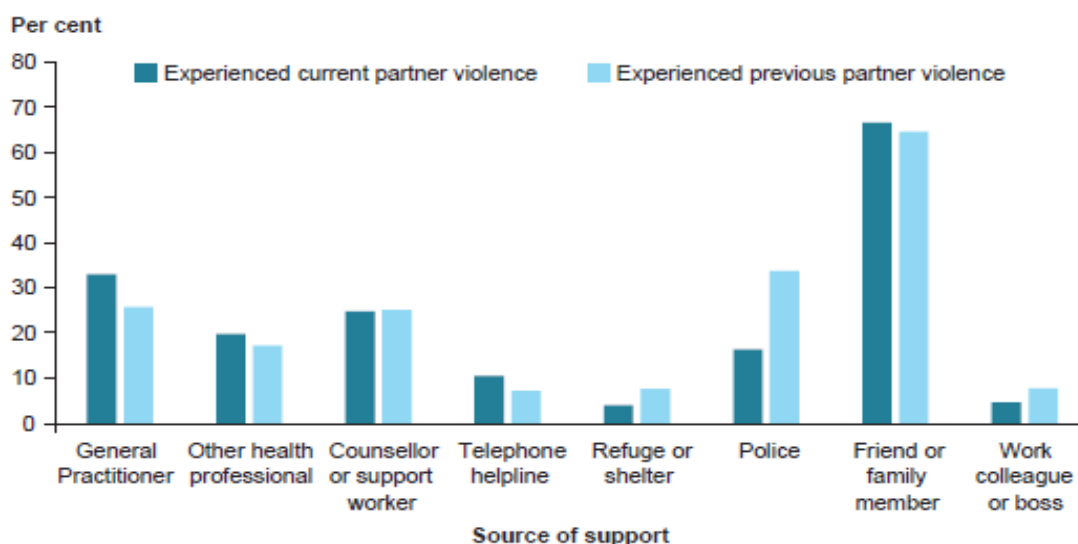


Fig 6: Women reporting/source of advice for domestic violence by sources of advice/reporting 2016 (Source ABS, 2017).

Currently, migration is a major contributor to population growth in Australia (ABS, 2019). The estimate of net overseas migration as at December 2018 was 2.8%

(248,400 people). This number is 6,800 higher than the number recorded in December 2017 (241,700), as shown in Figures 7 and 8 (ABS, 2019).

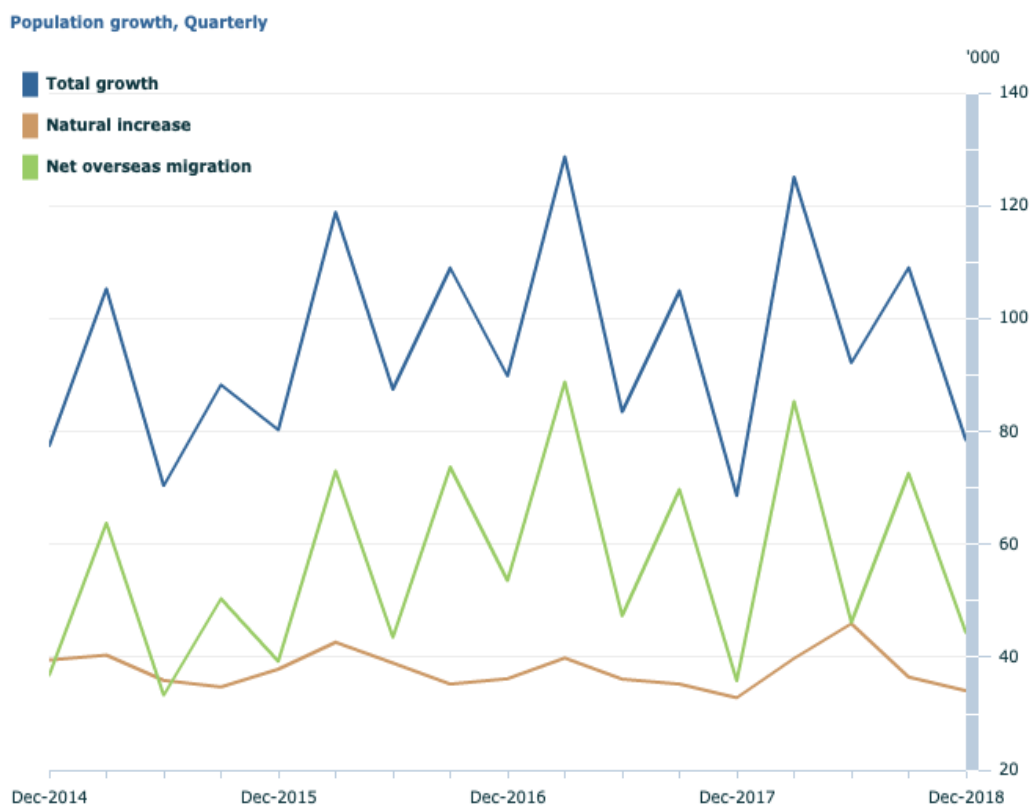


Fig 7: Australia population growth (Source: ABS 2019)

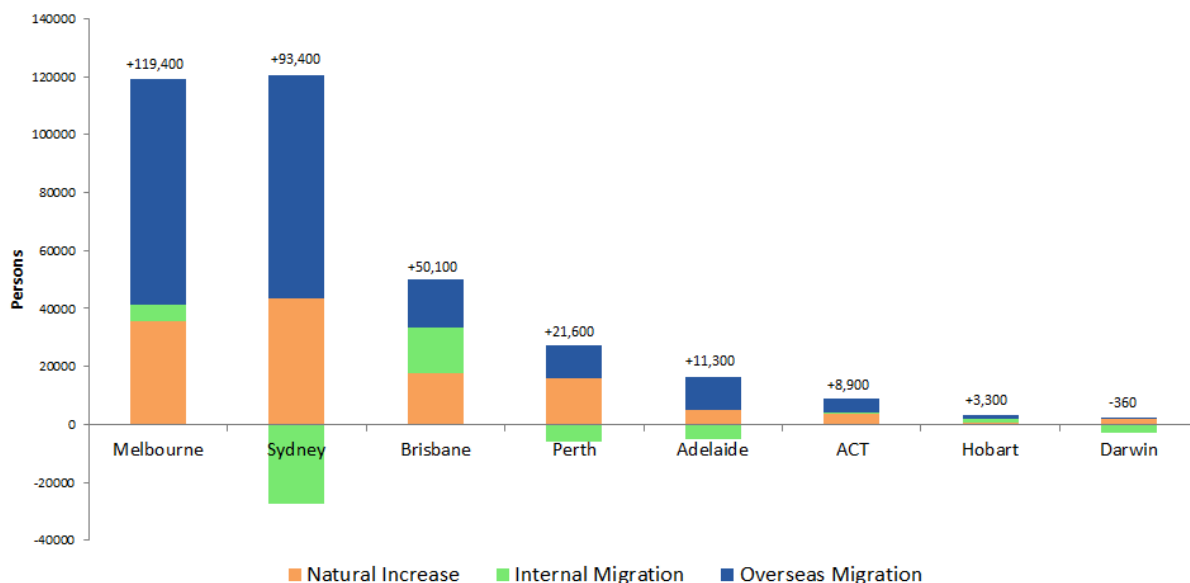


Fig 8: Component of population of capital cities in Australia, 2017-2018 (Source: ABS, 2019).

Figure 9 displays the rate of sexual assault victimisation among women by age group.

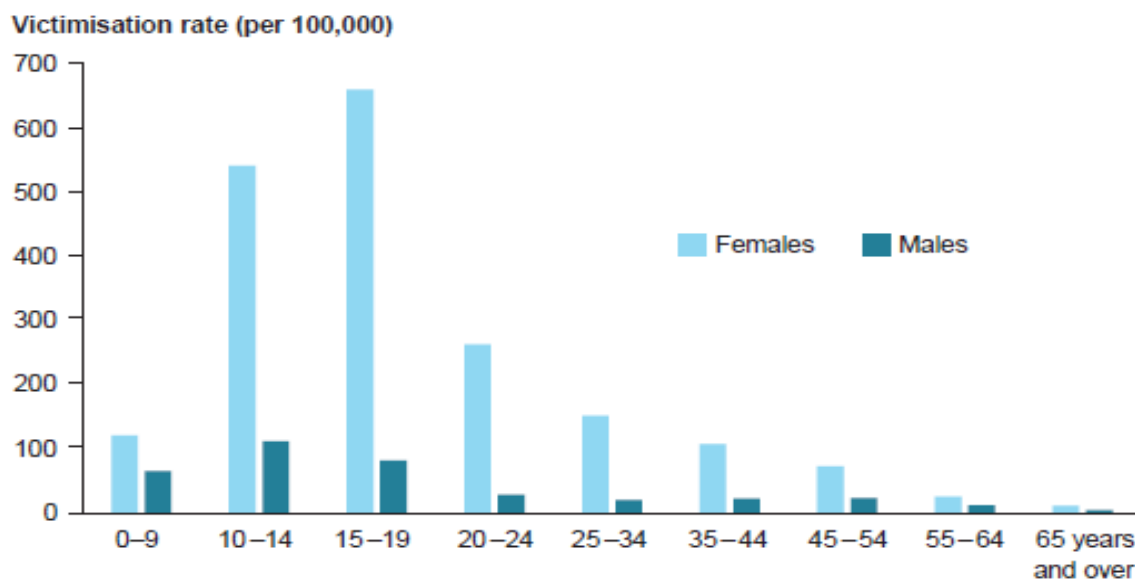


Fig 9: Sexual assault victimisation rate among men and women by age groups (Source: ABS 2017).

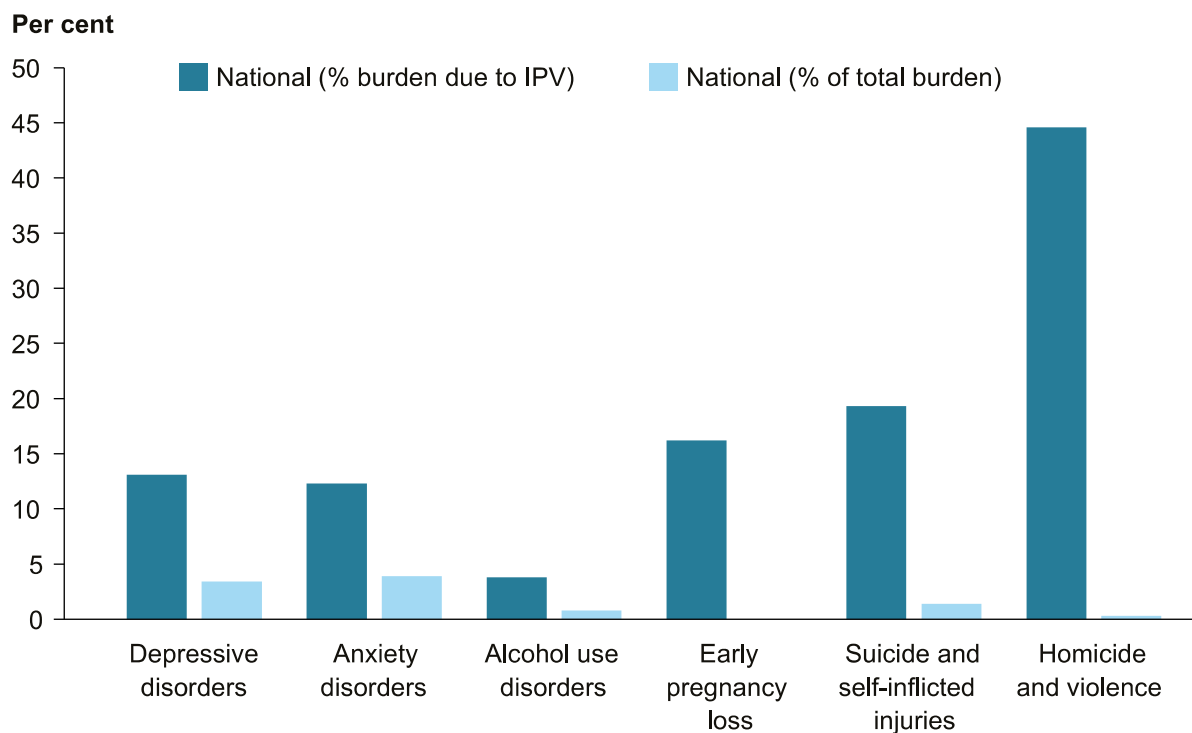


Fig 10: Component of IPV in the burden of each disease in comparison to the percentage the disease makes to the total disease burden for women aged 18 and over, 2011 (Ayre et al., 2016)

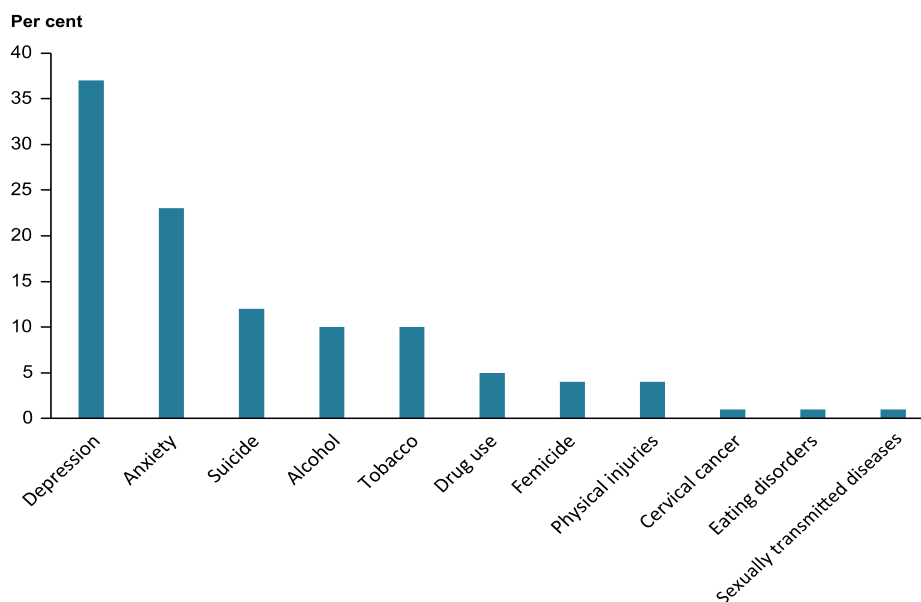


Fig 11: Cost effect of violence on physical and mental health of women by health condition, 2015–16 (Source: KPMG, 2016).

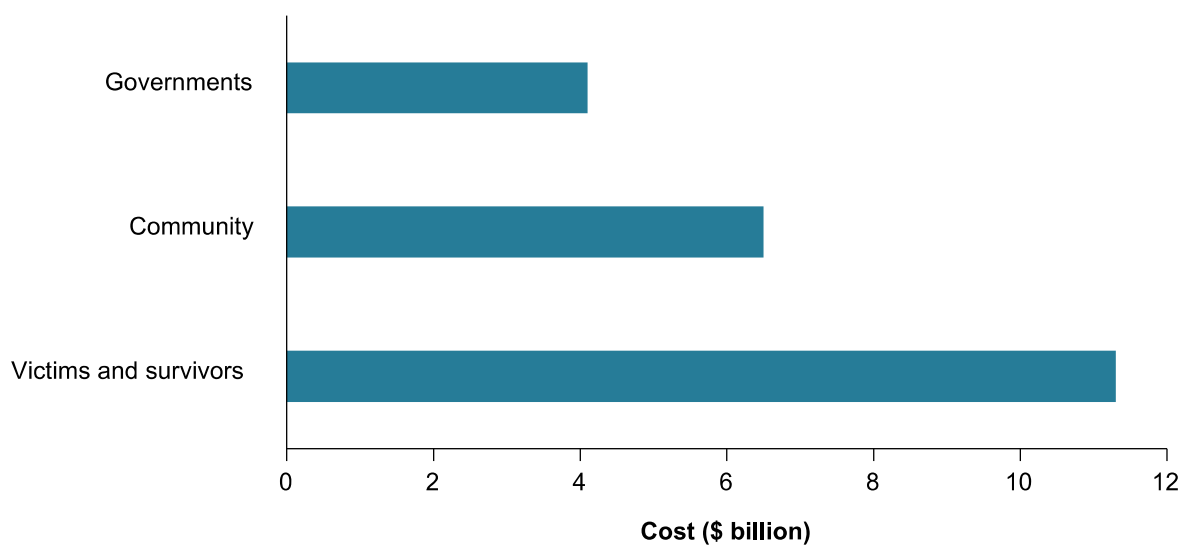


Fig 12: Cost of violence against women and children, 2015–16 (Source: KPMG, 2016).

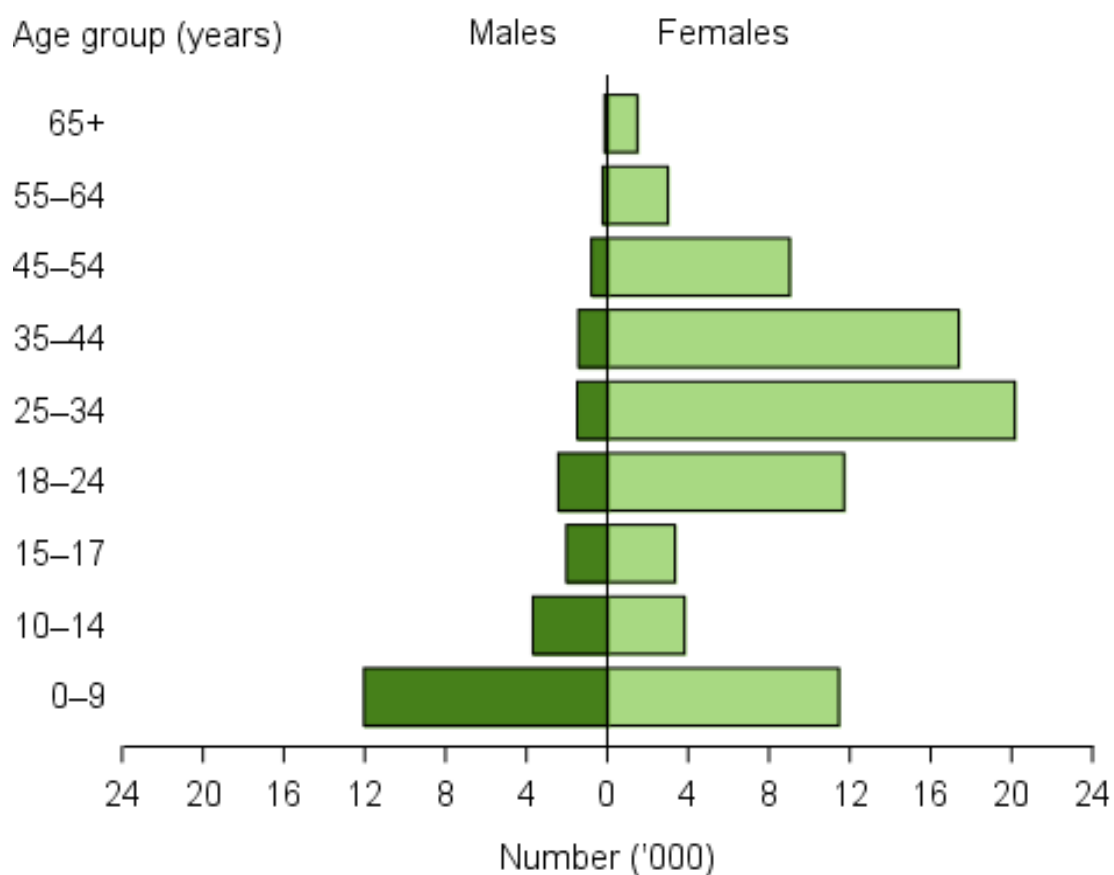


Fig 13: Clients of specialist homelessness agencies who have experienced domestic and family violence by age and sex 2015-16 (Source AIHW 2017).

Figure 14 explains reasons for seeking SAAP assistance in detail.

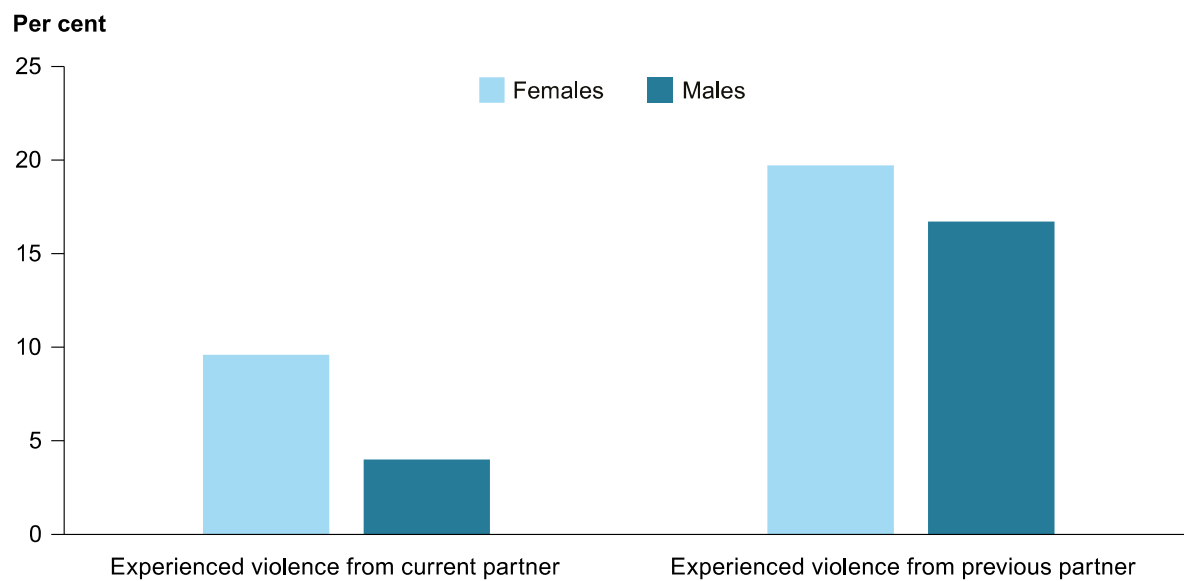


Fig 14: Women that took time off work due to intimate partner violence compared to men, by relationship status, 2016 (Source: ABS, 2017).

Appendix 5

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.603	.709	11

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.658	.744	10

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.743	.762	9

Appendix 6

Question 1	Open-Ended Response
RespondentID	Please tell us what aspects of your programs and services you perceive as relevant (or useful) to clients from Culturally and Linguistically Diverse (CALD) communities:
3626292048	Term of culture quite often misused to explain behaviour, forms of violence against women for CALD Background.
3626244492	We have a CALD specialist worker whose responsibilities include educating us and raising our awareness of the needs of people from CALD backgrounds and informing us about relevant specialist services and agencies.
3575863765	Client focused case management, bilingual staff, program activities that are open to clients from all different cultural backgrounds.
3515598680	My Service is a DV service , and we take a supportive approach in working with clients that we work with, we give them the ownership of their own life as we still know they are the best to know what they really need, even though it might be confusing sometimes for them due to what they are going through, it is still very important to give that option of control over their life at every point in time, we work with them by giving them options. We have groups and activities that help break the social isolation and other issues that might have come due to their DV experience, we offer counselling and other relevant DV services. We have bi lingual / Bi Cultural case managers.
3392540129	Our service prioritises cultural competence and sensitivities. Supplements this stance with training programs drawing on community leaders in the field. Staff are motivated to do the work. And the lens is socio-ecological in terms of its broader influence and impact on individual thoughts, feelings, behaviour. It steps away from a shame, blame, advise giving, expert knowing position re theory of change.
3390932900	Supporting them and the needs that they feel are important to them and doing this either directly or by referring out to other support services and networks and offering resources.
3387470424	Face to face counselling
3385280788	Systems theory allows clients to reflect on their individual, family relationships and cultural influences on their lives and wellbeing. The program employ counsellors with a diverse cultural and language background. Networks with other agencies and cross referrals to other agencies to best meet clients needs.

3384284716	Understanding their trauma background and resilience Understanding what their cultural beliefs and values are in respect to decision making when confronted with dilemmas
3384119638	Addiction counselling in context of displacement & feeling of isolation.
3384104237	We are fortunate enough to have staff who are also from culturally diverse backgrounds, who speak a range of different languages. It really is a very good centre for all sorts of reasons but best of all staff and volunteers are very open to learning about each others' cultures.
3384092673	Counselling
3383985110	Empathy
3383915848	Individual counselling, group work
3383831045	Self Awareness Positive Parenting Program Different types of abuse
3383693492	I worked amongst Maori and Pacific Island communities in New Zealand in a detached youth worker position for 10 years that sensitised and conscientized me to CALD context.
3383614866	Effective TRAUMA INFORMED THERAPIES: EMDR, Brainspotting, Somatic Experiencing AND the MATES Resourcing Program
3382298230	I work with family carers who care for a loved one at home. I support the carer to keep on caring at home as long as possible. I have worked with a number of carers who are first generation migrants or whose parents migrated and they grew up with a strong CALD influence. Most carers have good insight but there are some where their cultural background e.g. arranged marriage has caused ongoing distress which is exacerbated as the partner ages and starts getting signs of dementia.
3382188963	Cooperation with Family Support Team, able to access emergency funding and social work support for court appearance Ability to offer services for free
3382175839	My organisation works entirely with clients from CALD backgrounds and has done so for 26 years
3382134310	counselling information support
3382081302	Culturally sensitive counseling, interpreters, culturally sensitive women's only refuges, specialist women's counseling service and specialist domestic violence counseling
3382067796	N/A
3382048683	Respectful listening. Time spent is understanding the client's cultural beliefs re family violence. Belief in a client's capacity to make good decisions, given appropriate information and support. Awareness of the impact of previous trauma in a current situation of family violence. Education re emotional impact of family violence. Education re NSW and Australian law and services available to assist people impacted by family violence.

	Supporting the client to plan for physical and emotional safety and support. Supporting the client to plan and hope for a safe and fulfilling future.
3382008515	focus on exploration of what culture means and being mindful of making assumptions.
3381993903	...
3381961119	I work wiht students. Thsi gives them an avenue to talk of such matters. Follow up can be initiated if necessary
3381943107	helping them to understand that many of the issues they are confronting are a result of the different social constructs between their "new" culture in Australia and those of the culture that they " left"
3381895302	My current service does not cater for a specific grouping at this stage
3381888878	On call 24/7
3381881516	Counselling couples I work a great deal with domestic violence. At times they may experience domestic violence and be from CALD background. General counselling is also fine for CALD clients. Many of my longer term clients come from CALD communities. As I work in private practice, I find it best to not make assumptions and work with the individual and/or couple or family and go from there. Every family/couple/individual is different and requires something different from me and I find if I remain curious and stay in the moment with them, (whether from different culture or not) I develop rapport and trust. Previously, I worked in a CALD specific organisation and we had specific protocol to ensure good service was given to CALD clients.
3381856783	Not applicable to my practice
3381853722	we respect cultural differences & invite clients to educate us not only of re their cultural prospective but also their personal view of their cultural needs, work from a feminist framework, maintain a referral data base for all appropriate CALD organisations & respect an individuals judgement if a cultural referral is appropriate for them or not. organisation provides on going training for staff re CALD communities & possible needs
3381808816	I always try to gain a rapport and then I also try to link the client in to other services specifically for their culture or ethnicity to broaden the scope and hope of support being accepted.
3381793815	The educations department has ethical guidelines in relation to equal opportunity and does offer access programs to all women from all communities. Some programs are specifically targeted towards CALD groups however these services are diminishing.
3381627174	I come from a perspective of deep democracy so that within all our cultural or ethnic identities there are a range of collective and individual perspectives. Some individuals have more centrality or are more marginalised than others within their own communities as well as in mainstream culture. Whilst I feel it's important for me to have

	some prior knowledge of cultural history. I am also conscious of the range of power and privilege differences based on other cultural layers: education, socio-economic status, gender, age, migratory status, mental and physical health, ability/disability.
3381602750	Counselling services Parenting groups
3381587779	Specific workplace training programs CALD perspectives are integrated into all aspects of teaching
3381561792	counselling services Keeping Kids in Mind post separation parenting group Rollercoasters group for kids a range of counsellors from different cultural backgrounds collaboration with CALD communities
3381542988	Our community links Interpreters Culturally diverse staff Counsellors Training and development
3381542047	My clients are young (Muslim) Uni students - looking to assimilate, understand & rationalise other people's behaviour towards their religiosity. Not so much DV victims. My 'program' focuses on the 'know-thyself' practicum - along with introducing lifestyle assessment & neuropsychotherapy.
3381527055	I am in private practice in Sydney's eastern suburbs.
3381425443	information therapy groups
3381422480	My programs are around finding more about the client & background using preparing of food, art, bush walks... Ability to gain trust, so we can start the journey of healing & client's ability to find confidence to start again.
3381412251	Translation service. People from those communities working within those communities.
3381371976	Sexual health counselling Relationship counselling
3381234178	Being a CALD person myself is definitely useful! Our service is also very CALD friendly as we employ lots of counsellors and receptionists from CALD background!
3381048810	Provision of Counselling for individual and their immediate family (EAP Service) Strong Catholic Mission and Values within organisation that encourages staff to support one another, along with good management of staff in matters that affect them
3380377370	We employ staff from different cultural backgrounds and they have qualifications plus we expect further training We discuss as a group challenges and cultural differences, plus look to our training and experience
3380304610	All
3380124571	Information for support services
3380101918	We have 2 bilingual workers one who speaks Cantonese and Mandarin the other Serbian. This makes a big difference as so many clients are limited in accessing services due to the language barriers. Never mind the cultural aspects and then living in Australia.

3380095409	Casework (bilingual); trauma informed generalist counselling, CSA counselling; health promotion addressing the specific needs and interests of local CaLD communities
3380073311	rapport
3380055168	I am in Private Practice. If I am working with a client from another cultural background I take extra care to explore with them the factors affecting them that are cultural in nature. For example there may be cultural factors influencing certain women in Domestic Violence NOT to leave her husband. My position is to be sensitive to the cultural issues.
3380026037	Generalist counselling Respecting the client's autonomy (excepting where mandatory reporting exists) Understanding of living cross culturally Understanding of the migrant experience Availability of TIS service Working on a 24/7 counselling service
3380022827	Residential treatment one on on counselling Specific CALD program Mens and Womens groups
3379926179	Migrant and refugees Casework/Comunity development services and Language specific Couselling services
3379893986	Access to Interpreters Documents in CALD Languages Access to CALD services at no cost to the client
3366611600	Help them understand their situation and options available to them Provide information on available support service such as social security payment, housing benefit, legal protection and others assistance in accessing the domestic violence provision
Question 2	What kind of improvements would you recommend within your existing programs and services for Culturally and Linguistically Diverse (CALD) communities (if anything)?
3626292048	N/A
3626244492	Probably more time for more training.
3575863765	none.
3515598680	Currently we are doing what needs to be done, and we have recently ensured all staff members get trained in TRAUMA INFORMED CARE, as this is a huge aspect of DV.
3392540129	Continuing Professional development re CALD literacy.
3390932900	-
3387470424	More specific training for staff
3385280788	.
3384284716	Increase assessment phase to understand perspectives wholistically as often we are bound by service policies and procedures without incorporating the big picture and impact on outcomes
3384119638	More refined training

3384104237	I think that maybe having a list of people who speak languages other than English would be useful for helping people in our community.
3384092673	ongoing professional development
3383985110	Unsure
3383915848	Increased advertising within these communities
3383831045	none
3383693492	I can't answer that specifically as I don'y really have a specific program.
3383614866	none
3382298230	Not sure. We have several staff in case management who have themselves grown up in a CALD community and migrated to Australia.
3382188963	Be mindful of special needs of CALD clients such as restricted visa
3382175839	Advice and training from CALD workers themselves on appropriate policy and interventions for particular communities
3382134310	More understanding of cultural norms
3382081302	Evidence or research based guidelines regarding cultures that experience significant levels of domestic violence.
3382067796	N/A
3382048683	A specific policy would be good, I suppose. However, I work as a self employed practitioner within an organisation and the onus is on me to update my professional development and stay informed. I am constantly notified of any training that is available.
3382008515	resources in different languages, targeting minorities for resource and information sending
3381993903	...
3381961119	It would be good to have available other approaches that have been found to help.
3381943107	nothing
3381895302	Not applicable at this stage
3381888878	Further training on Domestic violence
3381881516	Training and assistance in when to organise translators/interpreters. Many community workers do not know when to do that. Training on not making assumptions and stereotypes and more training about how to spot racism.
3381856783	Not applicable

3381853722	none
3381808816	None at this stage. I find it quite rare to have these areas as clients.
3381793815	Training and supervision for individuals who work in these communities.
3381627174	I have trained many counselling and educational groups on principles of deep democracy and feel it is important to raise awareness of our own cultural lens our own values as practitioners.
3381602750	x
3381587779	annual staff development days on CALD communities needs
3381561792	training update on cultural sensitivity promotion in CALD communities
3381542988	None
3381542047	I can't see how a set 'program' can apply to any and all CALD community individuals? So a blanket fix would be a recipe for failure. Individual assessment based on past history , genetics, personality, social construct - etc. must be taken into consideration.
3381527055	-
3381425443	n
3381422480	I am always looking for improvements in my practice. Improvements in my organization perhaps a workshop updating counsellors on the issue at hand and informing us (counsellor) on the legal assistance or legislation that has recently changed for the worse?!
3381412251	More awareness within the community for our service. Direct input about improved delivery from these communities.
3381371976	None
3381234178	Some specific training in the area will be beneficial, especially to new beginner counsellors.
3381048810	More awareness of the issues of Domestic Violence and what services are available to people Better training of Managers to help them to be more observant and proactive with staff members who experience this issue. Points of referral and follow up How to empower those who have suffered D V Educate across all levels of an organisation. With refugees where there is a cultural clash it is important to be able to understand issues and get the support of elders within community where possible
3380377370	We need certainty in funding to continue the work we do
3380304610	Nil
3380124571	Information for support services

3380101918	Having information their in many languages especially the dominant languages in the area e.g. St George area need things in arabic, serbian and Cantonese/Mandarin. Bi-Lingual workers are essential and that is another barrier in itself. Find working with Lebanese clients they don't want a person that is Lebanese as feel somebody will find out they are getting help. Next issue, confidentiality is so important! Need to take time to explain to clients limitations of confidentiality especially if suicidal, etc. Interpreter services have being cut back so this is having a huge impact on our service. We have spent 2 weeks trying to find a Spanish speaking person to assist with a client who speaks no English. The government used to pay, now we rely on other services but they are limited in what they offer. Information in letter boxes would really assist, so people know what is available in their communities.
3380095409	further staff training, stronger connections with each local CaLD community and with individuals and families within each community
3380073311	existential-phenomenological approach
3380055168	I work mainly with women who are experiencing Domestic Violence. Unfortunately it is an issue that spans across all cultures as you would be aware. So the improvements I long for are for all women who are living in an abusive situation. I work in the Hills District of Sydney, where the one solitary shelter recently closed. There is nothing for women in this area. My office is 3 kilometers from the Sikh temple where I have heard terrible stories of violence towards women. Improvements: I a part of a newly formed foundation - yet to launch - which is going to set up a resource/drop in centre for women in this area who are in DV. It's called the Lisa Harnum Foundation (in honour of the woman who was thrown off a balcony by her fiance). We need funding - not just for CALD clients - but for all women in DV.
3380026037	Reviewing specific CALD counselling sessions (I work on a phone support line where all calls are taped and reviewed for coaching purposes). Reviewing conducted by people from a CALD background Having CALD community members provide training
3380022827	more workers better funding
3379926179	Training more bi-lingual workers in counselling and casework
3379893986	None
3366611600	More education in the CALD community on how to prevent domestic violence
Question 3	Any additional comments:
3626292048	I found this survey to be quite broad
3626244492	No

3575863765	no.
3515598680	NO.
3392540129	No
3390932900	-
3387470424	None
3385280788	.
3384284716	Sometimes it has been difficult to put a safety plan in place for women with D.V as they don't utilise it for many reasons so you can feel powerless and frustrated as a counsellor to make effective change
3384119638	Best of luck
3384104237	Thank you for this chance to participate.
3384092673	no
3383985110	No
3383915848	No
3383831045	CALD Clients take long to open up due to their cultural boundaries and taboos. I come from an ethnic and cultural background myself so I can encompass cultural barriers much easier. I can conduct my counselling in 5 different languages and several other ethnic dialects to make the client at ease and to gain the client's trust.
3383693492	As a male family and couple therapist I encounter cases of domestic violence in my practice. I would like to see a more concerted campaign to make domestic violence an unacceptable behaviour in Australian society with a focus on male offending behaviours. I would also like to see more treatment options for men who wish to change their behaviours, or at the very least some campaign that encourages men to seek professional help.
3383614866	none
3382298230	No
3382188963	No additional comments
3382175839	I answered 'I don't know' to many of the questions because I found them very simplistic, overgeneralised, and not related to the complex reality of practice. In reality many dimensions may be going on at once in the health professional's mind. I'm sorry to say this but I found the questionnaire very simplistic and I almost stopped doing it, but because I am sympathetic to the topic I continued.
3382134310	no
3382081302	No further comments.
3382067796	N/A

3382048683	In question 18 the answers given don't match the question.
3382008515	no
3381993903	..
3381961119	None
3381943107	nil
3381895302	Nil
3381888878	Nil
3381881516	No.
3381856783	No
3381853722	important to listen to clients needs as not all CALD clients want culture to be taken into account when working with them or be referred to CALD organisations. Examples might include: 1.if they are escaping situation where culture is not in individuals interest & client looking to take on new culture (in original culture woman is forced to care for needs of extended family) or 2. in small communities where community gossip can endanger or create ongoing issues for clients (as experienced when working with clients in smaller Africa communities within Sydney)
3381808816	More funding is required for CALD specific services in this field.
3381793815	Funding and the way it is administered is ALWAYS a problem!
3381627174	Thankyou and look forward to hearing about the results of your study.
3381602750	x
3381587779	Not sure if I answered 18-22 correctly as the ratings didn't really seem to follow the question - or maybe that is just my understanding!
3381561792	none
3381542988	None
3381542047	Good Luck in all your future endeavours.
3381527055	-
3381425443	I would like to have a register that lists me
3381422480	No further comments
3381412251	No
3381371976	None
3381234178	No

3381048810	No
3380377370	Currently there is uncertainty for funding with a fear that funding will go to religious organisations - ,we come from a community response and expectation which picks up the ethic perspectives including aboriginal
3380304610	No
3380124571	Questions were confusing and difficult to answer
3380101918	Found number 18 hard to give an answer. I work with very difficult clients who have experienced domestic violence. I stick with them no matter what their behaviours may be, I stick with them which helps them but I also let them know when they cross the line. Educate clients on how to communicate in better ways. This is hard for clients who have experienced domestic violence as they need to learn how to trust themselves again, due to being so Mind Fucked. Sorry for the swearing but this term really covers it for the clients I work with.
3380095409	I can't answer some of these questions because it requires generalising as if every member of every "CaLD community" is the same and/or because I don't recognise the concepts in my practice (e.g. I don't require clients to "cooperate").
3380073311	no
3380055168	Thanks
3380026037	Question 1 to 13 were confusing to me. What I mean by my answers was that I don't have any prior knowledge of someone from a CALD background so I don't know if they 'understand themselves" or can solve their own problems. Each person is unique whatever background they come from. However, in theory, I don't assume people from a CALD background are somehow less able to solve their own problems, than a person say from an English background.
3380022827	Domestic violence work is always focused around safety for the victim First
3379926179	More equity and access to services for CALD communities
3379893986	No
3366611600	CALD workers should work for CALD communities.