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DOMESTIC VIOLENCE IN AUSTRALIA'S CALD COMMUNITIES: ASSOCIATION BETWEEN DEMOGRAPHICS OF FRONTLINE WORKERS AND SELECTED THERAPEUTIC APPROACHES

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Abstract

Similar to the global scenario, domestic violence (DV) is a public health problem even in Australia. Although the mental health effects of domestic violence are well established, there is a dearth of literature about the demographic characteristics of frontline workers and their preference of therapeutic approaches in engaging with victims of domestic violence from Australia's Culturally and Linguistically Diverse (CALD) communities. Data was collected about the demographics and preference for Cognitive Behaviour Therapy (CBT) and Person Centred Therapy (PCT) therapeutic approaches from a sample of N=60 frontline workers associated with medical organisations in New South Wales (Australia). A MANOVA was used to test for an association between the demographic characteristics of the frontline workers and preference for CBT or PCT based therapeutic approaches. The results of the multivariate tests did not find the main effects of any of the demographic factors to be significantly associated with a preference for CBT and PCT based therapeutic approaches. However, follow-up tests indicated that the PCT Perception Score was significantly different by gender and years of experience of the respondent. The findings from the study can be used by policy makers and other researchers to formulate domestic violence educational packages for frontline workers customized according to their gender, years of experience and preference for certain therapeutic approaches.

Keywords: Domestic Violence, Frontline Workers, CALD Community, Therapeutic Approaches.

1.Introduction

According to the World Health Organization, "Violence against women is not a new phenomenon, nor are its consequences to women's physical, mental and reproductive health. What is new is the growing recognition that acts of violence against women are not isolated events, but rather form a pattern of behaviour that violates the rights of women and girls, limits their participation in society, and damages their health and well-being. When studied systematically, it becomes clear that violence against women is a global public health problem that affects approximately one third of women globally" (WHO, 2013). Along with being a public health issue, violence against women is also a human rights issue. There is evidence to show that women experience domestic violence in far greater rates as compared to men.

There are many definitions of domestic violence. According to the definition used in the Australian government's National Plan to Reduce Violence against Women and their Children 2010-2022, domestic violence refers to acts of violence that occur between people who have, or have had, an intimate relationship (Dunkley & Phillips, 2015). According to Hegarty, Hindmarsh and Gilles (2000) Domestic violence is a complex pattern of behaviours which may include physical acts of violence, sexual abuse and emotional abuse.

According to estimates, globally, 1 in 3 (35%) of women have experienced either physical and/or sexual intimate partner violence or non-partner sexual violence in their lifetime. Majority of this is intimate partner violence (WHO, 2016). The 2005 report on WHO Multi-country study on women's health and domestic violence against women in 10 mainly low and middle income countries indicated that in the 15 to 49 years age category, approximately 15%

of women in Japan and 71% of women in Ethiopia reported physical and/or sexual violence by an intimate partner in their lifetime. But, the problem of domestic and family violence is not restricted to low and middle income countries. Developed nations such as the United Kingdom (UK) are also grappling with this problem. In 2014, an estimated 1.4 million women suffered from domestic abuse in UK, according to the Office of National Statistics (ONS). According to the ONS, 28% of women in UK or approximately 4.9 million women have experienced some form of domestic abuse since the age of 16.

In Australia, domestic abuse is widespread. According to some estimates, one in six Australian women has experienced violence from a current or former partner and in 2015, the killing of 65 women could be attributed to assault from some form of family violence. According to statistics, in 2014, 1 woman died every week in Australia due to domestic violence assaults. In New South Wales, 24 women were killed in 2014, in incidents related to family and domestic violence. In New South Wales, 42% of all homicides are domestic in nature (Mitchell & Mitchell, 2015). The problem is so concerning that the Australian government, in September 2015, promised a package of measures of $100 million to protect victims of domestic and family violence.

Australia defines people from CALD communities as those people who have not been born overseas in countries which are the 'main English speaking countries'. These main English speaking countries, as classified by the Australian Bureau of Statistics (ABS) are Canada, the Republic of Ireland, New Zealand, South Africa, the United Kingdom (England, Scotland, Wales, Northern Ireland) and the United States of America. Australia has a fast increasing demographic of CALD communities. According to ABS (2007), 31% of Australians were born overseas and, of these, about two-thirds were born in non-English speaking countries. Hence, the segment of people in Australia who can get categorized as belonging to CALD communities has been steadily increasing.

Domestic violence and its consequences have been recognized as a social health issue since the early 70s, but despite this fact, information on its prevalence is limited in the CALD communities and as such it has been down-played in these communities (Morgan & Chadwick, 2009). There have been methodological limitations in CALD communities including the exclusion of certain groups due to language limitation on the part of the researcher/interviewer, lack of attention to socio-cultural context limited comparability due to limitation in sampling criteria, data collection methods and study framework (Yoshihama, 2008). All these factors have made it difficult to conclude on the precise nature and extent of DV in CALD communities.

As this paper deals with the association between the demographics of frontline workers and the therapeutic approaches used by them, it is essential to categorize 'frontline workers'. The 'frontline workers' for this study include psychologists, counsellors, therapists and legal aides.

Frontline workers are regularly in contact with victims and survivors of domestic violence in diverse workplaces and health care settings. They are generally faced with the challenge of understanding the different cultural perspectives of DV victims from diverse CALD communities. This understanding is important as it allows for better service provision and to be able to reach out more effectively to these diverse migrant communities to encourage them to report abuse, seek protection under the Australian law and to seek psychological support and counselling. But often, this understanding of different cultural perspectives becomes difficult due to lack of training about how to best engage with people from the CALD communities. According to Allimant and Ostapiej-Piatkowski (2011), in clashes of emerging cultural understanding, these frontline workers or practitioners report not knowing how to respond to women from CALD communities who are victims or survivors of domestic violence because of the practitioner's desire to maintain cultural sensitivity. These practitioners also have a fear of offending the client.

Domestic Violence, CALD Communities and Barriers to Seeking Help

Despite the laws against domestic violence, CALD women who are victims of abuse continue to face multiple barriers to accessing justice, which are both systemic and cultural and may continue to impact a woman's willingness and ability to seek help (Boas, 2009).

Usually, women belonging to CALD communities, especially migrant women, are economically and financially dependent on their spouses. At times, they may not even have their own bank accounts. In a lot of cases, due to visa restrictions, they are not permitted to work. Most of them have limited English language skills, which is one of the primary barriers that prevent these women from accessing help. They are frequently unaware of facilities such as translation services. Language and cultural barriers restrict women from CALD communities from accessing support and legal services. According to Ghafournia (2011), the limited availability of culturally sensitive translation and interpretation services could also prevent victims with limited English language skills from seeking help.

Migrant populations are also away from their families in Australia; this alienates abused women even further as there is no one to intervene in domestic abuse situations, which, back in their homeland, could have been resolved by extended family members and/or elders. This leads to lack of social interaction for such women, who feel emotionally and socially alone and culturally disconnected in a foreign land (Ghafournia, 2011).

Women from such communities are frequently unaware of their own rights. They are not aware of the legal system in Australia which prohibits family violence. According to Ghafournia (2011), many women belonging to migrant and CALD communities are not aware of their legal rights and also have limited knowledge of Family Allowance and other kinds of benefits provided by government. Their only source of information is their husbands and they are misguided by them at times. These women also lack knowledge about the support services available in Australia which provide housing, income and support to women who are victims or survivors of family violence. These women are also frequently unaware of Australia's legal system, especially in relation to immigration laws. This usually gives rise to fears that reporting violence could jeopardize their future in Australia or their benefits such as entitlement to programs or services.

Many cultures also place a high value on family honour and reputation. Women from such cultural backgrounds are scared to approach service providers as they fear their family honour could be jeopardized in case their 'secret' comes out. Women from CALD and migrant communities may experience a natural hesitation in reporting violence or in exercising choices related to separation and/or divorce. Frequently, they belong to cultures and societies which have strong prohibitions against divorce. There is also a social stigma attached to domestic violence which may prevent victims and survivors of domestic violence from approaching service providers. Women from CALD communities may also hesitate from seeking counselling for abusive relationship as there could be a cultural aversion to therapy. In a lot of cultures, seeking therapy, especially for something as private as marital relations, is looked down upon.

Women from CALD and migrant communities frequently do not speak up about domestic violence due to different perceptions and understandings as to what constitutes domestic violence in CALD communities. In some communities, domestic violence excludes emotional, psychological and sexual abuse. In some cultural backgrounds, it is assumed that violence, in some form or the other, is the right of the husband who is considered to be the head of the family and the sole breadwinner.

Research Gaps and Objectives

There is need to ensure that policies regarding prevention of domestic violence in CALD communities are strengthened by employing evidence based research and information for decision making (Morgan & Chadwick, 2009). Most research on DV in CALD communities has focused on Latina/Hispanic and Asians with limited research focusing on other groups such as African, Arabs, Caribbean's and Europeans. There have also been methodological limitations in CALD communities including the exclusion of certain groups due to language limitations on the part of the researcher/interviewer, lack of attention to socio-cultural context limited comparability due to limitation in sampling criteria, data collection methods and study framework. The aim of this research is to contribute to the knowledge base relating to DV, especially in the Australia's CALD communities. Since the frontline workers play an important role in engaging with and helping women from CALD communities, it is important to have an understanding of the demographic profile of the frontline workers and to establish is there is any association between the demographics of the frontline workers and their preference for the certain therapeutic techniques. Cognitive Behaviour Therapy (CBT) and Person Centred Therapy (PCT) therapeutic approaches are two of the most commonly used therapeutic techniques used by frontline workers. These two techniques have been chosen as the two main therapeutic approaches of interest for this study. Having insights into the association between the demographics of the frontline workers and their choice of therapeutic approaches may help policy makers in formulating better policies.

2.Methodology

Survey

Quantitative method of survey was used for procuring responses from frontline workers working in the field of domestic violence. The questionnaire was created by the researcher in order to address the objectives of this research. Towards this, the questionnaire collected information about the demographics of the frontline workers, various aspects of their experience and training in working with the CALD communities, and questions relating to preference for Cognitive Behaviour Therapy (CBT) based and Person Centred Therapy (PCT) based therapeutic approaches.

The survey questionnaire was sent via email to the participants. An online survey tool was used to administer the survey.

Sample

The total sample size in this study was 60, which is considered moderately representative as it has been selected from 9 premier medical organizations in New South Wales which deal with domestic violence victims. Convenience sampling technique was used for the purpose of sample selection. The sample of participants was frontline workers, including psychologists, counsellors, therapists and legal aides. These are representative of the broader population of the frontline workers in the organizations from which these participants were selected.

Data Analysis

The assumptions of parametric statistics were inspected and the data were examined for statistical skewness and kurtosis. The Kolmogorov-Smirnov (K-S) test of normality was used to check the statistical significance of normal distribution of the variables at alpha = .001.

Using the responses from the survey, two scores were computed. These are the CBT (Cognitive Behaviour Therapy) perception score, and the PCT (Person Centred Therapy) perception score. The scores were created as averages of the responses to the CBT and PCT preference questions. The CBT perception score has a range of 1 to 5, where 1 corresponds to strongly agree and 5 corresponds to strongly agree. The PCT perception score has a range of 1 to 5, where 1 corresponds to very good and 5 corresponds to very bad.

The statistical analysis technique of a multivariate analysis of variance (MANOVA) was utilised to test for the association between the demographic characteristics of the respondents and their preference for CBT and PCT based therapeutic approaches to deal with domestic violence clients from the CALD communities. MANOVA is known to be useful technique to test for the association between factors and multiple dependent variables (Timm, 2007). The factors that were tested for association with the CBT and PCT perception scores were the gender of frontline works, their profession, experience, awareness of their organisations' guidelines on dealing with cases of domestic violence, presence of additional guidelines for working with people from CALD communities in their organisation, having received training on working with victims/survivors of domestic violence specifically from CALD communities, whether the workers work with clients who have experienced domestic violence, and whether the workers work with clients from the CALD communities. The assumptions of MANOVA including the assumption of multivariate normal distribution of the dependent variables within each group of the independent variables were tested and met.

3. Results

Demographic Profile

The sample (N=60) used for the study consisted of frontline workers that deal with domestic violence. A vast majority of the respondents were females (n=51, 85%). The largest group of people surveyed by profession were counsellors (n=49, 81.7%). A majority of the people surveyed had between 5-14 years of experience (n=36, 60%). A vast majority (n=51, 85%) of the respondents indicated that they were aware of their organisations' guidelines on dealing with cases of domestic violence. A majority (n=32, 53.3%) of the respondents indicated that their organisation has additional guidelines for working with people from CALD communities. When asked about whether the respondents have received any training on working with victims/survivors of domestic violence specifically from CALD communities, the largest group of people indicated that they had not (n=26, 43.3%). The next largest group indicated that they had received training on working with victims/survivors of domestic violence specifically from CALD communities post-qualification (n=24, 40%). Only a small proportion (n-10, 16.7%) of the respondents indicated that they had received training on working with victims/survivors of domestic violence, specifically from CALD communities pre-qualification. When asked whether the respondents work with clients who have experienced domestic violence, a vast majority indicated that they had (n=50, 83.3%). Similarly, a vast majority of respondents (n=56, 93.3%) indicated that they work with clients from CALD communities.

Summary statistics for CBT and PCT perception scores are summarised in Table 2. The mean scores for the two therapeutic approaches below indicate that PCT based approach is more favoured by the respondents as it has a higher mean score (M=2.06, SD=0.55) compared to a CBT based approach (M=1.95, SD=0.45).

Table 1: Demographic Profile of the Sample (N=60)

Item	Category	Frequency	Percent
1. What is your gender?	Female	51	85.00
	Male	9	15.00
2. What is your profession?	Counsellor	49	81.70
	Social worker	2	3.30
	Case worker	2	3.30
	Psychologist	1	1.70
	Psychotherapist	3	5.00
	Court support/advocacy	3	5.00
3. How long have you been a member of the profession?	0-4 years	8	13.30
	5-9 years	22	36.70
	10-14 years	14	23.30
	15-19 years	6	10.00
	20 or more years	10	16.70
4. Are you aware of your organisation's guidelines on dealing with cases of domestic violence?	Yes	51	85.00
	No	9	15.00
5. Does your organisation have any additional guidelines for working with people from CALD communities?	Yes	32	53.30
	No	28	46.70
6. Have you received any training on working with victims/survivors of domestic violence specifically from CALD communities?	Yes, pre-qualification	10	16.70
	Yes, post-qualification	24	40.00
	No	26	43.30
7. Do you work with clients who have experienced domestic violence?	Yes	50	83.30
	No	10	16.70
8. Do you work with clients from CALD communities?	Yes	56	93.30
	No	4	6.70

Table 2: Summary Statistics for CBT and PCT Perception Scores (N=60)

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

Association between Respondent Demographic and Preference for CBT and PCT based Therapeutic Approaches

A MANOVA examined the effect of Gender, Profession, Experience, Awareness Organizations' Guidelines, Additional Guidelines CALD, Training Domestic Violence CALD, Work with Domestic Violence Clients, Work with CALD Clients on the preference for CBT and PCT based therapeutic approaches amongst the respondents. The interpretation of these results is useful as it can provide insights into the association between the preference for a particular therapeutic approach and the demographics of the respondents. The results of the multivariate tests did not find the main effects of any of the factors to be significantly associated with a preference for CBT and PCT based therapeutic approaches. However, follow-up tests indicated that the PCT Perception Score was significantly different by gender of the respondent ($F(1, 43)=4.278$, $p=.045<.05$); and the CBT Perception Score was significantly different by the experience of the respondent ($F(4, 43)=3.559$, $p=.014<.05$).
The most striking finding in the data analysis was perhaps how the CBT and PCT perception scores differed by gender and experience of the frontline workers. The mean PCT Perception Score for females (1.735) was significantly more than that of males (1.221) indicating that females preferred PCT more compared to males. The mean CBT perception score was the highest for respondents with the most experience of 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). This was followed 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 indicates that there is no clear trend for the preference for CBT as a therapeutic approach and the experience of the respondent.

Table 3: Gender by PCT Perception Score

Dependent Variable		Mean	Std. Error	95% CI	
				LB	UB
PCT Perception Score	Female	1.735	0.243	1.244	2.226
	Male	1.221	0.334	0.548	1.894

Table 4: Years of Experience by CBT Perception Score

Dependent Variable		Mean	Std. Error	95% CI	
				LB	UB
CBT Perception Score	0-4 years	1.558	0.23	1.095	2.021
	5-9 years	1.79	0.217	1.352	2.227
	10-14 years	1.768	0.182	1.402	2.134
	15-19 years	1.595	0.249	1.094	2.097
	20 or more years	2.204	0.227	1.746	2.662

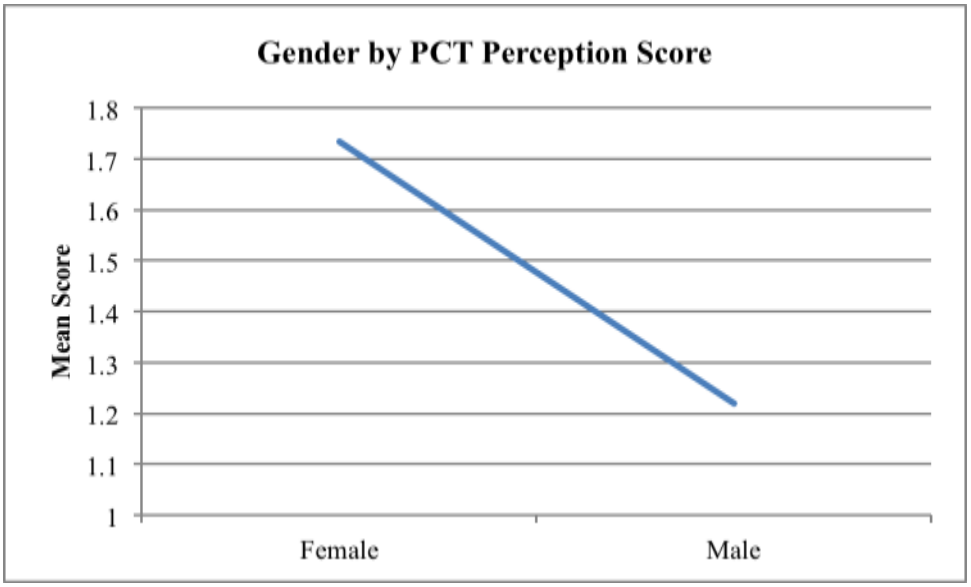

Figure 1: Gender by PCT Perception Score

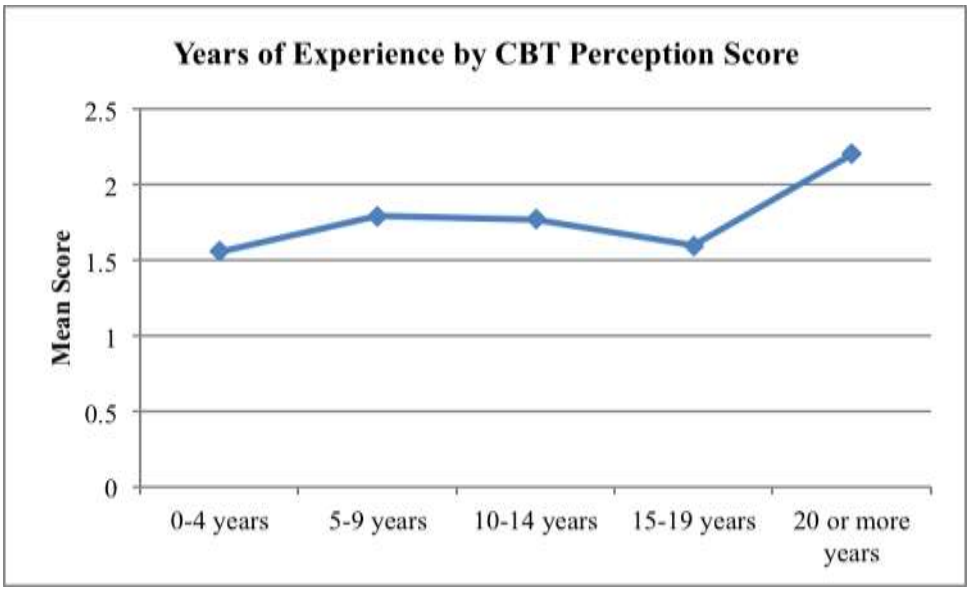

Figure 2: Years of Experience by CBT Perception Score

4. Discussion & Conclusion

From the quantitative analysis, it is clear that the findings were significant for factors such as gender and years of experience. This means that the preference of frontline workers for a specific therapeutic approach while dealing with a domestic violence survivor/victim belonging to CALD communities is dependent on these two factors.

As per the data analysis carried out, the CBT perception score for female frontline workers was found to be less than that of male frontline workers. This implies that male frontline workers consider CBT to be a more effective technique than female frontline workers. The mean PCT perception score for females was more than that of males indicating that females preferred PCT more compared to males. Thus, as far as gender is concerned, there was a clear preference for therapeutic techniques based on gender. Since the sample used in this study comprises predominantly of females, almost all the respondents surveyed preferred the PCT based therapeutic approach. One of the reasons why female frontline workers who

were surveyed preferred the use of PCT based therapeutic approach over the use of CBT based therapeutic approach, could be the fact that most of the respondents who worked with domestic violence victims/survivors from CALD communities were women. Males made up approximately 15% of the sample; and even amongst the male respondents, less than 50% worked with domestic violence victims/survivors from CALD communities. As discussed earlier, domestic violence cases where the victims/survivors belong to CALD communities are more complicated simply due to the added layers of barriers faced by the victim/survivor such as cultural, religious and societal taboos, financial dependence of the victim, immigration issues etc. Hence, it could be said that those frontline workers who worked with domestic violence victims/survivors from these communities preferred the use of PCT based therapeutic approach simply because they understood the variety of added complications and during therapy, recognized the fact that an individualistic approach, such as the CBT may not work with clients who belonged to collectivist cultures. Clients belonging to CALD communities came from cultures that are not individualistic in nature. Almost all these communities are collectivist or communal in nature and hence, the transition of these clients into western cultures that were individualist in nature might be causing some of the known issues with accessing and utilising services. Domestic violence victims and survivors belonging to such communities did not report domestic violence to authorities usually due to a variety of cultural, familial, financial, immigration issues. Hence, the clients that were in therapy with these frontline workers were ready to get help. In a bid to make therapy successful and viable for such clients, most of these frontline workers adopted methods that allowed therapy sessions to be customized to the needs of the clients, the assumption being that the client knows her problems the best and hence, is in the best position to actually work out a solution for the same.

With respect to the data analysis carried out, the CBT perception score according to number of years of experience was the highest for frontline workers with 20 or more years of experience and the lowest for 0-4 years and 15-19 years of experience. The mean CBT perception score was the highest for respondents with the most experience of 20 or more years. The groups with the least preference for CBT were respondents with 0-4 years of experience, followed by respondents with 15-19 years of experience. This indicates that there is no clear trend for the preference for CBT as a therapeutic approach and the experience of the respondent. The only conclusion one can draw from this finding is preference for CBT as a therapeutic approach changes for frontline workers in different phases of their careers.
The findings from the study can be used by policy makers and other researchers to formulate domestic violence educational packages for frontline workers customized according to their gender, years of experience and preference for certain therapeutic approaches.

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