Improving responses to refugees with backgrounds of multiple trauma:

Pointers for practitioners in domestic and family violence, sexual assault and settlement services

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FOREWORD

This practice monograph brings together five contributions from writers who are recognised for their expertise and experience working with refugees who have histories of trauma, including torture, sexual violence and domestic and family violence. Each contributor offers valuable insight into the enhancement of practice across work with refugee women who experience domestic and family violence. The contributions cover: practice issues for domestic and sexual violence workers; practice issues for settlement workers; practice issues for men's workers; and a tool to assist practitioners across sectors to understand the vulnerabilities that may place women at risk of further harm or trauma.

Collectively, the contributions underline the importance of cross-sectoral collaboration and of the need for multi-agency responses. As with all areas of domestic and family violence work, the development of appropriate responses to the needs of women who have multiple experiences of trauma is unlikely without agencies from settlement services, torture and trauma services, sexual violence and domestic and family violence services working together, and without input from women themselves.

Improving responses to refugees with backgrounds of multiple trauma: pointers for practitioners in domestic and family violence, sexual assault and settlement services is the first practice monograph to be published by the Australian Domestic and Family Violence Clearinghouse.

The Clearinghouse hopes that this monograph will contribute to ongoing dialogue within services and agencies about ways to better listen to and support women who have come to Australia seeking asylum or safety.

Consolidated references from all contributions are included at the end of this monograph.

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Australian Domestic and Family Violence Clearinghouse

This is our very first practice monograph and we would really appreciate your feedback. Please follow this link to complete our short practice monograph survey.

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ABOUT THE CONTRIBUTIONS

Dr Lana Zannettino, a senior lecturer in Sociology at Flinders University in South Australia, provides a background and overview of the issues relevant to working with refugee women with prior trauma histories. In the conclusion of the monograph, Lana identifies the ways in which each contribution has provided new understandings of the themes and issues outlined in her introduction to the paper.

Dr Eileen Pittaway and Ms Rebecca Eckert, of the Centre for Refugee Research (CRR) at the University of New South Wales, examine the specific challenges faced by settlement workers in assisting refugee clients affected by domestic violence and prior experiences of trauma. They suggest opportunities to improve practice by settlement or refugee workers who may be less familiar with issues of domestic and sexual violence.[1]

Ms Annabelle Allimant and Ms Beata Ostapiej-Piatkowski from Harmony Place in Brisbane[2] identify considerations for domestic violence and sexual assault workers who are assisting culturally and linguistically diverse (CaLD) clients (including refugee clients) experiencing mental health issues, including those arising from prior trauma.

Dr Jill Parris, a psychologist working at the Ecumenical Migration Centre (EMC) writes on clinical work with refugee men who are violent in the context of intimate relationships. Using two client case studies from her own practice, Dr Parris provides insight into the experiences of men's own prior trauma, coupled with settlement and refugee experiences. She goes on to identify how this may impact on potential behaviour change. Dr Parris concludes with guidance for practice for family counsellors and men's workers who work with refugee clients.[3]

In the final contribution to this paper, Dr Eileen Pittaway, Dr Linda Bartolomei and Ms Rebecca Eckert from the Centre for Refugee Research (CRR) present *Women At Risk* Assessment Tool. The tool is designed to assist Australian service providers in identifying migrating women who, due to experiences of, and vulnerabilities to, violence may require additional assistance with settlement.

Key Points

- Research and practice with refugee women seeking assistance for settlement and other needs demonstrates high levels of exposure to multiple traumatic incidents.

- These incidents include many acts of sexual violence, including rape, forced sex through economic abuse ('survival sex'), forced marriage and sexual abuse of children.

- Prior experiences of sexual violence often increase the isolation and shame felt by refugee victims of domestic and family violence in Australia, compounded by ostracism and exclusion from their own communities.

- Service providers in the domestic violence and sexual assault field, as well as settlement services, are not always aware of the extent of harm and the impacts of prior experiences of horrific trauma on the needs of refugee women who present to their service.

- Increased understanding, cultural safety and provision of a safe space to talk about trauma are important if services are to improve their responses.

Refugees, sexual and domestic violence and prior experiences of trauma: introduction and context

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Introduction

Recent research has demonstrated that refugee women seeking help for domestic violence in countries of resettlement, such as Australia, are likely to have experienced multiple incidents of trauma as a result of their exposure to war, loss, displacement and encampment (Pittaway 2004; Pittaway & Rees 2006; Rees & Pease 2007; Zannettino 2012). Frequently these experiences involve sexual violence and abuse occurring over an extended period of time and in a myriad of contexts (Heineman 2011; Leatherman 2011). Practitioners working with refugee women affected by domestic violence in countries of resettlement need to be aware of the likelihood of such histories. More specifically, they must be cognisant of how the mental and physical effects of refugees' pre-arrival experiences can impact on their wellbeing and opportunities for successful settlement in a new country. They must also consider how such experiences can both contribute to and compound current experiences of violence in their intimate relationships (Pittaway 2004; Rees 2004; Zannettino 2012).

Rape and sexual assault can have long-term negative effects on women's psychological and physical health (Campbell & Wasco 2005). For refugee women, the experience and effects of domestic violence following resettlement in a new country can be particularly devastating, given that many have endured sexual and gender-based violence prior to their arrival. There is considerable reason to be concerned about the wellbeing of refugee women, many of whom have had extensive histories of sexual violence and abuse (Heineman 2011). The United Nations High Commissioner for Refugees (UNHCR 2003) estimates that 80% of all refugee women experience rape and sexual abuse. Rape is the most common form of systematised torture used against women during times of war and civil unrest (Leatherman 2011). Women who have endured such experiences have an increased vulnerability to further abuse or sexual exploitation in their countries of origin (Allen & Devitt 2012; Rees 2004). They are also more vulnerable to intimate partner violence and sexual abuse upon resettlement in a new country (Pease & Rees 2008; Pittaway 2004; Schmidt 2005). Moreover, these women face unique and particular challenges in dealing with and addressing the effects of domestic violence, due to their past experiences of trauma (Pittaway 2004; Sharma 2001; Zannettino 2012).

It is estimated that 80% of the world's refugees are women and children (Department of Immigration and Citizenship (DIAC), 2013). Many of these will have a background of multiple traumas that may make them more vulnerable to, and intensify the effects of, abuse. It is, therefore, imperative that researchers and practitioners working in the area of refugee health, and violence and abuse understand and respond appropriately to refugees affected by domestic violence. In this practice monograph, the authors identify the multifaceted and cumulative effects of traumatic experiences, pre-arrival. More specifically, they demonstrate that, for refugees, the effects of multiple traumatic events are experienced within and across a range of personal, social, institutional and political domains. These include, but are not limited to, the experience of sexual and other forms of violence resulting from war, witnessing and/or being involved in the atrocities of war, grief and loss, social and institutional persecution, displacement and encampment.

This practice monograph aims to extend current understandings of, and responses to, refugees seeking assistance for domestic violence who have experienced multiple traumas, including sexual violence. The monograph brings together writers who have an impressive background in working with refugees who have multiple experiences of trauma in their pre-arrival experience and since settlement. It presents and explores empirical accounts of practitioners whose work takes into consideration the ways that trauma, particularly experiences of sexual violence, can contribute to and compound the risks and effects of further abuse in countries of resettlement.

Sexual violence in war and conflict

Over the last twenty years, much has been written about sexual violence in the context of war and conflict. A number of important themes relating to the complexity of traumas experienced by refugees, especially women and girls who have been sexually violated during conflict and its aftermath, can be identified from this literature. First, sexual violence is the most pervasive form of violence against women in the context of war. The raping of women in combat and occupation zones is a nearly universal feature of military campaigns (Mullins 2009). While men generally comprise the majority of victims of human rights abuses

during armed conflict (Plumper & Neumayer 2006, cited in Leiby 2009), patterns of victimisation indicate that women are targeted more often in ways that are directly linked to their gender and sexual identity and to their identity as the bearers of future generations, and key protectors of a community's culture (Lykes et al. 1993; Sharlach 2000, cited in Leiby 2009).

Second, sexual violence against women and girls is commonly used as a strategy to terrorise, control, displace or eliminate targeted groups (Bartels et al. 2010; Burnet 2012; Khanna 2008; Leatherman 2007; 2011; Leiby 2009; Longombe, Claude & Ruminjo 2008). Perpetrators are often motivated by a desire for power and domination (Longombe et al. 2008). Sexual violence fulfils a wide range of functions during armed conflict. It can be arbitrary, resulting from the breakdown of community protections and restrictions, but it is also often systematic with a wide variety of aims (Leatherman 2011). These include demoralising an enemy that culturally places high value on women's purity and men's ability to protect them, or rewarding troops by fostering access to sex (Heineman 2008). Women and girls are particularly vulnerable to multiple instances of victimisation throughout the various phases of conflict, from its emergence and escalation, through to its termination and aftermath (Leatherman 2007).

Third, a woman's suffering does not end with the cessation of war; women continue to live with the physical and emotional trauma of their injuries (Bartels *et al.* 2010; Khanna 2008). Women must continue to care for children, including those born of rape, and in many cases, their husbands and families treat them as 'damaged goods, living symbols of a nation's humiliation and bearers of "enemy" children' (Farr 2002, cited in Leatherman, 2007, p.58; Hanlon 2008; Longombe et al. 2008). Other women are turned away by their husbands and communities and many are forced to stay with their captor after the hostilities have ended (Leatherman 2007). Women and girls who have been raped and shunned by their husbands and families are at a much higher risk of re-victimisation in new wars, across phases of conflict (Bouris 2007, cited in Leatherman 2007).

In many cases, women experience further victimisation and harm because of the lack of adequate health care and support structures for assisting victims of sexual violence. This leaves them vulnerable to the effects of sexually transmitted diseases, including HIV/AIDS (Hanlon 2008; Leatherman 2007). The shame and psychosocial stigma that survivors of rape suffer is another form of re-victimisation. For many women, just reaching out for help, even if such help is readily available, is difficult as this may serve as another catalyst for victimisation (Leatherman 2007). Refugee women who have been sexually violated often keep their

trauma hidden from immigration officers and other officials for fear of being viewed as prostitutes and consequently being denied refugee status or visas as a consequence (Pittaway & Bartolomei 2001).

Understanding pre-arrival experiences of violence: multiple and cumulative trauma

Much of the literature concerning sexual violence against women and girls in the context of war has discussed the traumatic outcomes, both physical and psychological, for the populations and individuals affected (see for example, Bartels et al. 2010; Jorden, Matheson & Anisman 2009; Khanna 2008; Liebling-Kalifani et al. 2010).

While sexual violence is the most pervasive form of violence against women and girls in conflict, this form of violence often occurs in tandem with physical and other forms of systematised violence designed to control, demoralise and subjugate women. The context, perpetrator motivation and phases of conflict during which the violence occurs vary. Perpetrators may be combatants or persons in authority, who are variously motivated to commit such acts (e.g. to control or decimate). Such violence occurs in numerous contexts (e.g. on streets and in camps), as war eliminates the spaces in which women can find safety (Leatherman 2011). Some women can be subjected to rape and other atrocities on numerous occasions and in various phases of conflict (e.g. in the aftermath of war). The experiences of violence are often multiple and the effects are cumulative.

In this way, sexual and other gender-based violence in the context of war and conflict make the differences around 'public violence'; that is, large-scale, state-sponsored or state-supported violence, almost indistinguishable from those of more intimate or decentralised forms of violence, such as domestic violence. The boundaries between 'public violence' and 'intimate violence' are further blurred by the fact that, for many refugee women, violence at the most intimate level has been utilised for political purposes. Women's bodies and minds are the primary site of subjugation in both public and intimate forms of violence.

Domestic violence and sexual assault in refugee communities

While sexual violence in war and conflict has been reasonably well documented, there is a paucity of research focusing on the sexual assault of refugees in countries of asylum and resettlement with a background of prior trauma. A study by Taylor and Putt (2007) was the only article found for this practice monograph that focuses on the sexual assault experiences of women from culturally and linguistically diverse (CaLD) backgrounds. The study identified several barriers that prevented CaLD women from seeking help for sexual violence, including:

- not wanting to shame and embarrass the family and community,

- fear of losing a relationship if the perpetrator is the victim's husband,

- not considering sexual violence by a husband to be a crime, or feeling obliged to submit to his sexual needs,

- fear that such violence is symptomatic of a failed marriage, which could be seen as the victim's fault,

- desire to keep the family intact and protect the children's welfare,

- possible loss of family support,

- fear of humiliation by the police and the criminal justice system,

- fear of deportation ,

- loss of confidentiality and privacy, and

- fears resulting from adverse police experiences in their past.

While some studies in the field of domestic violence make a link between the pre-arrival traumas of refugees and their experiences of domestic violence in a new country (see for example, Pittaway 2004; Pittaway & Rees 2006; Rees & Pease 2007; Zannettino 2012), none of these studies focus specifically on sexual violence. Other studies concerning refugees and domestic violence highlight how cultural and social factors, rather than a background of trauma, impact on women's experiences of abuse (see for example, Bhuyan & Senturia 2005; Lockhart & Danis 2010; Nilsson, Brown, Russell & Khamphakdy-Brown 2008). However, a number of important themes pertaining to refugees and their experience of violence in countries of asylum and resettlement can be identified from this literature.

First, refugee women are more vulnerable to domestic violence due to the traumatic experiences that they and their families have endured prior to their arrival in a new country (Pittaway 2004; Pittaway & Rees 2006; Pittaway, Muli & Shteir 2011). For women coming from war-torn regions of the world, domestic violence occurs against the backdrop of historic trauma arising from war and migration (Zannettino 2012). For many women, domestic violence is one experience of violence in addition to many others experienced and witnessed prior to immigration (Bhuyan & Senturia 2005; Zannettino 2012).

Pittaway and Rees (2006) apply a framework of cumulative risk to draw attention to some of the specific and compounding issues that can make refugee women vulnerable to domestic violence. They identify several cumulative effects that impact on domestic violence in the refugee context, including:

- heightened gender inequality resulting from external pressures that lead to more extreme cultural practices concerning women and girls than in the traditional society, and

- men's traditional identities and roles being threatened by their experiences of trauma and persecution, and time they spend in refugee camps, which they suggest results in an increase in violent behaviour. This can also be exacerbated by symptoms of post-traumatic stress disorder and other psychological problems.

Furthermore, women who have experienced rape and sexual abuse in situations of armed conflict are more vulnerable to rejection, abandonment and further abuse by the male members of their family. Pittaway and Rees conclude that there are universal causative factors in cases of intimate partner violence, such as male power and patriarchal cultures, that are exacerbated by the abuses and disadvantages faced by both refugee men and women in their countries of origin and when living in refugee camps.

In addition to the pre-arrival experiences of refugees, factors relating to their settlement in a new country have also been identified as contributing to domestic violence. These include:

- social isolation,

- a sense of 'not belonging',

- separation from family members,

- racism and discrimination,

- low socio-economic status,

- a lack of access to, or knowledge about, support services,

- difficulties with English language acquisition,

- lack of access to appropriate and affordable housing, and

- a lack of education support. (UNHCR 2011; Rees 2004; Rees & Pease 2006).

Additionally, issues such as the potential for family shame if abuse is disclosed, community connections, disruption to traditional gender roles, and concern for marital commitments taking precedence over concerns for the welfare of individual women, have also been shown to contribute to the greater risks experienced by refugee women who live with domestic violence (Bhuyan, Mell, Senturia, Sullivan, & Shiu-Thornton 2005; Tse 2007; Zannettino 2012).

Second, domestic violence can exacerbate the mental health effects of refugee women's pre-arrival trauma experiences and can be just as debilitating as the traumas inflicted on them during war and escape. Porter and Haslam (2005) conducted a meta-analysis of 59 studies of refugee mental health and found that refugees reported lower mental health than non-refugees. A meta-analysis of 7,000 resettled refugees in 'Western' countries (Australia, United States, United Kingdom, Italy, Norway, Canada and New Zealand), based primarily on studies using semi-structured interviews, found 1 in 10 to have Post Traumatic Stress Disorder (PTSD), 1 in 20 to have major depression, and 1 in 25 to have generalised anxiety disorder (Fazel, Wheeler, & Danesh 2005, cited in Meffert & Marmar 2009 p.1836). Further to this, domestic violence has been shown to have a detrimental effect on refugee women's mental health, including depression and suicidal ideation (Nilsson *et al.* 2008; Zannettino 2012). A study of trauma victims conducted by Perry et al. (in Boutros, Waldvogel, Stone, & Levine 2011) showed that, while survivors of genocide-associated trauma reported more somatic complaints and panic symptoms, survivors of domestic violence had an increased incidence of symptoms of depression, general anxiety and panic. As Pittaway and Rees (2006, p.20) suggest:

Domestic violence can cause as much, if not more, grievous bodily and psychological harm to women and children as armed conflict. A violent home is simply a different type of war-zone.

This argument is supported by Zannettino's (2012) study of domestic violence in the Liberian community in South Australia, which found that Liberian women's experience of domestic violence appeared to deepen the wounds already inflicted on them by the catastrophes of war, loss, displacement and encampment. Additionally, most of the women had internalised domestic violence as a continuation of their ordeal.

Third, domestic and sexual violence can become an obstacle for refugees in achieving successful integration and settlement in a new country. An Australian study conducted by Pittaway et al. (2011) found that despite the great potential of refugees and migrants from the Horn of Africa (HoA) to successfully integrate into Australian society, they face numerous obstacles, including sexual violence. Women in the study reported that their histories of rape, engaging in sex in order to survive, and having children born of rape, made them vulnerable to further sexual exploitation and abuse as well as preventing them from connecting with their own community. This further exacerbated their loneliness and social isolation in the Australian community.

Responding to refugees affected by multiple experiences of trauma

There is a moderate amount of literature that focuses on clinical responses to refugees who have been traumatised by war and its aftermath.[4] While there is a dearth of literature that focuses on responding to refugees who experience sexual assault and other forms of violence in countries of asylum and resettlement, studies conducted in the field of domestic violence shed the greatest light on violence in the lives of refugees. A number of important themes and theoretical frameworks pertaining to intervention in the lives of refugees experiencing abuse can be identified from this literature.

First, there is general agreement in the literature that domestic violence in refugee communities emerges at the intersection of culture, gender and trauma (James 2010; Pease & Rees 2008; Rees & Pease 2007; Sokoloff 2008) and that a theory of intersectionality should inform policies and health and welfare practice concerning refugee communities affected by domestic violence (Pease & Rees 2008). The central premise of intersectional theory is that gender oppression is changed by its intersections with other forms of inequality and oppression such as those based on class, race, ethnicity, sexuality or marital status (Sokoloff & Dupont 2005). This means that strategies for violence prevention need to acknowledge culturally-specific factors in particular communities rather than attributing blame to a particular culture for violence (Nayak, Byrne, Martin & Abraham 2003).

Pease and Rees (2008) do not point to culture itself as a key determinant of violence against women. Rather, what is of concern is how domestic violence is shaped by other forms of oppression that cut across gender divisions, particularly during settlement for newly arrived refugees. They propose that an intersectional analysis will assist in identifying both similarities and differences in men's violence against women in diverse cultures and communities. Issues such as community acceptance of violence against women and the low social status of women tend to be universally experienced and, therefore, transcend particular cultures. Despite the commonality of these issues across cultures (including Anglo-Australian culture), they are likely to manifest in culturally specific ways in refugee

communities and be intensified by a context of war, displacement, political structures and fundamentalist religious beliefs (Ely 2004).

Second, the complex reasons underpinning domestic violence in refugee communities means that intervention is not straightforward (James 2010). James (2010) identifies several principles that are fundamental to working with refugees. These include:

- the therapist earning the trust of their client, which is built through maintaining confidentiality and adhering to agreements,
- the therapist's flexibility regarding when and how they meet with families, such as visiting isolated women in their homes, and
- therapists adhering to the principles of client self-determination and empowerment.

These principles assist clients, particularly women, to have as much control as possible in the decisions that affect them.

James (2010) also suggests that therapists must gain a full understanding of the stages of each person's journey – before, during and after war – including their refugee and resettlement experience. She suggests that as outsiders to the community, therapists must earn credibility by learning as much as possible about their clients' country of origin and the conflicts and atrocities they may have endured. James (2010) also proposes that therapists must raise and discuss the meaning of domestic violence with both men and women, while understanding that women's loyalty to their husbands and communities may prevent them from disclosing violence if they believe that doing so will lead to family breakdown. James (2010) concludes that it is important to challenge abuse and violence in the name of culture, while being able to respond to the unique circumstances of refugees. This involves taking into account the intersections of culture, trauma and displacement. Rees (2004) argues that domestic violence workers need to have a developed awareness of the effects of torture and trauma. This includes an understanding of the manifestations of post-traumatic stress disorder and other mental health impacts arising from past and current experiences of trauma, and that this needs to be factored into interventions.

Third, there is a degree of consensus in the literature that responses to refugee women affected by domestic violence should proceed from a human rights framework (James 2010; Rees 2004; Zannettino 2012). Rees (2004) argues that the contemporary emphasis on social and political rights in relation to state-sponsored violence against women has made it easier to advocate for legal and international responses to domestic violence. Additionally, a human rights analysis allows for the examination of women's experiences and rights

from the perspective of their unique cultural and social histories and lived realities, in the post-migration context (Rees, 2004). James (2010) suggests that a human rights framework enhances the effectiveness of interventions with men who use violence. This is because it allows them to view women's rights to be free from the threat of violence as something which is as compellling as their own rights to education and work. She emphasises the importance of viewing domestic violence as a human rights violation rather than simply a gender issue.

Conclusion

Many refugees, particularly women and girls, have endured horrific experiences of sexual violence and abuse in the context of war and its aftermath. This paper highlights the cumulative effects of abuse and the significant continuities between sexual and gender-based violence in the context of war. In particular, it highlights violence that occurs in the context of intimate relationships prior to and/or following resettlement in a new country. In both contexts, women's bodies are the site of control and subjugation. The multiple experiences of trauma have a serious impact on the mental health of refugees and can make them more vulnerable to further abuse in countries of asylum and resettlement. This paper responds to the dearth of literature focusing on practice responses to refugees affected by domestic violence and sexual assault and builds on contemporary understandings of the ways that trauma impacts on these experiences.

Domestic violence, refugees and prior experiences of sexual violence: factors affecting therapeutic and support service provision

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Introduction

There has been increasing acknowledgment of the horror of rape, sexual torture and gender based violence experienced by women and girls in conflict situations and during their flight to asylum. However, the ongoing impact of this violence on women and girls, their families and communities remains less understood. Resettled refugee families are simultaneously struggling with the complex challenges of settlement into a new and often very different culture, while also dealing with the sequelae of having survived torture, including systematized sexual abuse and gender violence. To work effectively, service providers in both the refugee and domestic and sexual violence sectors require knowledge and understanding of the impacts of these pre-arrival experiences. They would also benefit from appropriate identification and response strategies which recognise the complex and multilayered nature of family and domestic violence in refugee communities.

In order to work effectively with refugee women experiencing family and domestic violence, we have to understand the impact of the pre-arrival experiences on individuals, families and communities. We are not only dealing with the present, but also with the past. The horrific realities of underlying phrases such as 'systematised sexual violence', 'multiple trauma' and 'torture' are often not fully understood and integrated into the consciousness and practice of service providers working with refugee women and girls in Australia. When women are targeted for rape in conflict situations, it is a form of torture for those women and for families and communities. It is often the enemy's way of humiliating and demonstrating their power over the men in the community. To deliver effective services it is critical for workers to understand these experiences and the meaning and impact of such abuse on everyone involved.

Research has shown that women rarely experience one traumatic incident in isolation and that many women and girls have experienced more than one traumatic incident (Pittaway & Bartolomei 2011; Eckert, Pittaway & Bartolomei, 2012). It has also been shown that the compounding effect of multiple abuses can make women more vulnerable when they experience future violence, and can impact on women's resilience and wellbeing (Bartolomei, Pittaway & Pittaway, 2003).

In this section of the paper, the needs of refugee women who have experienced prior physical and sexual violence will be explored, as well as some of the key practice issues arising from clinical and support work with refugees. In particular, the factors which may limit effective practitioner responses will be considered. The information below is underpinned by eleven years of extensive research into domestic violence in refugee communities undertaken by the UNSW Centre for Refugee Research (CRR), both in Australia and internationally.[5]

Understanding the pre-arrival experience

The refugee experience is characterised by exposure to high levels of violence. Almost all refugees have either witnessed or been subject to violence, including rape, torture, public humiliation, murder, and the loss or disappearance of family (Martin 2004, 2010; UNHCR 2006, 2008; Pittaway & Bartolomei 2001, 2005, 2011). Refugee women and girls are targeted for rape and sexual exploitation and abuse in conflict, in flight and in refugee camps and urban refugee sites (Bartolomei et al. 2003; UNHCR 2008; Pittaway & Rees 2006; Hyndman 2000; 2004; Pittaway 1991). Many refugee women and families are resettled with an already accumulated set of traumatic experiences resulting from the violence and atrocities they have witnessed, their long endurance of human rights violations, and the impact of persecution and flight.

The effects of violence, torture, and the trauma of flight from home are amplified by conditions in countries of asylum. Existence is often a daily struggle, with poor access to food, water, housing and health. People live in a state of insecurity and uncertainty. Many live in protracted refugee situations, or what has been called 'warehoused' (USCRI 2011), where they have been in camps and urban areas from eight to thirty years. Both single and married women may be forced to sell their bodies, as 'survival sex' in order to feed themselves and their families. Forced marriage of young girls is common. Refugee women also experience high levels of domestic violence in both countries of asylum and in post-conflict settlement situations (UNHCR 2006, 2008; Pittaway & Bartolomei 2011; Hajdukowski-Ahmed et al. 2009).

Shame & silencing

Across the CRR research, perhaps the most common word in the discourse about women's experiences of sexual violence is the word 'shame'. This is used to describe both a refugee woman's response to rape and sexual abuse, and the response of her family and community (Pittaway & Bartolomei 2011; Doney 2009; Eckert et al. 2012). The power of shame, at times, sees raped women ostracised or even killed (Hajdukowski-Ahmed 2009; KWO 2004). In many cultures, husbands and communities may reject women who have been raped, because they may believe they have been shamed by the attack against their 'honour'. Women may not be allowed to stay in their communities, or are blamed for their loss of virtue. Shame is also a very effective tool of torture. The shame assigned to women is part of the collective consciousness of many communities, who are often unable to cope with the horror of the events. Workers must understand the power of shame and how this is used to destabilize families and communities.

Shame also silences discussion by service providers around the issues and women's experiences. One of the most important findings of the CRR research is that the significance and compounding impact of pre-arrival experiences of refugee women and girls is often not acknowledged or addressed by families, communities and services. Their experience of systematic and endemic sexual violence creates a particular dynamic and tension within refugee communities. Refugee women reported that they often feel they were silenced and not able to talk about what had happened to them. Workers also indicated that they often do not feel well enough informed about the issues to offer appropriate services (CRR 2011a; Eckert et al. 2012).

Yet in contrast, in the CRR research, conducted with over 1500 refugee women, participants freely discussed rape and sexual abuse. Most commented that service providers had previously 'stopped' them talking about their experiences of sexual violence. Researchers were frequently thanked, with variations of, 'this is the first time we have been able to talk about what has happened to us, somebody is listening', recorded in every research site.

Increased vulnerability

For families adjusting to the process of resettlement, along with the legacy of conflict, persecution and flight, trauma impacts on their ability to deal with the challenges and stresses of adapting to a new environment. Family relations are altered by the aftermath of displacement and the impact of torture (Doney et al. 2009; CRR 2011a, 2011b; Zannettino

2012). Many women experience anxiety about family and friends left behind, guilt and shame, feelings of helplessness in an unfamiliar environment, fear and insecurity, and cultural dislocation (Pittaway 2013; UNHCR 2002; Martin 2004; Eckert et al. 2012).

The quality of the settlement environment plays a significant role in enabling trauma to be overcome, and can subsequently impact on women's experiences of domestic violence (Pittaway 1999; Eckert et al. 2012; Rees & Pease 2006; Martin 2004). It is important that services understand the unique set of compounding factors that can lead to the heightened vulnerability of refugee women to domestic violence. This may include previously established patterns of domestic violence, as well as the often extensive psychological impacts of prior and multiple traumas, particularly sexual violence (Bailey-Smith 2001; Rees & Pease 2006, 2007; Gozdziak 2009). Lack of a strong social network or community, lack of close family, or other forms of social isolation, can all contribute to the vulnerability of women (Iredale 1996; Pittaway 1999; Deacon & Sullivan 2009; CRR 2011a, 2011b). These factors are discussed in the final section of this monograph in detail.

Issues for Service Providers

As well as developing an enhanced understanding of the pre-arrival experiences of women refugees, and the harm and risk arising from multiple trauma experiences, there are other factors which impact on the ability of services to meet the needs of refugees who may be experiencing domestic and family violence. These include the dilemmas arising from a desire among workers to be culturally sensitive and culturally aware, where the silencing has been caused by cultural 'defences', and vicarious traumatisation.

Cultural sensitivity

An assumption made by many workers in both domestic violence and settlement service sectors is that domestic and family violence is culturally acceptable in some refugee communities. A related obstacle is the popular use by mainstream workers of 'culture' to explain domestic violence in refugee or CaLD communities.

Yet many of the fundamental causes of domestic violence in refugee communities are shared with the wider community. The gendered nature of domestic violence is rooted in systems of patriarchal power relations that transcend culture, nationality and religion. The subjugation of women to men is, with very few exceptions, a universal phenomenon. It has been noted that the stronger the patriarchal culture, the more effective is the use of rape as a strategy of war and conflict (Pittaway 2009).

For many refugees who come to Australia from protracted refugee situations, their cultural heritage is also complicated by an overlay of 'refugee culture', built up over years in refugee sites in countries of asylum. This refugee culture is often fiercely protective of family and community norms, in order to protect some vestige of traditional life in conditions which threaten and often destroy these structures. Refugees have reported that adherence to traditional norms is far stricter in camps and urban areas than before flight (Pittaway et al. 2010).

Additionally, bi-lingual workers may not be trained to deal with the issues of shame around experiences of gendered violence, and the impacts of multiple traumas in their communities. This may make the situation more difficult for women who are vulnerable because of prior trauma. Across the CRR research projects, common statements made by bi-lingual workers included:

- We don't talk about things like that in our culture

- It doesn't happen in our culture

- That is quite acceptable in our culture

- Women are not allowed to admit to that in our culture.

These attitudes can increase the silencing experienced by women and may make it less likely that domestic and family violence will be disclosed to the settlement workers.

Non-CaLD workers experiencing confusion about their own cultural awareness may find that it is difficult for them to challenge such statements.

Workers can feel they are walking on a mine-field of cultural appropriateness, yet when faced with evidence of the harm and trauma experienced by clients, bilingual workers are often genuinely surprised and upset that they have not addressed these issues (Doney et al. 2009).

There is also a lot of 'conventional wisdom' about not talking about experiences of torture with refugee women, based on a view that it is better not to disturb painful memories (Pittaway 1999; Eckert et al. 2009, 2012; Doney et al. 2009; CRR 2011a). However, our research suggests that a lack of understanding and absence of a safe space where women can retell their stories causes the trauma of their pre-arrival experiences to be constantly relived, or expressed in other ways (CRR 2011a).

Workers need to develop an understanding of the client's cultural and other belief systems, in order to make sense of their world. This is a difficult process that requires the exploration and co-creation of ideas with the client. Yet it is essential for breaking down the worker's own unquestioned assumptions (Bailey-Smith 2001).

Vicarious traumatisation and burnout

One of the most important responses to refugees who have experienced multiple and compounded trauma is that of simply listening to refugees' stories, and providing a safe, validating and non-judgmental environment where they can heal their wounds. However, workers may be deeply affected by repeatedly hearing descriptions of atrocities and severe abuse. Many suffer from vicarious, or secondary, traumatisation. Their professional and personal lives may suffer as a result, to the point where they are unable to keep working with clients. Many workers also suffer from burnout and exhaustion due to the difficulty of their cases. Those who feel the clients' problems are unsolvable may feel that their interventions are futile and meaningless. This, in turn, can lead to an erosion of self-esteem and decreased sense of professional efficacy (Dane 2000).

Provisions must be made for staff, and professional supervision made available, to identify and assist with cases of vicarious traumatisation. Self-care strategies need to be built into response frameworks to ensure successful service provision. The Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS) NSW, offers an excellent course for staff working with traumatised populations, called 'The Accidental Counsellor', (see www.startts.org). Courses such as this could be explored for use with staff working with survivors of violence.

Towards improved practice

Refugee women report that programs which empower them to take control of their own lives, and equip them with the knowledge necessary to navigate the social and legal infrastructure, also give them skills and courage to face up to domestic violence (CRR 2011a). They stressed the need for refugees to be educated about Australian laws to protect women and families, through small community based prevention and education sessions in appropriate languages. These should be available to men, women and young people.

The issue of domestic violence in refugee communities needs to be addressed in the context of the complex and closely interrelated circumstances which impact on their lives. Central to working with refugees is the provision of adequate and effective on-arrival and continuing settlement services. Domestic and family violence and sexual violence services have to be an integral part of this service network, and these services need to be aware of the harm and vulnerability caused by prior experiences of trauma. One of the major recommendations from all CRR research is that staff who work with refugees receive thorough and comprehensive training on the pre-arrival experience of

refugees, in particular women and girls. Workers from refugee services have highlighted the need for training and skills development in identifying and responding to domestic and family violence. They report that they do not have the resources to deal with this problem. Often they do not have the cultural knowledge necessary to work at this level with communities. Training and models of best practice are regularly not available. Government and non-government service provision is under-resourced and not always able to adequately deal with the need for services for these women and their families (RCOA 2003; Pittaway 2005; Eckert et al. 2009).

Domestic violence workers and other specialist service providers also require increased training in order to better address domestic and family violence in refugee communities . The CRR has produced a number of training materials around this subject. These are listed at the end of this paper.

Work with perpetrators of violence is also crucial. Not all refugee women wish to remain with abusive partners, but some do. Having survived as a family for years during conflict and war, and finally reaching a country of hoped-for peace and happiness, many women wish only that the violence will stop and normal family life will resume. This is particularly the case if domestic violence did not occur before displacement and resettlement (Versha & Venkatraman 2010).

Refugee men have also identified the need for services and specific material targeting men in their communities. This might include posters, pamphlets and TV and radio advertisements in appropriate local languages and the use of celebrities such as sports stars. They stressed the need to present domestic violence as a 'men's issue' as well as a 'women's issue'.

Finally, any effective practice response requires involving refugee communities in the development and delivery of services and programs.

Conclusion

The unique issues and circumstances that exacerbate or compound domestic violence in refugee situations need to be understood and incorporated into the development of adequate responses by service providers. Further education and training courses delivered to all people who work with refugees is also necessary. It is also critically important that refugee communities are consulted and participate fully in these processes to ensure the complex and multilayered issues surrounding family and domestic violence can be addressed.

Best practice considerations when responding to people from CaLD backgrounds, including refugees, with mental health issues and experiences of domestic and sexual violence[6]

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Introduction

The experience of being a refugee raises a range of complex mental health-related issues. Issues of grief and loss, displacement, loss of role and status, rapid changes in environments, having family members still living in unsafe places, prolonged vigilance, uncertainty and intense fear all have varying levels of impact. The often secretive nature of past and current trauma-related experiences can lead people, particularly women, to harbour heightened feelings of isolation (Refugee Council 2009).

Many practitioners may believe that engaging with people in their early days of arrival in Australia about their domestic and sexual violence experiences may be intrusive. However, the extensive gendered violence that women and girls are exposed to in war-affected areas and refugee camps is well documented, indicating a high level of need for support. Furthermore, women and girls continue to be at risk on arrival, due to inherent vulnerabilities and lack of knowledge of service and justice systems in Australia. Counsellors can be uncomfortable talking about domestic and sexual violence with clients, especially with clients outside their own culture. Additionally settlement or support services may not refer clients to alternative services dealing with domestic or sexual violence, because of their service modality of working with the entire family.

When working with a person from a CaLD background, the practitioner may need to discuss the concept of counselling and therapeutic relationships, as practiced in Australia, as these may be unfamiliar in the person's traditional culture and society (Ostapiej-Piatkowski and McGuire 2008). Issues associated with a therapeutic relationship, such as role boundaries, confidentiality and the limitations of such, the role of interpreters and responsibilities associated with duty of care are critical to discuss with the person. Such discussions provide opportunities for clarification, ensuring that the person seeking professional counselling understands and has confidence in the process.

Working within a multicultural framework requires practitioners to maintain acute listening and observation strategies, with a cultural lens that seeks ongoing clarification of content and meaning. We assert that a multicultural framework is essential in working with people, irrespective of their backgrounds and presentation. A difference for practitioners working with a person from a CaLD background lies in their ability to reflect on their own cultural values and beliefs, and how these may intrude on accurately assessing the person's presenting situation. Key considerations include: awareness of cultural differences; awareness of assumptions and prejudices; interpretation of a person's presentation from a western perspective; and supporting a recovery and empowering approach to interventions while ensuring cultural safety (Ostapiej-Piatkowski and McGuire 2008). Considerations made by a professional counsellor should support and lead a person to continue their journey to wellbeing, while empowered by knowledge and understanding of their situation in the context of life in Australia.

Best practice considerations

✓ Contact with a person from a CaLD background requires that the practitioner foster an appreciation of diverse worldviews and personal experiences.

✓ Practitioners' self-reflection and awareness of their own cultural perceptions is essential, as they bring a myriad of professional experiences and their own core values, beliefs and diversity to their work with people.

Assessment

The first contact a practitioner has with a person seeking assistance for domestic violence or sexual assault is critical in laying a foundation for future engagement in what may be a therapeutic relationship. As frail as the trust may be at this stage, the practitioner faces a window of opportunity, within which the practitioner can explore with the person possibilities for a positive, supportive, informative and respectful relationship.

For domestic violence and sexual assault practitioners, the initial assessment phase with a person from a CaLD or refugee background is critical to positive outcomes. Information gathering while making an assessment enables a practitioner to explore a person's current situation and ensure that appropriate strategies are in place. The results of the involvement discussed and agreed upon will need to be continually re-assessed by the practitioner. This is necessary in order to evaluate whether or not the person's initial presentation and needs remain current and relevant (Allimant and Anne 2008).

When working with someone from a CaLD background, it is critical to seek information such as:

- the language the person is most comfortable with;

- migration experiences, individual spiritual beliefs and relevance to their everyday life;

- cultural considerations relevant to the person's current predicament and links and roles related to significant others.

An assessment may require a number of sessions before a relevant and informed plan of responses is reached.

The clarification of roles and expectations is an essential aspects of cross cultural engagement. Although it might appear that the understanding is there, especially after a victim/survivor's prior contact with other support services, at times there is a need to explain the role of the practitioner in a simple and clear way. It is important that professionals explain the reason for contact and any expectations they might have of the person. This information may need to be re-visited a number of times during contact.

Practitioners need to be mindful of the fact that their service or organisation constitutes an institution and, as such, might provoke diverse emotional responses within people from CaLD backgrounds, including refugees. The past experiences of authority and institutions held by people from CaLD backgrounds are often traumatic and ambiguous. One cannot assume that people who have had contact with government departments are clear and informed about the safety of that interaction. More often than not, people retain a fear of institutions and authority, and this issue needs an appropriate, understanding response.

Practice example:[7]

A young woman disclosed her current situation in a government office through a professional interpreter. The information disclosed in the privacy of that office was inappropriately shared with her family by the interpreter, which resulted in the woman experiencing serious consequences.

The saving moment in this case of a grave breach of confidentiality was that the young woman was so distraught and isolated that she could only return to the worker at this office. In spite of her fears, she disclosed what had occurred and the worker was able to take appropriate action in reporting the interpreter involved and assisting the young woman.

Similarly, written information provided to the person, if not explained and understood, can provoke anxiety and stress. It is the unknown, or misunderstood expectations, that can lead to distress for people from CaLD backgrounds. For example, people commonly assume that they need to take some action when they receive a formal communication. However, this may not necessarily be the case. A lack of fluency in English can make it very difficult for people to follow up what needs to be done. Often workers encounter people experiencing high levels of distress resulting from letters from departments or institutions containing well-intended information. Translated information or letters form more appropriate means of communication; however attention needs to be paid to the recipient's level of literacy in their own language. Many communities do not have a written language (for example, Rohingyan, Neur), and many people may lack formal education or literacy skills in their own language.

Best practice considerations

✓ A person's previous experiences with legal, mental health services, social systems may lead to fears and concerns about practitioners as 'authority figures'. The person may come from oppressive or corrupt regimes, where institutions and services form part of a system.

✓ Consider one's own authority: how might you allay fears about authority figures?

✓ Ensuring that there is a clear understanding of the person's level of literacy is crucial and needs to be part of an initial assessment.

✓ Going through written information with the person, clarifying and explaining content is very important. People affected by violence and trauma may be confused and may not have the capacity to retain a lot of information. Hence, supporting understanding is essential.

✓ The language used needs to be clear and simple at all times, with further clarification of content as perceived relevant by the practitioner.

✓ Determining the safety risks for the person is paramount.

✓ It is also vital to determine the emotional wellbeing of the refugee or CaLD person. Past experiences of trauma, re-lived while being in a foreign country with no language capacity, can lead people to experience high levels of emotional distress.

✓ Check with the person whether sending written information to their home address is appropriate in terms of confidentiality. Such action may expose persons and create safety risks. People may prefer not to receive any correspondence, or provide an alternative postal address..

Mental health: distress associated with sexual violence

Mental distress for a person who has survived sexual violence is typical and can be exacerbated over time (Boyd 2011; Wasco 2003). Furthermore, there is some evidence that survivors of sexual violence constitute the largest group who experience post-traumatic stress disorder, or PTSD (Calhoun & Resnick 1993, cited in Astbury 2006). We have observed that survivors' initial and often critical self-perceptions of their role in the violence, together with decisions as to whether to seek any support, are strongly influenced by cultural and societal values related to those experiences. It seems that it is this initial negative self-appraisal by survivors within a cultural and social contextual frame that can induce strong emotional distress and often complex mental health related issues.

For example, many women from CaLD backgrounds, including refugees, who have experienced sexual violence, have strong, well-founded fears of reprisal from their community. This is due to the taboo status associated with being sexually assaulted or raped. In many societies, from our experience, sexually violated women are considered 'damaged', bringing dishonour to the family and community. In such contexts, isolating (or in extreme cases, removing or killing) the person who has been assaulted may be seen as being in the best interests of the family and whole community.

For some, the experiences of sexual violence are further intensified when mental illness and associated stigma are disclosed. Perpetrators may use this against women, preventing disclosures about subsequent violence, or ensuring the disclosure is dismissed by others as if it is unlikely to be a factual recount.

In our experience, some women from CaLD backgrounds express feelings of disempowerment when they disclose their sexual violence experiences to appropriate authorities. This is exacerbated when the women are told that cultural issues or their enmeshed relationships make cases like theirs too problematic to pursue, or that there is insufficient evidence and the case will be dropped. On many occasions, women are simply told to keep away from the perpetrator and the community. We are aware that such recommendations target the victims/survivors for isolation, ostracism, reprisal and fear.

Furthermore, such responses not only impact on those who disclose, but may also prevent others from coming forward for support. Consequently, many survivors from CaLD backgrounds rarely openly disclose their experiences of domestic or sexual violence, and continue to struggle in silence. These social considerations and consequent issues need to be addressed as a priority by practitioners so as to improve access and facilitate an environment of cultural safety.

For people who have already experienced trauma, including sexual violence, being re-traumatised can be a turning point in their mental health. Australia is perceived as relatively safe by many women from CaLD backgrounds. However, a new experience of domestic or sexual violence can fracture women's perceptions of the country as a safe environment and collapse of any sense of security. Reliving past experiences of trauma can be triggered by new violent incidents, and these past experiences also need to be addressed.

Issues of interpersonal violence and related trauma have their own impact on every survivor. The combination of past and current trauma impacts can form toxic mental health environments that continuously influence a victim/survivor's life on all levels of existence (Allimant & Ostapiej-Piatkowski 2011). Workers supporting people with these issues need to be cognisant of such experiences, their impacts and appropriate therapeutic approaches. Practitioners must also be aware of diverse understandings and interpretations of human experiences, and the extent to which these can dynamically influence an individual's worldviews, self-recognition and identity.

The stigma and consequences of being identified within a community as a victim of sexual violence can impact not only on the person, but also on the family and significant others. For many vulnerable people, their family and/or community constitutes their primary, if not only, social support. Other repercussions may include reduced marriage prospects for a victim/survivor and their siblings, and a tarnished reputation of the family within the community. Harmony Place often sees whole families dealing with the impact of sexual assault. Practitioners need to be aware that a person who has experienced sexual violence might not only lack appropriate support from their family, but may also be dealing with the family's additional stress.

Multilayered trauma

Our therapeutic work with women from CaLD backgrounds who may have a background of multilayered trauma informs us that it is not so much the form, or perceived severity, of violence experienced that defines the extent of impact on a person's well-being. Rather, it is the influence that those incidents of violence have on the person's self-perception, identity and their worldview. This necessitates that a practitioner be mindful of how a new experience of violence, such as domestic violence or sexual assault, may impact on a person.

A person's self-assessment following violence is most strongly drawn from their particular social and cultural background (Ahrens 2006; Allimant and Ostapiej-Piatkowski 2011). For instance, a woman with experiences of sexual violence within a society where women are required to keep their bodies 'pure' may draw different conclusions about herself as a victim, than a woman in a society where clear laws place responsibility for such violence on the perpetrator. This self-appraisal will strongly influence whether such women ever disclose or seek support.

On countless occasions, we have been reminded that one woman may retain a strong sense of identity and resilience in spite of her severe conflict-related experiences, while another woman's perceptions of self-worth after similar experiences is that she is 'nothing' and 'deserving of such violence'. The way women self-identify following experiences of violence and trauma will determine their response to subsequent relationships and their capacity to negotiate safety and respect.

Cultural considerations

Even though a practitioner's information and knowledge of a given culture might be of great assistance in the therapeutic relationship, it is important to be mindful of the source of information. For instance, cultural information provided by male community elders or leaders may be challenged or negated by information from women in the same community.

We have emphasised the importance of cultural awareness and sensitivity when working with refugees and persons from CaLD backgrounds. It is equally important to remember that the aspects of any given culture will be reflected differently in each and every individual. Influential factors such as social status, education, family, age, gender, settlement, grief and loss, torture and trauma, migration experience, and health cannot be overemphasised. Each of these factors will affect how an individual responds to their particular experience of domestic and sexual violence and trauma.

Best practice considerations

✓ It is important to seek advice from sources that reflect the person's gender, social status, settlement experiences, geographic location, age, ethnic group etc.

✓ If planning to have a cultural advisor present at sessions, it is important to check with people first as to the appropriateness of this and any concerns they may have related to confidentiality.

Complex – whose interpretation?

The experience of 'complexity' when working with refugee and CaLD survivors of multiple traumas is often a reflection of the practitioner's resources. A practitioner may assess a situation as 'complex' because they do not have sufficient knowledge of the presentation, or the context they work in may not have adequate resources. For example, there may not be the resources to fund professional interpreters; allocate sufficient time to ensure appropriate contact with a person from CaLD backgrounds; provide appropriate equipment for telephone interpreters; or organisational policies and procedures do not support multicultural professional development strategies for their staff.

Best practice considerations

✓ The importance of using professional interpreters cannot be overemphasised when working with people from non-English speaking backgrounds. It is crucial to attend to the gender requirements for interpreters and to check whether people have a preferred interpreter. A practitioner needs to be mindful that people from non-English speaking backgrounds are often from small communities where social, familial, church and community connections are close, and a person's fears of disclosure within the community are often well-founded.

Responding to refugees affected by domestic and sexual violence: working with men

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Introduction and context

This section will focus on clinical work with refugee men who are violent in the context of intimate relationships. Two case studies built on learnings in clinical practice will demonstrate how clients who were traumatised in their countries of origin are supported as they confront their own violence and sexual abuse within their relationships. The case studies will specifically focus on engaging and working with men. Once some aspects of the cases have been unpacked, I will place these within a general counselling framework and describe how the work fits into the wider context of the Australian service system.

Rules of engagement with any refugee affected by trauma

While I draw alongside refugees to help them and their families settle successfully in Australia, I do this by honouring and hearing their story as it is told. I do this by respecting the heritage of each individual, community and culture, and believing that each person can harness his or her own resources. I accept that for each person, a fact is a fact and their perception is reality. The power of imparting information remains with them.

I work to empower clients by:

- taking time to sit quietly and wait expectantly - this helps build safety

- being open to hearing about crisis in the refugee's terms

- being with the client without becoming overwhelmed by fear

- not passing judgement on the person but stating clearly and directly my responsibility as a worker in relation to violence and sexual abuse

- proceeding at the refugee's pace

- trusting

- not asking too many questions while asking enough to ensure that each person is safe

- not always needing to understand

- staying with the uncertainty

- not hiding vulnerability

- engaging with people in a gentle manner and working with people as equals (respect where the client comes from and be prepared to learn from his/her culture. Do not take yourself too seriously)

- learning from those we help.

This work may occur with individuals, families or groups and might include counselling, bodywork and mindfulness, or arts-based activity using the individual's and community's creativity.

Creativity, often in non-verbal form, is central to the process of healing for those who have traumatic experiences. Energy trapped in the body when a 'fight or flight' response was not possible can be released as people symbolise, externalise, communicate their experiences and rebuild what has been destroyed (Parris 2012).

This work is underpinned by attachment theory and relies on building a strong safe relationship. It is dependent on the counsellors' ability to take responsibility for their own boundaries, professional ethics and their area of accountability. In this 'safe space', the client is offered the opportunity to explore their own perceptions and experiences. They can try out different perspectives and strategies for coping with traumatic experiences and for developing their intrinsic feelings and self-worth (Miller 1999; Parris 2012).

www.adfvc.unsw.edu.au
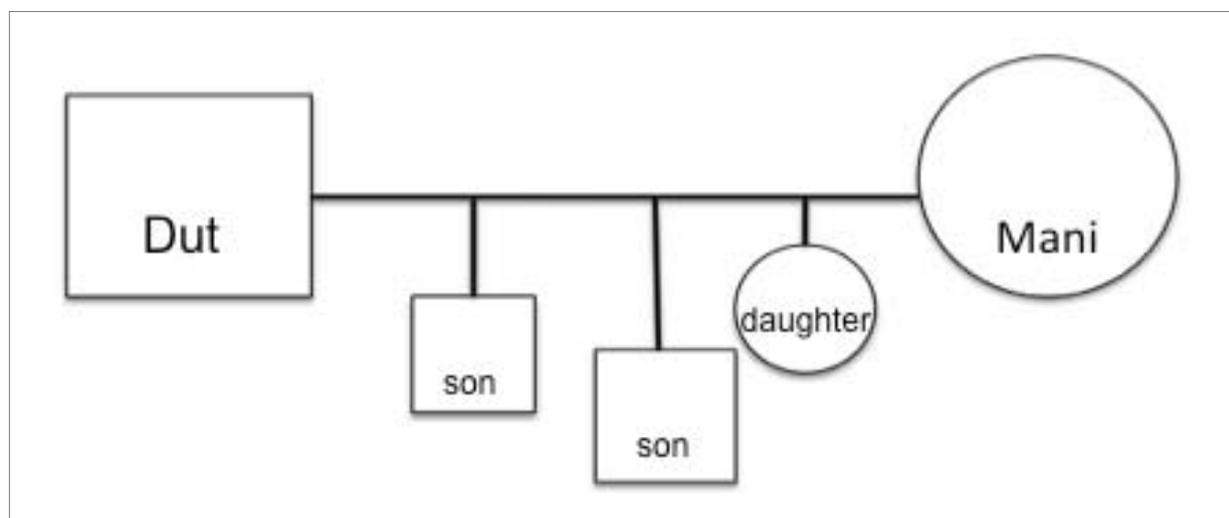
Case studies

Dut and Mani

Figure 1: Dut and Mani

Mani and her children arrived in Melbourne in June 1999. They came as one of many families who were granted asylum as part of the UNHCR Resettlement Scheme. They were immediately supplied with a house, all basic furnishings and household equipment. There was even a small supply of food and toiletries to meet their immediate needs.

A settlement worker who spoke Mani's language supported Mani and her children as they became familiar with the local shops, bank and Centrelink. The three children were settled into schools and Mani, herself, began attending English language classes. She was introduced to a group of Dinka speaking people who had lived in Australia for several years. Friendships blossomed and the initial settlement process was cushioned by these relationships.

As soon as Mani was settled, she went to the Red Cross and asked for help to find her husband, Dut. The family had been separated when fleeing their village attacked by soldiers from North Sudan. Dut was located and joined his family in 2003.

Initially, everyone was very excited by the reunion, but soon after his arrival Dut became unhappy. He did not like the way his family, and particularly his wife, questioned his authority as head of the household. He also resented Mani's connection with the broader Sudanese community and was jealous of the support Mani gave and received. He did not accept her explanation that without this Mani could not have managed the family. There was an argument over money that escalated into a physical fight. After hitting and kicking Mani in the belly, Dut dragged her into the

bedroom by the hair, forced her to the floor and raped her. He then demanded that she clean herself up and go to the bank and withdraw the money he wanted. He took the money and disappeared for two days. When he returned home Mani was compliant and Dut now demanded violent sex on a regular basis.

The children, who had not been present when Dut first was violent and forced himself on his wife, became angry at the change in the family dynamic and the oldest son got into trouble at school. Mani was called in to the school and, in a tearful interview with the welfare coordinator, whom she knew, she talked about the change in family circumstances and was referred to counselling.

A worker was assigned to this case and met Mani at home on a day that Dut was at English classes. Initially, the work with Mani was slow, and focused on parenting. Mani was reluctant to speak about either her past or her relationship but after some months, the worker arrived to find Mani bent over in pain and the full story tumbled out.

The worker immediately worked out a safety plan with Mani and arranged to see Dut the following afternoon. Dut was angry that there is 'no place for the man' in Australia but decided to leave the house rather than have an intervention order taken out against him. He also agreed to have counselling. This took place in an office environment.

What follows are a few short extracts from sessions, which highlight some aspects of their counselling.

Dut's Story	Counsellor's thoughts and interventions
You say I must not hurt my family and I don't want but they are very different. Here is very different too. The children they are king and they want, want, want. They do not listen. Mani also not listen. She is the boss and I have nothing. In Africa, I bring the money. Here she has money and power and I am nothing. My family is upside down.' *'I am here, but I am not here. All the time I hear the fire and the screaming and at night in my dreams I run but I cannot get away. They burn my village to the ground and they catch us and. I want my mind to stop. I want to stop the nightmares.'* *'You are a strong person. Can you make the nightmares stop?'*	It is clear from the outset that while Dut is willing to hear about 'Australian law', he is too trapped in a patriarchal mindset, the guilt about losing his family in Africa and the horrors of war to work at change in the present. The first session is focused on keeping the family and Dut safe so that he can do the work. Dut agrees that he wants everyone to be safe and quickly moves on to how out of control he feels. Dut agrees to move out of the house and stay with a friend with whom he does English classes and to keep away from his wife and children. He will phone them and tell them of the arrangements. All interventions are gentle but boundaries are firmly set.
'I need to go home. My family needs me. I have been gone so long. There is no place for the man in Australia, no respect. *She will get strong again and she will tell me to go forever. She does not understand. She says when the woman comes here she goes crazy because of the freedom. I do not want her to be crazy. I want her to look after her family and me. This is her job. I want a new baby also. I am a man.* *'In my village I see bad things. I see fire and men killing and make people do bad things.' Tears*	Dut is desperate to go home. He has phoned his wife incessantly. He cannot focus on anything except trying to get back. There are threats and anger but also desperation and compliance. The gentler and calmer the intervention, the more anxious Dut gets. Just before the session ends he begins to talk about his flashbacks. I calm him and suggest he talks about these things when we have more time so we can take it slowly.
No show	Mani says Dut is very angry but has not come around. He phones and threatens her. I suggest she changes her sim card and blocks her number. We discuss what she will do if Dut comes around. Mani will call 000.

This case study has demonstrated the balance between the use of clear boundary setting to maintain safety within the family and an honouring of the perpetrator's need to be assisted as he chooses to explore and integrate past trauma. This work can only be done if the client wishes to explore trauma. Many settlers wish to put their trauma away without unpacking it. It is my belief that it is very difficult to change violent behaviour without building on trauma work.
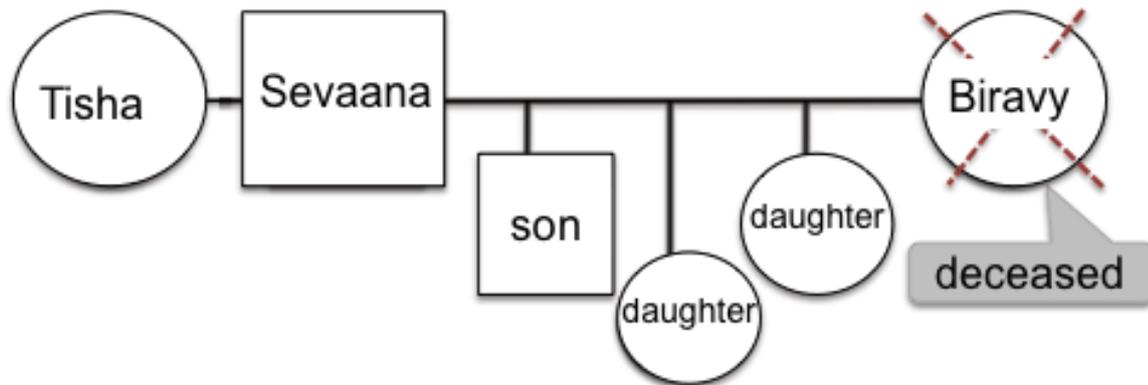
Sevaana and Tisha

Figure 2: Sevaana and Tisha

Sevaana and Biravy were married in Sri Lanka as teenagers. Their parents arranged their marriage and soon after their honeymoon Sevaana went away to work in Saudi Arabia. Each time he returned home his wife fell pregnant. She died when the hospital in which she gave birth to the third child was bombed. The baby survived. Sevaana's parents took the children in and arranged a second marriage to Tisha.

When a bomb exploded in the home next to Sevaana's parents a month after this marriage, the new family fled by boat to Australia. After a short stay in detention, Tisha and the children were released into the community while Sevaana remained. The family was finally reunited three years later. Sevaana was lucky because he soon got a well-paid job because of skills he had picked up in Saudi Arabia.

The family soon settled into a new location, the two older children changed schools and the smallest stayed at home with Tisha during the day. All went well for the family until the little one went into kindergarten and began bullying others. Tisha was called in and the family was sent off for family therapy.

The therapist soon realised that the problem expressed by the little girl was in fact related to a power issue between the parents. Couples counselling commenced.

What follows are a number of short extracts from sessions that highlight some aspects of counselling. It is important to know that Tisha had individual sessions throughout so that safety could be monitored.

Sevaana and Tisha's story	Counsellor's thoughts and interventions
Sevaana: *'I will not talk about my life in front of any person who speaks my language except my wife. This is impossible.'* Tisha: *'I am not afraid. I will call the police immediately if anything happens at any stage. I also do not want the community to know about our difficulties at this stage.'* Counsellor: *'This is not recommended but if you both insist we will give it a go.'*	The first step in counselling was to discuss the issue of an interpreter. Despite very clear statements that a neutral trained interpreter was essential, Sevaana refused to work through anyone outside of his wife. Tisha agreed and counselling went ahead on the condition that she have individual sessions between couple counselling so that safety could be checked.

Sevaana and Tisha's story	Counsellor's thoughts and interventions
Sevaana: *'My parents arranged the marriage. I agreed to look after Tisha and she must do what I say and keep my house and look after the children.'* Tisha: *'All this is my job I understand but Sevaana gets angry that the children come to me. But they do not know him. When he shouts for his dinner the older boy and girl shout at the little one. They did not do this when Sevaana was not with us. Also the children get upset when he makes me share his room at night. The children are used to sleeping with me.'*	In the beginning, both parties stated clearly that they had never thought about love. They had a contract and Sevaana felt that Tisha was not doing what she was told. The session explored the contractual arrangement of their marriage. This was contrasted with Australian beliefs. The rights of both women and children to live in a respectful non-coercive environment were highlighted. The Australian legal framework, which protects all parties in a marriage and family, were clarified. Both Sevaana and Tisha were pleased with the clarification but talked about their fear of Australian authorities, based on their experiences of detention.
Both Sevaana and Tisha talked about how painful it was to be treated like family property rather than as individuals. Warmth grew between the couple as they heard and accepted each other's feelings about living a life with very little control. Both talked about how Australia had replaced the authoritarian position of their families and how the process of seeking asylum had been exhausting and destructive of them as people. Sevaana's face became black with anger as he talked about the callous treatment he had endured in detention.	While sessions were focused on trauma, both Sevaana and Tisha reported that the children had become friendlier to each other and the kindergarten teacher had confirmed that the youngest child was fitting in much better. There had been no further bullying. At home, Sevaana had become much gentler and occasionally helped with meals and washing dishes. However, he would not manage the children because this was definitely woman's work. Both parties agreed that sex was still a problem. Tisha felt safe but was not satisfied with Sevaana's attitude.
When Tisha and Sevaana felt resolved about issues related to seeking asylum, they both wanted to get straight to the point. They wanted to think about marriage the Australian way. Tisha: *'I want a separation under the same roof. I do not want to have to come into your bed. I do not want sex until you can say you love me.'* Sevaana: *'I am happy to live in separate rooms as long as no one knows about it.'*	The couple discussed their new understanding that sex without choice is violence. They agreed that love was a new concept and while each respected the other, there was no love. I asked the couple to each draw a series of pictures of how they would know that love had come. Both took time to accept drawing as useful, however once they drew their first picture they became excited by the differences their work produced. In their first drawings, Sevaana's picture was of them hand in hand and Tisha's had the whole family sitting together in the sun. They both expressed surprised that Tisha seemed to care more for the children than Sevaana and that there would be great difficulty if they separated permanently because of the kids. After this, both were keen to use drawing to share their ideas. When the couple left counselling, they were still experimenting with living separate lives under the same roof and enjoying doing so. They had never dreamed that they could contemplate falling in love. They agreed to return to counselling if either of them felt unsafe and said they were clear about the law and would abide by it.

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The work above required an ability to sit with not understanding or judging the culture in which this relationship was spawned. In light of their treatment as asylum seekers, any assertion that the clients must accept Australia's approach to relationships could have invited strong pushback.

Positioning in relation to other services

Counselling refugees involves a wider scope of support work, as well as therapy., as clients who are new to Australia often need guidance linking into relevant support systems. For example, it can be impossible for a client to focus on personal issues while they are having difficulty with housing or work. The support work may include formulating, providing and negotiating referrals. It may also include walking alongside the client as they negotiate these transitions in relation to vulnerable and dependent family members.
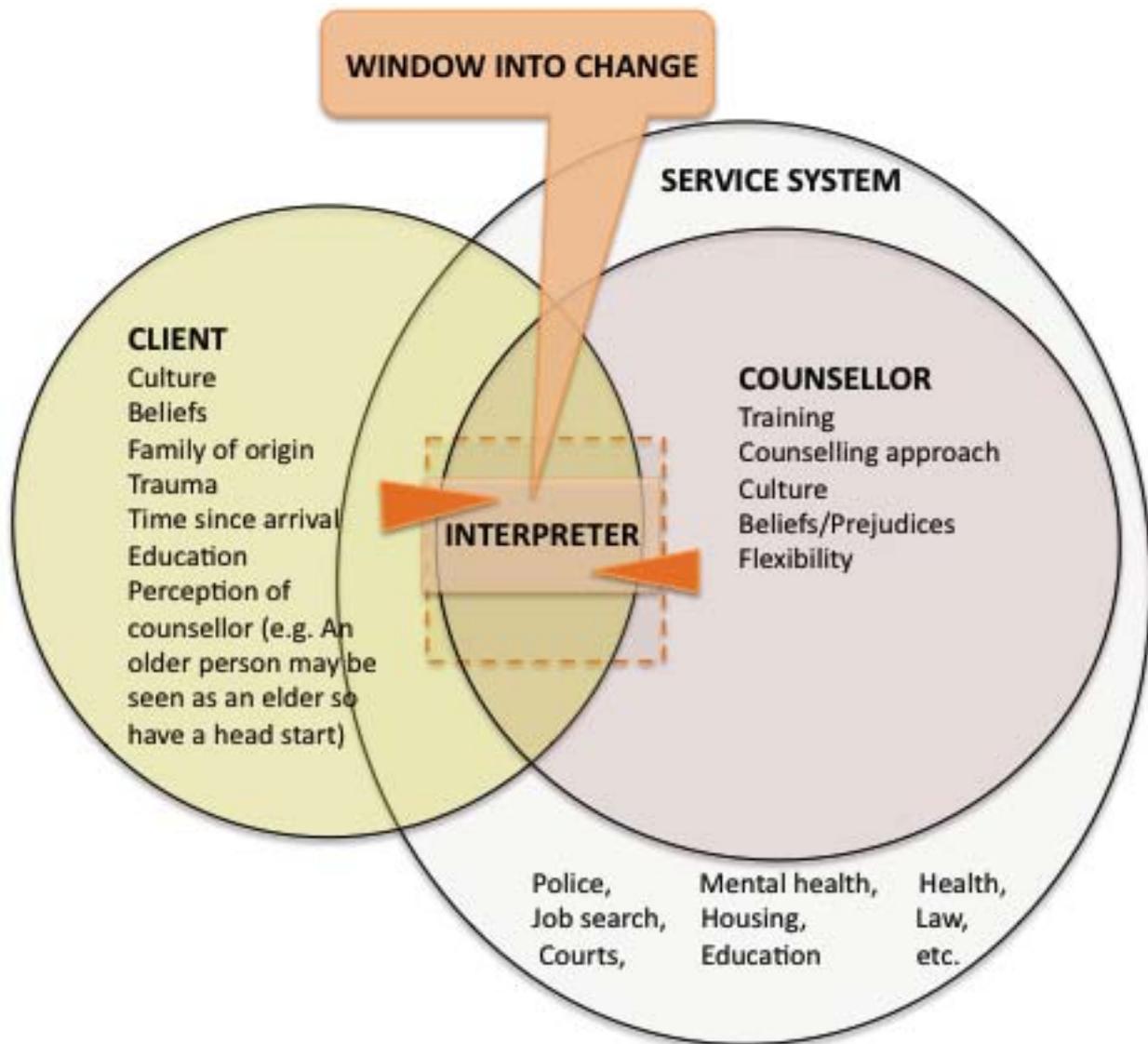

Figure 3: window into change

The diagram above captures some of the complexity of this work as the counsellor takes on the role of counselling anthropologist while he/she explores the world of the client, themselves and service systems.

Some dilemmas

How does one negotiate the following dilemmas?

1. **Interpreters**: While policy clearly states that using qualified interpreters is essential, this is not so easy in practice. Interpreters are seldom trained to hold emotions and many have been traumatised themselves. Holding a traumatised interpreter and the client at the same time can be difficult. The client is often not happy to use an interpreter from their own community because they do not trust that confidentiality will be upheld. On the other hand, using a family member can allow coercion or biased translation, to name only two of the most obvious issues.
    Using interpreters adds a complexity to counselling. However, if a client does not understand the counsellor, counselling is impossible. Therefore, some form of interpreter is essential and one must work to mitigate the above risks.

2. **Secondary trauma**: Working with any trauma is difficult, even more so when working with refugees who have faced wars, famine and flight. Secondary trauma is a pitfall for the unsuspecting. Supervision and debriefing are important and, even with these, an understanding of why one does such work and how it fits with our life stories is essential. Think before taking on such work and if you choose to do it, take good care of yourself.

3. **Supporting the partner of a traumatised person:** Life can often be difficult for the family members of a traumatised person and it is important to monitor their responses and to direct them to their own support where necessary.

4. **Second order change**: When working with trauma and then building on this to address violence the work is not complete until second order change has occurred. First order change consists of acknowledging and observing behaviour in oneself, learning to behave differently, reconceptualising memory and celebrating changes. However, second order change only happens when the violent person can see his behaviour from outside himself and finds some way to work at changing the way he acts, not only in his family but also in the world. This is often evidenced in social or political involvement or other forms of standing against violence in society.

5. **War crimes**: As a worker, there are clear guidelines in relation to reporting present and past violence within Australia. However, when one is confronted with war crimes where a person has committed a crime under coercion or threat to himself or herself, it becomes muddier. Where there is doubt, talking to police may be helpful. A general discussion within the counselling fraternity is perhaps indicated.

6. **Detention of asylum seekers**: It is clear from the difficulties faced by the asylum seeker couple, Sevaana and Tisha, in relation to their perceived 'bad treatment' regarding their asylum claims by the Australian Government, that their willingness to live by Australian law is tempered by their feelings that they have been violated by the laws of this country.

Pitfalls

There are a number of pitfalls that can be avoided:

*   Letting theory get in the way of empathy - it is always important to think about what you might have done in similar circumstances.

*   Rushing in without giving the client enough psychological and physical space to prepare themselves for working with their trauma - when working with trauma, make sure that your client is psychologically safe before even beginning to think about talking about it. Do this by watching your own and your client's breathing and your client's body posture and eye movement.[8]

*   If the client becomes distressed, calm him down by bringing his attention back to the present through reconnecting him with his surroundings by asking:
    *   What can you hear?
    *   What can you see?
    *   What can you feel? (The seat of his chair, the temperature of the room, his feet on the floor etc.)
    *   What can you taste?
    *   What can you smell?

*   Ignoring your client's concerns about the interpreter.

*   Forgetting that the family of your client needs ongoing contact to ensure their safety.

*   Becoming overwhelmed by your client's story - always be ready to hold firm boundaries and ground experiences in the present.

*   Burnout - take very good care of yourself.

Helpful hints for practice

1. Recognise and reinforce the resilience and tenacity of the clients you work with. Let your client know how you respond to the horror and brutality men are capable of and acknowledge the ravages of trauma on the soul:

    *   allow this work to connect you with every human's right to respect and dignity

    *   be open to your own prejudice and take time to think and rethink your judgments and beliefs. You may be surprised by preconceptions you were not aware you held.

2. Take time to show respect for your client and for your own place in society. Do this by not rushing in to counselling. Rather, allow time each session for your client's traditional greeting and enquiring about family and their wellbeing. This formal process allows the client and the counsellor to reconnect with what is important in terms of heritage, place and belonging.

3. Manage personal boundaries with clients well:

    *   Clients often find it difficult to be on time, which makes setting and keeping appointments difficult.

    *   Supporting clients may require you to arrange and accompany them to meetings that are not a usual part of a counsellor's work in a western style practice.

    *   If you see people in their homes, be careful to clarify your role: not as a friend but as offering a specific professional counselling service.

Conclusion

The two case studies above raise some of the issues of working with men who have faced trauma in their countries of origin. This work raises the dilemmas of working and empathising with trauma while ensuring that the family's safety is assured as far as possible. The dilemmas raised above need to be debated openly if support of refugees facing family violence is to be effective. Of particular concern is the issue relating to the detention of asylum seekers and the trauma associated with this practice.

The *Women at Risk* Assessment Tool

EILEEN PITTAWAY, REBECCA ECKERT, LINDA BARTOLOMEI, CENTRE FOR REFUGEE RESEARCH (CRR), UNIVERSITY OF NEW SOUTH WALES

Background: settlement and multiple experiences of trauma

Many practitioners working with refugees who have experienced domestic and family violence are unaware that sexual and gender based violence is an intrinsic part of the refugee experience for the majority of refugee women and girls, as noted in the earlier CRR contribution to this paper. In 1989, UNHCR commenced the *Women at Risk* Program, aimed at the protection of vulnerable refugee women and girls. The program identifies extremely vulnerable women and girls and fast-tracks their resettlement to other countries. Australia is one of the few countries which has a *Women at Risk* Program. It receives an average of 800 cases each year (UNHCR 2011; DIAC 2012). Many women who have also suffered major trauma and rape are also resettled on other visa categories, such as the 200 Refugee Visa (Eckert 2010).

Since 2002, staff from the Centre for Refugee Research (CRR) at the University of New South Wales have been working with women who have experienced sexual and other forms of violence, in eleven countries. In that time, they have documented many of the common factors experienced by refugee women in all sites that increase their vulnerability to harm. Based on this research, the CRR developed a 'tool' to assist the United Nations Refugee Agency (UNHCR) and non-government organisations in the identification of, and response to, women and girls who are most at risk of abuses of their rights. The 'Heightened Risk Identification Tool' (HRIT)[9] was trialled in three camps and two urban refugee sites by UNHCR, before being adopted as standard operating procedure by UNHCR and its partner NGO agencies internationally in 2007. It is highly regarded as an effective tool in the protection of refugee women and girls (UNHCR 2006; 2008).

Concurrent with this work overseas, the CRR has been working with women who have been resettled to Australia. We recently completed a research project involving over 500 women who came to Australia as refugees and 100 settlement service providers. The research has identified that for many women, the risks of harm continue after arrival in Australia. It has identified some of the potential indicators of increased need, experienced by women. This has informed the development of a similar assessment tool for use in countries of resettlement, referred to here as the '*Women at Risk* Assessment Tool' (Eckert et al. 2012).

In the experience of the Centre for Refugee Research, refugee women are typically extremely resilient, having survived conflict, persecution and flight. They have often protected their families in horrendous and dangerous camps and urban refugee sites. Despite these experiences, the majority of women and girls at risk do settle successfully into Australia and their children do well in school and society. During this process, they face a range of challenges experienced by other newly arrived refugees. However, women who have survived extreme risk and violence do often encounter additional barriers to successful settlement. The things they have experienced prior to their settlement have specific consequences, which can impact on their ability to make the adjustments necessary to fit into a new culture and a new society. Trauma compounds the impacts of the other challenges they have to face. Many suffer in silence for years. Refugee women rarely experience one risk or form of abuse in isolation. Many have experienced more than one of these traumatic incidences (Pittaway & Bartolomei 2001; Eckert et al. 2012). It has also been shown that the compounding effect of multiple abuses can make women more vulnerable to future violence and impact on women's resilience and wellbeing (Bartolomei et al. 2003). Some women will require special attention to support them in their settlement. Others may never need assistance. For those women who do, the *Women at Risk* Assessment Tool detailed below assists service providers to identify and respond to their particular needs and issues of concern.

Responding to risk

The *Women at Risk* Assessment Tool has been developed to assist service providers to identify those women who need additional assistance, as they face the challenges of settlement in a new and alien country. Importantly, it is designed to provide a holistic and effective approach to problem solving, using a series of checklists and action points. The checklists do not include problems such as: finding affordable and suitable housing; lack of fluency in English language; finding employment; dealing with Centrelink; and intergenerational conflicts. These are problems faced by the majority of new arrivals and should be addressed by Humanitarian Settlement Service (HSS) providers. However, sometimes it is the inability to resolve problems in these areas which brings risks and trauma to the fore. This highlights a need for all service providers to work as a team to address the problems.

The tool is designed for use by people who have good communication skills and who are used to working with refugees or women survivors of violence or both. It is very important that the lists are not used as prompts for intrusive questions. It may take several visits for a level of trust to be established that enables women and girls to feel comfortable to disclose some of these issues to a worker.

A comprehensive training package has been developed for people wishing to use the tool. It focuses on issues such as the importance of confidentiality and methods of interviewing and working with women and girls who have suffered from severe trauma and sexual torture. Staff from the CRR are available to provide this training if required, and can be contacted at www.crr.unsw.edu.au.

Women at Risk Assessment Tool, Australia

The tool involves four stages. It is important that each stage is used with the full participation of the women and girls concerned, and only with their permission.

Stage 1

The first stage is an initial interview with women and girls that should occur on arrival in Australia, usually with their HSS provider, or at a later stage if they present to a service provider with problems. It is a preliminary step that involves the completion of a checklist about women's experience prior to arrival in Australia. Research has shown that if a woman or girl has experienced one or more of the issues in the following check list, they may continue to be at risk of ongoing human rights abuses following resettlement (Doney et al. 2009; Eckert et al. 2012; DIAC 2013).

If any of these pre-arrival experiences are disclosed and if the woman or girl is requesting assistance, then the worker should use stages 2 – 4 of the tool.

Stage 1 Checklist: Pre-arrival factors which can indicate the need for an urgent response

Women and girls are considered to be more vulnerable where one or more of the following factors is present:

- a single woman without family protection
- a girl who is an unaccompanied minor
- an elderly woman without family support
- a rape victim
- a sexual torture victim
- a woman who has a baby or babies born of rape
- a single mother without family support
- a single woman who was forced to share accommodation with men
- a woman who was homeless
- a woman or girl forced into survival sex
- a woman or girl threatened with, or in, a forced marriage
- a woman or girl who has experienced severe domestic violence or marital rape
- a woman or girl with disability, suffering from HIV/AIDs or other serious diseases
- a woman or girl in a same sex relationship
- a woman or girl in a marriage which is considered socially unacceptable in her community
- a woman or girl with severe trauma or mental health issues.

Stage 2

In the second stage, the worker explores factors that are present in Australia to identify what urgent assistance is needed. In some cases, Stage 1 may not take place, if a woman presents to a service wishing to discuss her current situation and it is more appropriate to commence at stage 2 of the process. This list has been compiled from interviews with over 500 women in three states.

Stage 2 Checklist: Current factors which indicate the need for an urgent response

Is the woman or girl?:

*   experiencing ongoing harassment of self or children or threats of rape and sexual violence because of her visa status as a Woman at Risk

*   single, pregnant and without family or community support

*   with a child or children conceived from rape

*   at risk of harmful cultural practices

*   in a forced marriage or being coerced into a forced marriage in Australia

*   homeless

*   living in insecure shared accommodation, possibly with males

*   experiencing rejection or victimisation by their own community in Australia

*   isolated from their own and host communities because of shame factors

*   suffering from misunderstandings and conflict over women's and children's rights

*   experiencing increased vulnerability due to separation from family members

*   suffering impairment in daily functioning due to severe psychological trauma

*   being forced to engage in 'survival sex', in order to meet basic needs for economic security, housing etc

*   living in fear of child protection agencies because of lack of knowledge of child-rearing practices in Australia

*   living with a disability or serious illness

*   living in situations of family and domestic violence.

Upon completion of stage 2, it is likely that the woman or girl will have disclosed a number of experiences and risk factors impacting on her settlement. With their permission, the worker will then move onto stage 3.

Stage 3

The third stage is the development of a comprehensive case plan to address all areas of risk that have been identified. This should cover a short and medium term response, and a long term plan. The tool contains pro-formas and models to assist the worker and the woman or girl to do this. It involves working co-operatively with different agencies, which need to agree on a case manager who can ensure that all aspects are addressed in a timely manner. Research has shown that a lack of co-ordination between service providers is a major problem for many women at risk.

The worker is required to list all protection measures needed and currently available, for each of the risks identified, or violations suffered, and then to identify an adequate response to each.

Checklist Stage 3: Responding to risks

Workers should consider whether the following needs have been addressed:

*   safe and supportive short term accommodation

*   appropriate and secure long term shelter

*   legal redress if a crime has been committed

*   appropriate health services

*   access to education

*   access to mental health services

*   community acceptance and support

*   counselling/emotional support

*   any others which have arisen in Stage 2 or 3, not listed.

Following the completion of the Stage 3 checklist, an action plan is then devised which:

*   identifies the most appropriate responses available

*   identifies gaps in available service delivery

*   in collaboration with the woman (and her children) or girl, agreement on the actions to be taken

*   involves all of the organisations and agencies which will take part in the provision of an effective solution

*   establishes an effective and supportive referral mechanism

*   agrees on the actions to be taken by all concerned players with time lines for action

*   if possible, arranges a case conference with the woman and all agencies involved

*   agrees on an overall case manager.

Stage 4

The fourth stage of the process involves devising a comprehensive monitoring mechanism for the case plan, agreed on by all concerned parties and overseen by the lead agency. Steps to be taken will include:

- review actions by all people involved taken at 1, 3 and 6 months
- adjustment of any part of the plan if necessary
- closing the case when appropriate and in consultation with the woman or girl concerned.

We hope that this new tool will prove to be as useful in countries to which some of the most at risk refugees are resettled, as the HRIT is overseas. It has already been successfully trialled by settlement services in Victoria. While designed to be user friendly, the tool is more effective if staff receive training before implementing the tool. The tool and training package is available from the Centre for Refugee Research, and training can be arranged if required: email crr@unsw.edu.au.

Conclusion

LANA ZANNETTINO, FLINDERS UNIVERSITY

This practice monograph sought to extend current understandings of and responses to refugees seeking assistance for domestic violence who have experienced prior trauma in the context of war, displacement and encampment. It presented and explored the empirical accounts of practitioners whose work takes into account the ways that trauma, particularly women's and girls' experiences of sexual violence, can contribute to and compound the risks and effects of further abuse in countries of asylum and resettlement. The authors highlight the many circumstances of abuse, its cumulative effects and the significant parallels between sexual and gender based violence in the context of war and in intimate relationships. In both contexts, women's bodies are the site of control and subjugation.

Dr Eileen Pittaway and Ms Rebecca Eckert argued that many of the fundamental causes of domestic violence in refugee communities are shared with the wider community. The gendered nature of domestic violence is embedded in systems of patriarchal power relations that transcend culture, nationality and religion. However, their contribution also highlighted the ways that resettlement challenges faced by refugees are compounded by pre-arrival experiences, creating a context that exacerbates their experiences of domestic violence.

Pittaway and Eckert identified and discussed the key challenges faced by refugee and migrant workers, including their perception of being insufficiently informed about the dynamics or prevalence of domestic violence in refugee communities to be able to offer appropriate services. One of the most difficult aspects of service provision is simply listening to refugees' stories and providing an environment in which they can heal their wounds. Many workers also suffer from burnout and exhaustion due to the difficulty of their cases. Moreover, the desire to be culturally sensitive can be so great that workers find it difficult to challenge ideas that may perpetuate violence and abuse in refugee communities. Pittaway and Eckert warned against the taken for granted assumption that violence in refugee communities is culturally determined, as this undermines the economic and political factors associated with the occurrence of domestic violence. They highlighted the need for a safe space in which women can retell their stories so that the trauma of their pre-arrival experiences are not relived or expressed in other contexts.

Pittaway and Eckert also identified ways forward in responding to refugees affected by domestic violence.

One of the first steps to be taken to address domestic violence and trauma in refugee communities is to provide increased training for settlement service providers. Interventions require an understanding of the propensity for domestic violence when social structures are weak or inadequate. Professional supervision needs to be made available to staff to identify and to assist with cases of vicarious traumatisation. Working with perpetrators is also crucial in addressing domestic violence as many women want to stay with their partners in relationships that are free from violence. They also stressed the importance of all refugees being educated about Australian laws to protect women and families.

Ms Beata Ostapiej-Piatkowski and Ms Annabelle Allimant identified and explored best practice considerations for domestic violence and sexual assault practitioners working with CaLD clients affected by multiple traumas. They suggested that the first contact a practitioner has with a client seeking assistance for domestic violence or sexual assault is critical in providing a foundation for future engagement in a therapeutic relationship. Information gathering while making an assessment enables a practitioner to explore a client's current situation and ensure that appropriate strategies are in place. An assessment may require a number of sessions before a relevant and informed plan for responding is reached. They also pointed out that practitioners need to be mindful of the fact that their service/organisation constitutes an institution and, as such, may trigger distress in CaLD clients who may have had negative experiences with institutions in the past. They also made the point that the counsellor needs to recognise that refugees have multiple experiences and traumas in addition to being affected by domestic violence. The experience of being a refugee raises a range of complex mental health-related issues such as grief and loss, displacement, loss of role and status, rapid changes in environment, having family members still living in unsafe environments, prolonged vigilance, uncertainty and intense fear.

Ostapiej-Piatkowski and Allimant argued that working from a multicultural framework requires practitioners to maintain acute listening and observation strategies, with a cultural lens that seeks ongoing clarification of content and meaning. A major difference in working with a client from a CaLD background, they suggested, is that the practitioner needs to be able to reflect on their own cultural values and beliefs. In addition, they must assess how these attitudes may intrude on accurately assessing the client. The stigma and

consequences of being identified within a community as a victim of sexual violence can have a deleterious impact on the client and her family. Past experiences of trauma may be triggered by new violent incidents and the combination of past and current trauma can have a detrimental impact on women's mental health. Practitioners supporting clients with these issues need to be cognisant of such experiences, their impacts and relevant therapeutic approaches. Ostapiej-Piatkowski and Allimant also warned against inadvertently imposing heightened feelings of 'complexity', stemming from organisational constraints, onto clients from CaLD backgrounds.

Dr Jill Parris drew on two client case studies from her own clinical practice to argue how men's experiences of prior trauma, combined with settlement and refugee experiences, can contribute to their perpetration of violence. Parris' analysis of her own therapeutic work in the two cases presented showed how men who were traumatised in their countries of origin were supported as they confronted their own violence and sexual abuse within their relationships. Parris' practice is based on attachment theory and relies on building a strong and safe relationship with the client, which she argued is dependent on the counsellors' ability to take responsibility for their own boundaries, professional ethics and their area of accountability. Her case studies demonstrated the balance between the use of clear boundary setting to maintain safety within the family and an honouring of the perpetrator's need to be held as he chooses to explore and integrate past trauma. She argued that this work can only be done if the client wishes to explore trauma. Parris believes that it is very difficult to change violent behaviour without engaging with trauma work. She also discussed the importance of linking clients in with other support services while in receipt of therapy as it can be impossible for a client to focus on personal issues while they are experiencing difficulties with housing or work. The support work may include formulating, providing, and negotiating referrals. Like Pittaway and Eckert, Parris warned against the risk of vicarious traumatisation or secondary trauma and the need for this risk to be countered by supervision and debriefing, along with an understanding of why one does such work and how it fits with the counsellor's own life story.

Parris also argued that when working with trauma and then building on this to address violence, the work is not complete until second order change has occurred. Second order change only happens when the violent person can see his behaviour from outside himself and finds some way to work at changing the way he acts not only in his family but also in the world. This is often evidenced in social or political involvement or other forms of standing against violence in society. Parris highlighted the need to recognise and reinforce

the resilience and tenacity of clients and, like Ostapiej-Piatkowski and Allimant, suggested the need to be open to one's own prejudice, judgments and beliefs. Parris concluded that this kind of work raises the dilemma of working and empathising with trauma while ensuring that the family's safety is assured as far as possible.

Dr Eileen Pittaway, Dr Linda Bartolomei and Ms Rebecca Eckert from the Centre for Refugee Research (CRR) presented their *Women At Risk* Assessment Tool. The tool was based on the 'Heightened Risk Identification Tool' (HRIT), which has been adopted as a standard operating procedure by UNHCR in 2006. Pittaway, Bartolomei and Eckert argued that women who have survived extreme risk and violence often face additional barriers to successful settlement. Their experiences have specific consequences, which can impact on their ability to make the adjustments necessary to fit into a new culture and society. Trauma compounds the impacts of the other challenges they have to face. Women rarely experience one risk in isolation and many women and girls have experienced more than one of these traumatic incidences. The compounding effect of multiple abuses can make women more vulnerable to future violence and impact on women's resilience and wellbeing. The tool is designed to assist service providers to identify migrating women in need of additional assistance with settlement around their experiences of and vulnerabilities to violence. The tool canvasses: women's and girls' experiences prior to arrival in Australia; risk factors present in Australia; development of a comprehensive case plan; and devising a comprehensive monitoring mechanism.

All four contributions acknowledge and support the findings extant in the literature pertaining to refugees affected by domestic violence. Specifically, each counters the notion that violence is culturally determined. However, they simultaneously recognise that refugees face significant challenges, particularly multiple experiences of trauma, which make them more vulnerable to the experience of violence in countries of asylum and resettlement. Women and girls who have suffered sexual violence prior to their arrival in Australia are particularly vulnerable to domestic violence and sexual assault. Men who have witnessed or been involved in the atrocities of war may find it difficult to integrate such traumas in their lives or may find their masculinities challenged during settlement in countries where there is relative gender equality in social structures.

In terms of clinical practice, all four contributions support the major themes in the literature pertaining to responding to refugees affected by domestic violence. Most significantly, each contribution highlights the need to proceed from a human rights framework in working with clients. This was manifest in honouring the self-determination of the client while respecting,

but gently challenging, the cultural factors that may impact on their ability to address violence in their lives. These may include cultural values that are patriarchal or which make women feel that they deserve to be victimised due to their previous experiences of sexual violence. Each contribution also highlights the need for clients to be provided with clear information about Australian systems and laws, particularly those relating to the rights and safety of women and children. In terms of those who provide therapeutic and support services to refugees and their families, all four contributions emphasise the need for support workers and counsellors to reflect on and interrogate their own cultural values and beliefs. Finally, the contributors also emphasise the importance of receiving adequate supervision and debriefing to avoid the potential for vicarious traumatisation and burnout.

HELPFUL RESOURCES

Centre for Refugee Research (CRR) Resources

Available from **www.crr.unsw.edu.au**

From Horror to Hope: a training kit with a DVD, PowerPoint slides and materials dealing with domestic violence in refugee communities.

Welcome to Kakuma: a DVD which shows life in a refugee camp and the impact of sexual abuse on women and girls.

The *Women at Risk Training Kit:* supports the use of the *Women at Risk* tool.

STARTTS

Available from **www.startts.org**

The Accidental Counsellor: training for staff dealing with traumatised people

www.adfvc.unsw.edu.au

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ENDNOTES

1   The CRR has worked with women at risk in refugee sites in eleven countries since 2002. It works from a human rights framework, focusing on international refugee flows, internally displaced people, forced migration and resettlement issues.

2   Harmony Place (Multicultural Centre for Mental Health and Well Being Inc.) offers a range of services to CaLD clients, including a case management/counselling program for people experiencing mental health issues or illness. The program offers information, emotional support, psycho-education, advocacy and referral to mental health services and other service providers.

3   The EMC is based at the Brotherhood of St Laurence in Melbourne and offers services for refugees and migrants.

4   for Australian examples, see 'Rebuilding Shattered Lives' (VFST 1998); or Westoby & Ingamells (2010); and for international examples, see Kira, Ahmed, Wasim, Mahmoud, Colrain & Rai (2012) or Masocha & Simpson (2011).

5   Publications resulting from this research include Pittaway (2005), CRR (2007, 2011a, 2011b), Doney et al. (2009), Eckert et al. (2010, 2012), Pittaway et al. (2010), Pittaway & Bartolomei (2011).

6   It is our practice experience that people have experiences of multiple traumas across various visa categories, including international students, asylum seekers or skilled migration. Experiences of war-related trauma, political oppression and persecution are often common experiences across arrivals (Allimant & Ostapiej-Piatkowski, 2011). Consequently, the phrase 'people from CaLD backgrounds, including refugees' is used in this section of the paper to reflect the work at Harmony Place.

7   Case examples come from the experiences of the authors. Identifying features have been changed.

8   If you wish to see a practical demonstration of this process, go to http://www.jillparris.com/p/african-stories.html and click on 'No to violence in the South Sudanese community' which will take you to a YouTube clip.

9   The Heightened Risk Identification Tool is an operational protection tool designed to enhance the identification of, and response to, at risk refugees (Pittaway & Bartolomei 2005; UNHCR 2010).

Note: It is recognised that the term 'risk assessment tool' has a specific use within the domestic and family violence sector to refer to indicators about which there is substantial research evidence of statistically significant increased risk of harm of future violence, or risk of lethality. (ed.)

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