THE IMPACT OF INTIMATE PARTNER VIOLENCE ON IMMIGRANT WOMEN'S HEALTH

by

Zari Abtahi

A thesis submitted in partial fulfillment of the requirements for the degree of

Master of Arts in Counselling Psychology

City University of Seattle

Vancouver, BC, Canada

October 2016

APPROVED BY

Bruce Hardy, Ph.D., Advisor, Counselling Psychology Faculty

Colin Sanders, Ph.D., Faculty Reader, Counselling Psychology Faculty

Division of Arts and Sciences

Abstract

This study is aimed at exploring the literature regarding the incidence, nature, and impact of intimate partner violence (IPV) on women's health. I will explore the incidence, nature, and impact of IPV (IPV and violence against women (VAW) are used in this thesis as interchangeable) on women in countries around the world. I focus on IPV against women in general and on IPV against immigrant women in particular. Based on findings, I draw recommendations for clinicians working with (immigrant) women who are experiencing domestic violence and are victimized by IPV.

Keywords: Intimate partner violence, violence against women, domestic violence, immigrant, women's health.

Acknowledgment

I have great appreciation for my dearest sons, Masoud and Behnoud, for being my constant source of love, encouragement, and inspiration. Special thanks to Masoud, who has been my source of motivation and strength, and has supported me to pave each path on the road to success throughout my study. I would like to extend much gratitude to Gary Thandi, my practicum site supervisor, who have referred me so many clients whom were either the victims and/or perpetrators of intimate partner violence. Thanks to the clients who have shared their personal stories and inspired me to learn more about the nature of intimate partner violence.

I am grateful and many thanks to Dr. Bruce Hardy, my thesis advisor, for his valuable feedback, comments and encouragement. Thanks to Dr. Colin Sanders, my second reader for support and encouragement in my journey to complete this thesis. Thanks to Dr. Gerda Wever, my editor for her support, feedback, and guidance in writing my thesis. Thanks to my dear friends for encouraging me to just finish this thesis. Special thanks to Ken Lewis for spending hours reading my writing and allowing me to bounce the ideas. Although this study has been only a literature review, I remain completely thankful for the opportunity to grow both personally and professionally.

Dedication

I dedicate this thesis to my dear late father, Sadegh Abtahi, who believed and knew the importance of education and dreamed that his children and grandchildren would endeavor for excellence through education.

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CHAPTER 1: INTRODUCTION

This study developed out of my personal interest and professional curiosity. I began my internship in a counselling agency, where most of my clients were referred either by local probation officers or social workers. Cases differed in terms of prior experience, cultural values, traditions, and many other aspects of day-to-day living. However, despite these differences, there were many similarities in the issues they were facing. Many male clients carried the intimate partner's perpetrator label, while the females struggled with shame, guilt, pain, threat, and frustration with intimate partner victimization. Before migrating to Canada, I had experienced working as a school counsellor with students and as a family counsellor with both families and children who had been victims of domestic violence. Moreover, I had been exposed to women suffering from domestic abuse and IPV in women shelters in Vancouver, Canada. Finding similarities and differences between such diverse cases has been a major influence for this study.

Purpose of the Study

The focus of this study is to explore literature regarding incidence, nature and impact of intimate partner violence on women's health. I will explain incidence, nature, and impact of IPV (IPV and VAW are used in this thesis as interchangeable) on women in countries around the world. Based on findings, I draw recommendations for clinicians working with (immigrant) women who are experiencing domestic violence and are victimized by IPV.

IPV: Statement of the Problem

Violence against women is a staggering global epidemic, deeply rooted in gender inequality and discrimination (UN, n.d.). Violence against women and girls is a global pandemic of alarming proportions, deeply rooted in gender inequality and discrimination (UN, n.d.).

> No woman or girl is entirely free of its risks or reach. It takes many forms and occurs in many places— domestic violence in the home; sexual abuse of girls in schools; sexual harassment at work and in public spaces; abuse during pregnancy; and rape in cities and in rural areas, in refugee camps and as a tactic of war. It includes harmful practices such as female genital mutilation/cutting, child and forced marriage, so-called 'honour' killings, acid attacks and dowry-related abuse; as well as newer forms, such as cyber-bullying and e-stalking via the internet and mobile phones (UN, n.d., p. 1).

A UN fact sheet (n.d.) documents the scale of the pandemic.

Global Stats

Between 15 and 76 percent of women are subject to physical and/or sexual violence in their lifetime, and most of this violence takes place within intimate relationships, with many women (ranging from 9 to 70 percent) reporting their husbands or partners as the perpetrator (UN, n.d.).In Guatemala, two women are murdered, on average, each day, and in India, 8,093 cases of dowry-related death were reported in 2007; an unknown number of murders of women and young girls were falsely labeled 'suicides' or 'accidents' (UN, n.d.). In Australia, Canada, Israel, South Africa and the United States, between 40 and 70 percent of female murder victims were killed by their intimate partners (UN, n.d.). Worldwide, up to 50 percent of sexual assaults are committed against girls under 16. An estimated 150 million girls under the age of 18 suffered some form of sexual violence in 2002 alone. The first sexual experience of some 30 percent of women was forced. The percentage is even higher among those who were under 15 at the time of their sexual initiation, with up to 45 percent reporting that the experience was forced.

Approximately 100 to 140 million girls and women in the world have experienced female genital mutilation/cutting, with more than 3 million girls in Africa annually at risk of the practice.

Over 60 million girls worldwide are child brides, married before the age of 18, primarily in South Asia (31.3 million) and sub-Saharan Africa (14.1 million). Violence and abuse characterize married life for many of these girls. Women who marry early are more likely to be beaten or threatened, and more likely to believe that a husband might sometimes be justified in beating his wife.

Trafficking ensnares millions of women and girls in modern-day slavery. Women and girls are 80 percent of the estimated 800,000 people trafficked across national borders annually, with the majority (79 percent) trafficked for sexual exploitation. Within countries, many more women and girls are trafficked, often for purposes of sexual exploitation or domestic servitude. One study in Europe found that 60 percent of trafficked women had experienced physical and/or sexual violence before being trafficked, pointing to gender-based violence as a push factor in the trafficking of women.

Across Asia, studies in Japan, Malaysia, the Philippines and South Korea show that 30 to 40 percent of women suffer workplace sexual harassment. In the United States, 83 percent of girls aged 12 to 16 experienced some form of sexual harassment in public schools.

Rape as a tactic of warfare is rampant—Conservative estimates suggest that 20,000 to 50,000 women were raped during the 1992-1995 war in Bosnia and Herzegovina, while approximately 250,000 to 500,000 women and girls were targeted for rape in the 1994 Rwandan genocide. Between 50,000 and 64,000 women in camps for internally displaced people in Sierra Leone were sexually assaulted by combatants between 1991 and 2001. In eastern Democratic

Republic of Congo, at least 200,000 cases of sexual violence, mostly involving women and girls, have been documented since 1996: the actual numbers are believed to be far higher.

Canadian Stats

According to Statistics Canada (2013, p. 4),

> more than 90,300 victims of IPV were reported to the police, including spousal and dating violence (representing 47% spousal violence and 53% dating partners violence). Police also reported 87,820 victims of family violence, which represents a rate of 252.9 victims of family violence for every 100,000 individuals in the population, in which females accounted for greater than two-thirds (68%) of all family violence; spousal violence stood for the most common type of family violence at 48% by a current or former spouse either married or common law. Although adults in their twenties and thirties experienced the greatest risk of IPV victimization, IPV was highest among the ages of 20 to 24. The homicide rate against a female intimate partner was 3.74 per million populations. In fact, the rate of intimate partner homicide for female victims was 4.5 times higher than for male victims.

In 2013, about 336,000 persons between 5 to 89 were victims of a police-reported violent crime (Stats Canada, 2013). A quarter of these victims (27%) had been victimized by an intimate partner, 53% by dating partners, and 47% by spouses.

One third (33%) of victims of intimate partner violence were victimized by a former spouse or dating partner (Stats Canada, 2013). Two thirds (nearly 61,000) of victims of intimate partner violence were victimized by a current intimate partner (Stats Canada, 2013). The majority of victims of police-reported intimate partner violence are female (Stats Canada, 2013). In 2013, women accounted for nearly 80% of victims of police-reported intimate partner violence (Stats

Canada, 2013), when 175,000 women were victims of police-reported violent crime. Women, accounted for more than half (52%) of all victims of violent crime.

About four in ten female victims (41%) were victimized by an intimate partner, which was 3.5 times higher than for men (12%) (Stats Canada, 2013). In contrast, men were more frequently victimized by a friend or acquaintance (40%), or a stranger (36%) (Stats Canada, 2013).

Stats on IPV against immigrant women in Canada

While Aboriginal women differed from non-Aboriginal women in their risk of victimization, the likelihood of reporting victimization to police did not (Stats Canada, 2013). Approximately four in 10 Aboriginal women victimized by their spouse indicated that police were contacted, which is not significantly different from the proportion for non-Aboriginal women (Stats Canada, 2013). Likewise, among non-spousal violent incidents involving Aboriginal women, about one-quarter were reported to the police, similar to the proportion for non-Aboriginal women (Stats Canada, 2013).

Reporting spousal violence incidents to police did not vary between visible minority and non-visibility minority women (Stats Canada, 2013). Rates of reporting spousal violence against women were also similar between immigrant and non-immigrant women (Stats Canada, 2013). Overall reporting rates to police were similar between visible and non-visible minorities, and between immigrants and non-immigrants (Stats Canada, 2013).

The Cost of IPV

Violence against women has enormous direct and indirect costs for survivors, employers and the public sector in terms of health, police, legal and related expenditures as well as lost wages and productivity (Stats Canada, 2013). Annual costs of intimate partner violence were

calculated at US$5.8 billion in the United States and US$1.16 billion in Canada (Stats Canada, 2013). In Australia, violence against women and children costs an estimated US$11.38 billion per year. In Fiji, the annual estimated cost was US$135.8 million or 7 percent of the Gross Domestic Product in 2002 (Stats Canada, 2013). Domestic violence alone cost approximately US$32.9 billion In England and Wales.

A recent Justice Canada study estimated the cost of one type of intimate partner violence, spousal violence, on Canadian society at $7.4 billion in 2009 (Zhang, Hoddenbagh, McDonald, & Scrim, 2013, as cited by Stats Canada, 2013). Most of these costs were related to victim costs, such as pain and suffering, counselling expenses, and legal fees for divorce, while the next highest costs were those of third parties (e.g., families, employers, and social services) and the criminal and civil justice systems (e.g., police, courts, corrections).

In addition, children who witness domestic violence are at increased risk of anxiety, depression, low self-esteem and poor school performance, among other problems that harm their well-being and personal development UN Fact sheet. In Nicaragua, 63 percent of children of abused women had to repeat a school year and they left school on average four years earlier than other children.

Children, both girls and boys, who have witnessed or suffered from gender-based violence, are more likely to become victims and abusers later in life. For example, surveys in Costa Rica, Czech Republic, Philippines, Poland and Switzerland revealed that boys who witnessed their father using violence against their mother were three times more likely to use violence against their partners later in life.

In 2006, United Nations Universal Declaration of Human Rights and the Declaration on the Elimination of Violence, as well as many international agreements against women have

recognized women's fundamental human right to live free from violence (United Nations General Assembly, 2006).

Theoretical Framework: Feminist Theory

This section briefly explains the philosophical framework for the study, which is feminist theory. The core of feminist theory lies in the fact that men and women should have equal rights politically, culturally, legally, economically, and socially (Humm, 1995). Most feminist theorists enquire how ethnicity, culture, sexuality, nationality, and age interact with gender. Feminism is a broad category comprising various sociological theories and philosophies concerned with matters of gender difference (Frye, 1983). It is concerned with uplifting women and bringing to light the different ways women have played a role in the society (Giddens, 1991).

The theory is suitable for this research because it explains the different ways in which women experience gender-based violence. From a psychoanalytic feminist point of view, power struggles between men and women arise from Freud's explanation of the three levels of awareness, emotions, and lifespan development (Harding, 2004). Feminists' fundamental point is that patriarchy and gender-based violence create inequality.

This theoretical foundation is also useful in its application. Samaphorn Theinkaw and Somporn Rungreangkulkij (2013) did a qualitative research aimed to explore the perspectives of Thai abused women regarding the effectiveness of postmodern feminist empowering counseling (PFEC) for them. Their findings showed that the abused women who received PFEC based counseling achieved changes in three areas of their lives:

Thought changes: men and women are equal. Participants showed that their lives were improved. They thought that they had the same rights as their husbands because they were both human and that their husbands were not the owners of their lives. For example, one abused

woman said: “I want to change him so that he can know that men and women are the same. He is not the owner of my life. However, I myself have to start changing first, not to be his disadvantage. I think I have the same rights as him. I am also a human.” (P4, as cited in Theinkaw and Rungreangkulkij, 2013, p. 40)

Belief changes: being abused is not fate. Participants showed that their lives were improved because they had changed their beliefs about abuse being fate. They felt independent and gained self-confidence. For example, one abused woman said: “It is not about fate. I can choose to respond... (ha ha ha). I think I can choose. No one can force me. I am not under any power. I can do myself.” (P2, as cited in Theinkaw and Rungreangkulkij, 2013, p. 40))

Emotional changes: feeling powerful. Participants showed that their lives were improved because they had better feelings. They were more relieved, had encouragement and suffered less. For example, one abused woman said: “The indicators of my better life are deeply feeling that I am happier. It is inner. I am relieved. It starts in my mind. It is powerful. The encouragement helps me to be better. My behavior is also changed so much. I am calmer. I learn to avoid and have consciousness.” (P5 as cited in Theinkaw and Rungreangkulkij, 2013, p. 40)

Theinkaw and Rungreangkulkij (2013) concluded, in line with findings and conclusions by Sharma (as cited in Theinkaw and Rungreangkulkij, 2013) that PFEC is helpful in term of healing psychological wounds of abused women.

Definition of Terms

Immigrants

In this study immigrants are defined as women who were born outside of Canada, who have the right to work and live in the new country (Statistics Canada, 2015).

Intimate Partner (IP)

Intimate partners are spouses (marriage or common-law) and dating partners.

Intimate Partner Violence (IPV)

IPV is any kind of abusive behaviour happening within a couple relationship (marriage or cohabitation; they do not have to live together) that causes physical, psychological, and sexual harm. This includes psychological abuse, physical abuse, sexual coercion, and controlling behaviour between partners in the relationship. Intimate partner violence is "a pattern of assaultive and coercive behaviors designed to establish control by a person who is, was, or wishes to be involved in an intimate or dating relationship with an adult or adolescent" (UN as cited in Runner, Yoshihama, & Novick, 2009, p. 10).In this study, the terms IPV and domestic violence (DV) are used interchangeably.

Violence

Violence as the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, mal-development or deprivation (WHO, 2002, p. 5). Violence includes interpersonal violence (occurring between individuals), and self-directed violence (suicide and other forms of self-harm) (WHO, 2002).

Domestic Violence (DV)

Domestic violence (DV) is a wide-ranging term because it includes all kinds of violence against men, women, and children in a home setting. Domestic violence refers to any kind of threat or use of physical, psychological, and /or emotional abuse happening by any family member intending harm or forcing power and control. This includes partner violence and child abuse (Heise, Ellsberg, & Gottemoeller, 1999).

Physical Violence (PV)

Physical violence is the intentional use of physical behaviour with potential for causing harm, injury, disability, or death (Saltzman, Fanslow, McMahon, & Shelley, 2002; Heise, Garcia, & Moreno, 2008). Physical violence includes but is not limited to hitting, scratching, slapping, kicking, punching or shoving, pulling hair, choking or suffocating, beating, burning, and using a weapon against a person.

Psychological/Emotional Violence

Psychological / emotional violence is defined as behaviours, acts, threats, or coercive tactics that cause trauma in the victim, or may be perceived as emotional abuse by the victim (Saltzman et al., 2002). Psychological violence includes controlling victim's behaviour or isolating the victim, humiliating or embarrassing the victim, and withholding information from the victim or disclosing the victim's information with intent to harm (Saltzman, et al. 2002).

Sexual Violence (SV)

Sexual violence includes coerced sex in marriage and dating relationships, rape, sexual harassment (including demands for sexual favours in return for jobs or school grades), childhood sexual abuse, forced prostitution, child marriage, and violent acts against the sexual integrity of women. This includes female genital mutilation and obligatory inspections for virginity (WHO, 2002, p.18). Attempting or performing sex acts with a woman/girl who is ill, disabled, under pressure, or under the influence of alcohol or other drugs are also forms of sexual violence (Saltzman et al., 2002).

Perpetrator

A perpetrator is an individual who causes violence or who subjects a person to violence (Saltzman, et al. 2002).

Closing Thoughts

While IPV is indeed a global endemic, most types of offences committed by intimate partners in Canada have been relatively stable since 2009. According to police-reported data, the number of common assaults, the most frequently occurring type of offence against intimate partners, has declined in recent years (Stats Canada, 2013). The rate of intimate partner common assault fell by 11% between 2009 and 2013, driven by the drop in the rate of assaults against female intimate partners (Stats Canada, 2013). The rate declined from 344.2 female victims per 100,000 population in 2009 to 298.2 female victims per 100,000 population five years later (Stats Canada, 2013). Rates of common assault against male intimate partners decreased slightly throughout this period (-3 %) (Stats Canada, 2013). The decrease in common assaults may reflect changes in the incidence of this type of intimate partner violence or a change in the willingness of victims to report these crimes to the police (Stats Canada, 2013). For both men and women, rates of major assaults against intimate partners, including aggravated assault, and assault with a weapon or causing bodily harm, decreased 6% between 2009 and 2013 (Stats Canada, 2013). Rates of police-reported sexual assaults against female intimate partners rose 17% between 2009 and 2013. While these numbers are promising for the Canadian context, worldwide the violence against women is, as I hope to have shown in this chapter, staggering and endemic.

The following chapter focuses on the risk factors of IPV and the impact of domestic violence on immigrant women's health.

CHAPTER 2: LITERATURE REVIEW

According to the WHO (2013), IPV has serious physical, emotional and socioeconomic effects not only for the victims, their family, and society, but also creates major problems for public health. WHO (2013) also highlight the criminal component of IPV, including assault, threats, harassment, and homicide. Saltzman, Fanslow, McMahon, & Shelley (2002) describe IPV as physical, sexual, psychological/emotional violence, and threats of physical or sexual violence against women by a current spouse or former partner with whom they have or previously had an intimate or sexual relationship with. Donnelly and Burgess (2008) find similarities between intimate partner/spousal violence and dating violence, including emotional attachment between partners. Furthermore, Cui, Gordon, Ueno, and Fincham (2013) also found significant correlation between victimization in romantic relationships in adolescence and in young adulthood romantic relationships (p. 309), and such associations "existed beyond the effects of parent-child violence and general aggression tendencies, suggesting the continuation of relationship-specific violence." This finding is consistent with Spriggs, Halpern, & Martin (2009) findings that "violence relationships victimization" is a continuing process from adolescence to young adulthood (as cited in Cui et al., 2013, p. 309).

In this chapter, I will briefly discuss the prevalence of IPV, I will discuss health consequences and risk factors, and discuss IPV in immigrant women. I will conclude the chapter with a discussion of turning points for women who have experienced IPV—in other words, the most motivating factors for women to change their situation.

IPV: Prevalence of IPV

The prevalence of IPV is difficult to gage due to a number of factors, including under-reporting, inconsistent definitions used in surveys and studies, and the source of the data (e.g.,

from a community crime victim survey or from clinical and community samples) (Wong & Mellor, 2014). In 48 WHO population based surveys from around the world, between 10 and 69% of women reported being physically abused by an intimate partner at some point in their lives (Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002). In Hegarty and Bush's (2002) general practice survey in Australia, of the 37% of women who had experienced IPV, 1 in 4 (8.6%) reported experiencing physical abuse, 1 in 3 (12.5%) emotional abuse, and 1 in 10 (4%) sexual abuse.

Prevalence of IPV in USA

Goldman (1999) noticed that in the United States, up to 95 percent of all domestic violence cases are violence against women. According to the National Violence Against Women Survey (NVAWS), in the United States, violence against women is the most common form of IPV which affects almost 1.3 million American, about 22 million American women experience physical assault and almost 7.8 million are raped by an intimate partner during their life every year (Tjaden & Thoennes, 2000). Furthermore, The States National Crime Victimization Survey (NCVS) also points out that 876,340 women experience IPV in the United States every year (Rennison & Welchans, 2000). And also, the Council on Scientific Affairs highlights that in the United States 22 to 35 percent of women referring to urban emergency rooms show symptoms associated to ongoing abuse (1992), and a survey results in Texas show that 24 percent of women who had been abused required medical treatment (Teske & Parker, 1983).

Prevalence of IVP in Canada

Research on violence against women in Canada indicates the severity of the IPV problem. According to Canadian Women Study, half of all women in Canada have been victims of physical or sexual violence since the age of 16 (Statistics Canada, 1993). In 2010, the rate of IPV

increased by 19%, while the rate for male victims decreased in half (Statistics Canada, 2010). According to Statistics Canada (2010, p. 5), over 40,000 arrests are due to domestic violence which was about 12% of violent crime in Canada, but only 22% of all incidents are reported to the police and the real number is much higher. Every six days a woman in Canada is killed by her intimate partner and in 2011 the police reported 76 women (over 85%) were killed out of 89 spousal homicides. Burczycka, & Cotter (2010) find that in Canada, more than 3,300 women (with their children) escape from violence and sleep in emergency shelters every day, and about 80% of sex trafficking victims are girls and women . Also, 67% of Canadians have known a woman who has been abused physically or sexually (Angus Reid Omnibus Survey, 2012). Nevertheless, IPV often remains a major problem across Canada.

However, it is not uncommon for women who have been abused to experience all three types of abuse in their lifetime. For example, a Japanese study found that 57% of women who reported experiencing IPV had suffered all three types of abuse (Yoshihama & Sorenson, 1994).

Health consequences of intimate partner violence

Epidemiological and clinical research shows that IPV is consistently associated with a broad range of negative health outcomes (Ellsberg, Janse, Heise, Watts, & Garcia-Moreno, as cited in Wong & Mellor, 2014). The relationship between IPV and physical health is complex, but IPV may be immediate and direct (such as death and injury), longer term and direct (such as disability and chronic illness), indirect (such as self-perceived health and health behaviors), or all three (Wong & Mellor, 2014).

The most obvious and severe health consequence of IPV is homicide, with for example, IPV accounting for just under half (49%) of the homicides of women in Australia each year (Mouzos, 2005; Wong & Mellor, 2014). Another obvious and direct physical health impact of

IPV is physical injury, with fractures, lacerations, contusions, damage to the face, upper torso, breast and abdomen being the most common (Wong & Mellor, 2014).

> Although the short-term physical impacts of IPV are the most obvious and have a significant impact on women's health, there are a number of long-term physical health sequelae that are strongly associated with IPV, including traumatic brain injury (TBI), memory loss, seizures, gynecological disorders, adverse pregnancy outcomes, irritable bowel syndrome, arthritis, gastrointestinal disorders, sexually-transmitted disease, and chronic pain syndromes (Wong & Mellor, 2014, p. 3).

So, the physical health consequences of IPV often continue long after the abuse has ended. These consequences can manifest as poor health status and poor quality of life (Wong & Mellor, 2014).

It should be noted however, that the research findings are often variable, and that in many cases they are based on correlational data or simply an investigation of different health statuses of those with a history of IPV and those without such a history (Wong & Mellor, 2014). Clearly, it is not possible to do experimental research, and it may not be feasible to conduct longitudinal studies that include sufficient breadth to record the experience, level, and type of IPV a woman may experience in the future, and then follow up on a large range of health conditions (Wong & Mellor, 2014).

IPV: Risk Factors

There are underlying conditions and factors that make the occurrence of intimate partner violence more probable, which can be categorized into those at the individual level, the community level, and the societal level (Lee & Hadeed, 2009). Indeed, Lee and Hadeed (2009) go on to elaborate their assertion by observing that prior exposure to child abuse, indulgence in alcohol and drugs, witnessing parental violence and adhering to patriarchal values contributed to

intimate partner violence at the individual level. At the community level, wife-beating behaviour, exposure to violent crime, isolation and lack of social support systems were contributory factors.

Based on a large amount of historical document, women have always been the victims of IPV (Tomes, 1978; Dobash & Dobash, 1979; Clarke, 1992). According to Shetty & Kaguyutan (2002), cultures around the world approach IPV differently, and those cultures that fostered rigidity in gender roles, and ascribed to male dominance and poverty contributed towards intimate partner violence at the societal level (Lee & Hadeed, 2009). The World Health Organization (2000a) reports that women fill multiple roles in across socioeconomic levels in the society and bear responsibilities of being mothers, educators, wives and caregivers. In addition to women's demanding responsibilities and their conflicting roles, they experience considerable domestic violence, sexual abuse, and sex discrimination (WHO, 2000a).

Risk factors such as poverty, alcohol, and substance abuse and family dynamics (power and control issues) also increase the prevalence of IPV directly or indirectly. According to the World Health Report (2001), there was a high correlation between poverty and related conditions such as "unemployment, lack of social resources, low education, deprivation and homelessness" (p.13), and mental and behavioural disorders, including substance misuses. Jewkes (2002) indicated that poverty can increase the risk of violence through conflicts, male identity, and a women's effort to strive for more economic independence as well as higher education. In relationships where there are financial concerns, jealousy issues, heavy alcohol consumption or substance abuse, the risk for violence is higher. In Jewkes' (2002) discussion on the risk factors of domestic violence, he argued that women with higher education and socioeconomic status are more empowered and protected from abuse in general. Male perpetrators often use violence to deal with a "crisis of identity" caused by poverty, or "to control women" (p.1423).

Immigrant women are especially vulnerable to abuse by their intimate partners due to a myriad of reasons, which include lower immigration status compared to that of their spouses, deep-seated "cultural beliefs, and socio-political marginalization" (Ahmed, Driver, McNally, & Stewart, 2009, p. 614). Ogunsiji, Wilkes, Jackson, and Peters (2012, p. 1660) summarized the causes of increased vulnerability of immigrant women towards intimate partner violence as being lack of financial independence, which made the women dependent on their male partners or spouses, fear of deportation back to their home countries, language barriers and lack of awareness of the availability of services in the new country. In turn, Ahmed and his colleagues (2009) observe that socio-cultural norms of familism, collectivism, and patriarchy are responsible to the perpetuation of intimate partner violence among immigrant women. Ayyub (2000) also reports, "men who are familiar to a patriarchal family system often have a more difficult time in sharing power with their wives" (p. 244), though, they unsuccessfully try to minimize the effects of the host society/country on their wives and families.

Dobash et al. (1992) indicate that gender-based violence works to diminish women's economic and emotional dependency. According to Naved and Persson (2008), the risk factors that engendered violence on female partners particularly in Bangladesh for instance included gender role perceptions, Islamic religion, low social economic status, low education level, and dowry demands. In the United States, studies indicated that the country of origin of the immigrants, their socioeconomic status, and their acculturation level influenced intimate partner violence incidences (Fedovskiy, Higgins, & Paranjape, 2008). Notably, according to Du Mont and Forte (2014), the vulnerability of women, including immigrant women increased further when they had serious or chronic mental illness.

Intimate Partner Violence and Immigrant Women

Information regarding violence against immigrant women is often difficult to access and is inaccurate most of the time due to the presence of many unrecorded cases, deep-seated cultural beliefs that discourage publicizing of intimate partner violence, and even inability to identify violent acts as transgressions that require external interventions outside the home or family.

However, there have been major developments and research activity, particularly in the last two decade, that have brought about increased awareness of intimate partner violence as a specific kind of gender and domestic violence, reforms in criminal justice systems by availing channels for legal redress for victims, and involvement of social workers in identifying it and offering interventions. Indeed. Goodman, Smyth, Borges, and Singer (2009, p.2) observed that in the early days, focus was on domestic violence, which was portrayed as a problem afflicting all women as a case of gender oppression and was classless as well. This emphasis has had the benefit of raising public awareness regarding violence against women that was prevalent in society and increased the attention the employment sector, religious institutions, healthcare systems, and criminal justice systems accorded to intimate partner violence (Goodman, et al., 2009). Indeed, according to Dillon, Hussain, loxton, and Rahman (2013, p.1), the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), a United Nations General Assembly resolution increased the acceptance of intimate partner violence as a human rights issue that cut across cultures, which in turn had led to research being funded by international agencies for the first time. As such, with increased evidence from research, the public has been increasingly able to recognize intimate partner violence, and its prevalence and impact, which has elicited increased response from the public as well (Goodman, Banyard, Woulfe, Ash, & Mattem, 2015, p.2).

The World Health Organization (2014) observed that ethnic minority and migrant women were more vulnerable to intimate partner violence despite such violence occurring across all social groups globally. Mechanic and Pole (2013), in agreement with the observation by the World Health Organization (2014), observed that women who were poor and from minority ethnic communities experienced significantly more violence from intimate partners than those who were not afflicted by these conditions. In addition, in a cross-sectional study undertaken in Spain involving 10,202 women who attended primary care centres, it was revealed that 27.9 % of migrant women had experienced violence by their intimate partner compared to 14.3% of the indigenous Spanish women (WHO, 2014). Prevalence rates among migrant victims of intimate partner violence was dependent on the migrant status of the women, which included aspects such as the length of stay of the women in the host country, the administrative status, and the country of origin from which the women came (WHO, 2014).

Impact of Intimate Partner Violence on Immigrant Women's Health

Re-abuse or repeated intimate partner violence is common among immigrant women because of the numerous disadvantages they had compare to other women, and this aggravates their wellbeing even further (Ting, 2010). Incrementally, emotional and physical consequences of intimate partner violence of the health of the victims often overlap and were closely intertwined. Specifically some physical consequences aggravated the emotional or psychological wellbeing of the women while some emotional consequences increased the chances of occurrence of related adverse physical effects (World Health Organization, 2013).

Fedovskiy, Higgins, and Paranjape (2008, p. 45) observed that women from immigrant Latino communities in the United States might suffer higher rates of posttraumatic stress disorder and major depressive disorder than did other women (Fedovskiy et al., 2008). Varma,

Chandra, Thomas, & Carey (2007) shed more light to the origins of psycho logical effects of violence by observing that in India, women who had witnessed violence in their childhood during dowry negotiations or saw their fathers beating their mothers, and women who experienced domestic violence, and women whose husbands consumed alcohol regularly were at a higher risk of experiencing mental ill health. If such women were to morale and be attacked violently by their intimate partners thereafter, their mental health would worsen. Indeed, this was testimony of how culture could influence the perceptions of intimate partner violence among some ethnic groups where such acts were accepted as normal and routine.

Incidentally, due to the challenges that violated immigrant women experience, which make them not disclose the occurrence of intimate partner violence readily, the manifestation of mental health issues are often used as an indicator of violent incidents (Hegarty, 2011). In fact, culture played a big role in perpetuating intimate partner violence and in turn, increasing the risk of psychological trauma to the victims (Bent-Goodley, 2007). Indeed, Ogunsiji and colleagues (2012) observed that many West African immigrants and women generally were oblivious of the psychological effects of intimate partner violence because they considered it normal and part of married life, an observation that was collaborated by researches of other immigrant communities.

On the other hand, the process of immigration is often arduous and traumatic sometimes, particularly when it is undertaken illegally. Specific stressful situations associated with the migration process include difficulty in acculturation and difficulty in finding employment, which made men more likely to violate their intimate partners (Ogunsiji, et al., 2012; Shoultz, Magnussen, Manzano, Arias, & Spencer, 2010).

Anitha (2008) examined the extent to which UK government's policy towards immigrant women experiencing domestic violence responds to their needs. The research itself was

conducted in 2007 and included qualitative interviews with 30 South Asian women with no recourse to public funds due to their status as recent marriage migrants, who were living in the North West and Yorkshire regions of England. Anitha examined the working of a key concession within the Immigration Rules (2002), which theoretically offers an opportunity of exit to immigrant women facing domestic violence—the Domestic Violence Rule—in light of the reality of South Asian women's experiences, including the nature of domestic violence they face, their patterns of help-seeking, pathways out of the abusive relationship, and their experience of service provision. It was Anitha's central thesis that the effectiveness of this legislation is severely hampered by a failure to take into account the multiple dimensions of disadvantage that recent marriage migrant's face.

Women who come to the UK to join their fiances receive a six-month visa, within which period they are expected to enter into a marriage or common law (Anitha, 2008). Those who come to join their husbands are subject to a two-year probationary period of residency, also known as the 'two year rule' (Anitha, 2008). Through marriage, these women acquire their immigration status from their spouse's residency or citizenship rights (Anitha, 2008). If their relationship breaks down during this period, they face deportation (Anitha, 2008). Due to a recent change in UK law, if there is 'evidence' that domestic violence is the cause of marital breakdown, then they can apply for Indefinite Leave to Remain (ILR) under the Domestic Violence Rule in paragraph 289A of the Immigration Rules (Anitha, 2008). However, until a decision is reached on their application for ILR, women have no access to public funds or social housing.

For women from India, Pakistan and Bangladesh, abuse may be perpetrated by multiple members of the family, and notions of honour and shame may prevent women from leaving and

stigmatize women who do manage to leave (Anitha, 2008). The families of Hindu and Sikh women from India may have paid huge dowries to get them married to UK men, creating pressure to make the marriage work (Anitha, 2008). The women whose experiences Anitha examined came to the UK from India, Pakistan, and Bangladesh to join their fiance´s or husbands who are British citizens or had Indefinite Leave to Remain in the UK.

Eighteen out of 30 women included in Anitha's (2008) study reported physical and sexual abuse by the partner, and sexual abuse by their husband's relatives. Another common form of abuse recounted by women included exploitation of domestic labour accompanied by a denial of the women's most basic needs (Anitha, 2008). This included starvation, imprisonment, denial of adequate food, warm clothes, privacy, a bedroom or even a bed, and the denial of labour-saving devices such as washing machines and vacuum cleaners to assist in doing the housework (Anitha, 2008). One of Anitha's particpants:

> once here, I soon came to know that they only wanted a servant for their house... I was busy the whole day doing housework and when my sister-in-law used to come to her house from work at five o'clock, she would ring her parents for me. So I always had to go her house, make food for her family, do some cleaning and come back to my home at night... to make food for my in-laws' family. That was my routine ... My visa expired but (they) were not ready to apply for indefinite leave for me. His mother always used to say, 'Deport her!' (p. 194)

The women reported a combination of factors that impeded disclosure, such as stigma, fear of being ostracized from wider kinship networks, lack of adequate provision for non-English speakers, isolation, shame, guilt, and fear of jeopardizing marriage prospects of sisters (Gill, Izzidien, as cited in Anitha, 2008).

Most women also reported that their husband and/or his family monitored their movements to minimise the possibility of a disclosure and, in some cases, kept them imprisoned in the home. Their status as newly arrived marriage migrants, often unable to speak English and unaware of the laws in the UK also contributed to their vulnerability, as the perpetrators threatened them with deportation or in other ways:

> He told me several times that he had told everyone I was mad ... no one would listen to me. If I contacted the police, they could consider me mad and arrest me. (Anitha, 2008, p. 195)

Nineteen out of the 30 women who participated in this study had disclosed the abuse they were experiencing to family, friends or both, and sought support and advice while they were living within the violent family home (Anitha, 2008). Eleven women were unable to discuss their abuse with anyone (Anitha, 2008).

For many women, the decision to leave was taken in response to a deterioration in already ongoing and severe abuse (Anitha, 2008) — onset or escalation of sexual abuse by family members or fear for the safety of their children.

> I kept trying to make my marriage work. ... I tried everything possible to please my in-laws but I failed ... But when my daughter was born, they became very abusive. My daughter was only three months old when they hit me and even slapped her. I then went to neighbour's house and they rang the police. (p. 197)

In a research project conducted for the Fawcett Society, evidence was gathered about the support and services available to women facing domestic violence (as cited in Anitha, 2008). This study shows that, on average, a woman facing domestic violence has to make 11 contacts with agencies before getting the help she needs (Anitha, 2008). However, this rises to 17 if she is

from BME communities (Brittain et al. as cited in Anitha, 2008).

Contrary to the stereotypes of South Asian women being unwilling to approach services, this study shows that South Asian women make repeated attempts to contact services despite the additional and significant barriers they face in doing so (Anitha, 2008). Twenty-eight women in Anitha's study had contacted an average of four services each not including repeated contacts with the same service—one woman had monthly contacts with her GP for over a year and another had recently called the police to her home five times. However, it took most women several contacts with services to receive the help they needed and many women had not received any help at the time of the interviews despite several attempts to access support (Anitha, 2008).

Six out of the 30 women who participated in Anitha's (2008) study had accessed ER services following domestic violence, of whom five were accompanied by the perpetrator(s) who explained away their injuries to the A&E staff:

> He [my husband] once grabbed my hair and pulled my neck back – I couldn't move my neck. At the hospital, my mother-in-law told them that I had fallen down the stairs.

No attempt had been made to question the injuries or to pursue the explanation given despite research that indicates that a high percentage of women attending ER in the UK are survivors of domestic violence (Boyle & Todd; Sethi et al., as cited in (Anitha, 2008).

Similarly, Barkho, Fakhouri, and Arnetz (2011) examined the prevalence of intimate partner violence (IPV) among immigrant Iraqi women, and explored the association between IPV and self-rated health. A pilot study using a previously published, self-report questionnaire was carried out among a convenience sampling of 55 Iraqi women in greater Detroit (Barkho et al., 2011). The overall prevalence of controlling behavior, threatening behavior, and physical violence was a staggering 93, 76, and 80%, respectively (Barkho et al., 2011). Approximately

40% of the women reported having poor or fair health, and 90% reported experiencing one or more types of psychosomatic symptoms (Barkho et al., 2011). Self-rated health was inversely related to exposure to threatening behavior and physical violence, and positively related to knowledge of one's legal rights (Barkho et al., 2011). The prevalence of IPV in this sample was high and results indicated a significant association between exposure to IPV and women's physical health and psychosomatic symptoms (Barkho et al., 2011).

In conclusion immigrant women who suffer from intimate partner violence may experience psychological effects that adversely affected their health adversely. Indeed, depressive conditions, phobias, and anxiety, which were manifested as manifested themselves as unsafe sexual behaviour, high propensity for self-harm, smoking, abuse of alcohol and drugs, low self-esteem, physical inactivity, eating disorders and sleep disorders were displayed as the psychological or emotional consequences of intimate partner violence. This was worsened by their inability to identify the psychological problem due to cultural reasons, inability to sock interventions due to fear of shaming their partners and communities, incarceration and deportation.

Immigrant women undergoing or who have undergone intimate partner violence suffer from untold physical consequences, some of which continue to manifest long after the incidence of violence and abuse (Stockmaa, Hayashi, & Campbell, 2015). Anitha's (2008) study shows that when the immigration status of women is dependent on their husband, the power imbalances within a marriage are further weighed against women.

> For women facing domestic violence, the choices are stark: leaving an abusive relationship can mean deportation, and this threat is a powerful tool in the hands of the abusers. Due to the stigma associated with the break-up of the marriage and the blame

> that is attached to the women for leaving the relationship, many women who participated in this study feared further violence from their own families if deported. Honour killings are common in the regions of the subcontinent from which women who participated in this study originate. (Amnesty International 1999, Hariharan 2004, Anitha, 2008, p. 199)

Counselling women with experiences of IVP

Chang et al. (2009) did an interesting qualitative study (n=6) with women with past or current experiences of IVP, focusing on turning points, or those factors that motivated women to change their situation. The turning points women identified fell into five major themes: (1) protecting others from the abuse/abuser; (2) increased severity/humiliation; (3) increased awareness of options/access to support and resources; (4) fatigue/recognition that the abuser was not going to change; and (5) partner betrayal/infidelity (Chang et al., 2009).

Protecting others. When the women in Chang et al.'s study (2009) feared that the violence was affecting other individuals, they were less accepting, and started to think about changing their situation—especially when it involved the children. One woman in Chang et al.'s study said:

> Eventually, my daughter who's the oldest, he began to treat her really badly . . . . At that point, I knew that I wasn't going to allow him to continue to hurt her emotionally. . . . I'm sorry, you can do whatever you want to me to a point, but don't start doing this to my daughter and to the kids. (p. 254)

Another woman shared: ''My greatest motivation [to get help] was my children. When he wasn't satisfied hitting me, he started hitting my kids. And I didn't like that. Not to my kids. I said 'No' to this. Not them.'' (Chang et al., 2009, p. 245)

These concerns also applied to other family members and unborn children.

Increased severity. Another motivating factor was escalation in either the severity or level of degradation of the abuse—especially when they experienced violence to a degree that their lives were threatened (Chang et al., 2009). One woman told Chang et al.: ‘‘I knew that I came that close to being killed, and that was it for me. That was enough” (p. 245). Degradation and humiliation was also motivating for women to make changes. One woman described that when her partner’s abuse began to involve sexual violence, she left:

> He kept me in the bathtub and...he did stuff to me....like raped me . . . I felt the worst I’ve ever felt and I thought, I can’t take it anymore . . . I had my wallet and my purse hidden in my stepson’s treehouse. So after he went to sleep, I snuck out of the house and grabbed that and left. And I haven’t been back since.

Increased support. Another factor that helped women view their situations differently and consider change was the recognition that they had support from others (Chang et al., 2009). One woman described, her turning point ‘‘was when she [a IPV counselor] told me that they [local IPV organization for Spanish-speaking immigrants] could help me and that I wasn’t going to lose my children either” (Chang et al., 2009, p. 254). Another woman found support from an IPV victims’ advocate and another IPV victim:

> I got to the police station all beaten up and there I met [the IPV victims’ advocate] and...I didn’t know that somebody could help me. Then I met [another IPV survivor] there and we were almost the first ones [dealing with IPV] that we knew back then. We were scared, yes. But little by little we found the way to the light, to a new life (Chang et al., 2009, p. 254).

Another women mentioned: ‘‘Just with a simple caring word, you feel you are really worthwhile.’’ Another woman describes the impact of a discussion she had with her health provider: ‘‘She said to me one day, ‘Did you ever stop and realize that you have the right to decide what’s acceptable and what isn’t?’ . . . And ever after that, every time he acted strange, I’d think, ‘This isn’t acceptable” (Chang et al., 2009, p. 254).

Fatigue. Another factor that contributed to permanent change in women’s perceptions of their IPV relationships was a sense of fatigue (Chang et al., 2009). They described this fatigue as resulting from \attempts to change the abuser’s behavior (Chang et al., 2009). The fatigue was associated with loss of hope for the relationship with a recognition that the cost of remaining in the relationship was too great (Chang et al., 2009). One woman explained: ‘‘You get tired. You get tired and wore out. I mean you really do, mentally . . . I’m worn out mentally. I just can’t take it. . . . That’s when it [trying to find help] begins’’ (Chang et al., 2009, p. 255). Another woman said:

> When the turning point came, I was crying on the way to work. I was crying on the way home from work. I was crying at lunchtime. And it’s to that point that you just can’t do it anymore. You know, when you’ve been beaten down so bad that you can’t take it anymore. (Chang et al., 2009, p. 255)

Another turning point that decreased women’s willingness to tolerate the abuse was discovering that their abusive partners had been unfaithful (Chang et al., 2009). One woman stated: ‘‘The day that I caught him with his girlfriend . . . I just said, ‘I can’t do this anymore (Chang et al., 2009, p. 255). Another woman caught her husband flirting with another woman:

> That time I was pregnant and him and my brother-in-law had gone out to town to get

> something from the store and never came back. So, me and his sister went to look for them. . . . I looked in this bar and he was in there laughing and giggling. They were both with this woman . . . . So when he came home, I said ‘‘When this baby is born, I’m leaving.’’ I had had enough and I did [leave]. It was just like that little thing that did it. (Chang et al., 2009, p. 255)

In Closing

In this chapter, I have briefly discussed IPV prevalence and I discussed consequences, risk factors, and IPV in immigrant women. I also outlined motivating factors for women who experience (d) IPV to change their situation.

CHAPTER 3: RECOMMENDATIONS

In this chapter, I will outline recommendations based on previous chapters with a specific focus on counsellors and clinical supervision.

Financial Security

Batterers are able maintain control over their victims due, in large part, to the economic insecurity of women who are abused (Harrington Conner, 2014). Economic binds a woman to her abuser, drawing her in over and over again; it is one of the best predictors of continuing violence once the abuse begins (Harrington Conner, 2014). Financial insecurity increases the danger levels, limits avenues of escape, and reduces the likelihood that a survivor of intimate partner violence, once liberated, will remain free from her abuser (Harrington Conner, 2014).

The intersection between financial inequality and intimate partner violence poses significant risks to women who are abused, and the solution must be comprehensive.

Responses must take into consideration the economic implications of intimate partner violence and respond with economic solutions, including reform within our legal system, governmental programs, and labour industry (Harrington Conner, 2014). Our legal system must improve batterer-mandated support obligations, as well as court enforcement of those orders. At the same time, social welfare programs must be strengthened to appropriately meet the needs of battered women and their children and to end the cycle of violence fuelled by resource control, male-power, and abuse (Harrington Conner, 2014).

Clinical Counsellors

Clinical counsellors play an important role in helping clients and the victims of intimate partner violence (IPV) to overcome their psychological unrest, and this implies taking on empathic approach towards the victim. In the process, clinical psychologists may also be affected by the psychological trauma of their clients, and this might hinder the way in which they offer their therapy. It is important for them to remain strong and emotionally competent to take their clients through all sessions of therapy. Immigrant workers who are victims of intimate partner violence are examples of clients whose predicaments may affect the functioning of their clinical psychologists. Following this challenge, clinical counsellors who attend to immigrant women who are the victims of IPV may need support through supervision to guide them.

Quinn (2004) argues that within the field of psychotherapy and counselling, clinical supervision has grown. It is no longer viewed as a continuation of the therapeutic process, and in fact, some licensing bodies require clinicians to undergo clinical supervision training prior to being licensed as supervisors. However, the actual training with regard to clinical supervision still lags behind available research and knowledge, and this has resulted in a wide variety of styles, as well as quality (Quinn, 2004).

Research on this subject is scarce, but research that is available tends to emphasize the need to prepare clinical counsellors to receive supervision, and these studies have elucidated the ways through which such preparation can be attained (Campbell, 2000). It has been suggested that an important component of learning to be supervised is by learning the fundamentals upon which supervision is anchored. In other words, future supervisees are likely to benefit from their own experience of supervision if they were taught the fundamentals of what supervision entails.

Such fundamentals help the supervisee appreciate the role of their supervisor and take their recommendations with the seriousness they deserve.

Self-assessment of an individual's interest in receiving motivation is an informed first step that nurtures supervision acceptance (DiAnne & Lori, 2005). Clinical supervisors have identified different attributes that are beneficial for the supervision process. DiAnne & Lori (2005) indicated that those clinical counsellors who adapt well to clinical supervision have some psychological perspectives and openness such as; motivation and initiative, interest and desire, interpersonal curiosity, dependability, willingness to risk, empathy, intellectual openness, minimal defensiveness, habit of developing professional knowledge, receptivity to feedback, introspection, and personal, clinical and theoretical flexibility.

In a survey study, Vespia, Heckman-Stone, and Delworth (2002) found that both supervisees and supervisors listed the following as the most desirable supervisor qualities: shows "motivation to grow, takes responsibility for consequences of own behavior; actively participates in supervision sessions; demonstrates respect and appreciation for individual differences; and demonstrates understanding of own personal dynamics as they relate to therapy and supervision" (cited in Quinn, 2004, p. 363). Vespia et al. (2002) also noted that important positive attributes are acceptance and appreciation of individual differences while at the same time demonstrating individual dynamics as they relate to the therapy and supervision.

Practicum's instructors (supervisors) ought to encourage clinical counsellors to rate themselves on selected features and discuss with their supervisors on areas that require further clarification (Janet, 2002). It has also been found that junior clinical counsellors tend to have a misconception that supervisors only tell them what to do (Janet, 2002). Realizing this perception, supervisors are advised to participate in a variety of roles in relation to the needs of the

supervisee. In the teacher role, the supervisor is expected to guide the counsellors in areas such as learning techniques, applying interventions, and conceptualizing (Janet, 2002). With respect to the role of a counsellor, the supervisor is expected to facilitate self-growth and explore the counsellor's personal reactions. This may include providing alternatives rather than answers, and at the same time, ensuring that the interaction is collegial. Similarly, counsellors must reflect on their desire to learn new skills and knowledge, explore personal dynamics and reactions to clients, discuss ideas, and question on a collegial level (Janet, 2002).

Furthermore, supervisors need to be available and approachable because it has been found that these attributes help counsellors to seek help and assistance from their supervisors (Janet, 2002). Supervisors also bear the responsibility of monitoring and tracking the counsellor's work with their clients, providing regular and consistent feedback, offering suggestions for improvement, and at the same time, restricting the relationship to supervision. Further help of the supervisors can include offering counsellors suggestions on how to handle a given therapeutic condition, as well as providing practical support through modeling and coaching, giving emotional support through encouragement and reassurance, delivering feedback in a constructive manner, and being proficient as a therapist (Janet, 2002).

David and Archie (2004) also indicate that documentation of the supervision tasks is a crucial administrative role of the supervisor. Documentation, according to these authors, is a kind of risk management tool. David and Archie (2004) hold this opinion that supervision documentation necessitates growth, as well as professional development of supervisor and the counsellor.

Clinical supervisors is an important aspect of clinical psychology (Smith, 2009). Many organizations are realizing the need to have at least one supervisor in their organization to offer

timely guidance to the entire team of counsellors. Counselling is a complex profession because every situation that a counsellor faces is unique and must be given unique solutions. In line with this, the role of clinical supervisors comes in handy because it helps quench the difficulties that different counsellors face in an institution. Psychotherapy-based models of supervision seem to be a natural extension of the therapy itself.

Bumbling, King, Raue, Scwheitser, and Lambert (2002) highlight that clinical supervision of counsellors or psychotherapists, particularly in their initial stages of their career, have been found to be of integral help in professional development, and it guarantees optimal client outcomes. There is, however, limited data on the impact that clinical supervision has on therapeutic outcome and psychotherapy practice. Few studies that have examined this phenomenon have found that it has a positive impact on therapeutic relationship alliance, as well as symptom reduction. Therapists have seconded the role of clinical supervision as an educational procedure that improves professional competency and treatment skills (Bumbling et al., 2002).

There are different models of supervision. They include psychodynamic approach to supervision, feminist model, cognitive -behavioural model, and Pearson-centered model (Smith, 2009). These models highlight how supervisors ought to work with their counsellors. In the following paragraphs, I describe how these models can be employed under the context of clinical supervisor and their supervisory roles of clinical counsellors who work with immigrant women that are victims of domestic violence.

During supervision, the clinical supervisor and the supervisee may examine case-specific treatment, as well as process a way of enhancing not only therapist awareness, but also the skills necessary for the management of complexities of client work (Bumbling et al., 2002). It is important to note that within the speciality of counselling and psychotherapy, there is the notion

that supervision should enhance the impact of therapeutic intervention. For that matter, a supervisee must look forward to achieving greater clinical outcomes in client work than their peers who are unsupervised. There have been different studies that evaluated the significance of supervision on patient outcomes, and a majority found a positive association of the two phenomena (Bumbling et al., 2002).

In line with this, counsellors working with immigrant women who are victims of domestic violence can achieve better client outcomes if they are open to supervision. Supervision will help them develop a better working alliance with their clients, and as such, move closer to solving the psychological dilemmas of those clients.

Supervision's Role

A clinical supervisor wears several hats of responsibilities (Bumbling et al., 2002). They are in charge of integrating counsellors' self-awareness, development of clinical knowledge and skills, and theoretical development, as well as improving their functional and professional skills. These roles often overlap and tend to be fluid in the supervisory role. The supervisor for that matter acts as an advocate for the client and supervisee (counsellor). The supervisor is the integral link between the front line staff (counsellor) and the administration, and they monitor the compliancy with agency goals, procedures, and polices. The supervisor is also in charge of communicating the needs of the supervisee and clients to the administration. The most important aspect between the supervisor and supervisee is the alliance between the two. For that matter, the supervisor's roles can be grouped in the following categories (Furr & Carroll, 2003).

Teacher Role

In the teacher role, the supervisor helps the supervisees in the development of counselling knowledge and skills, as well as identifying learning needs. In this context, the supervisor

functions to model counsellor strengths, boost her self-awareness, transform her knowledge into practical skills, and promote professional growth. In line with this role, supervisors are professional role models or trainers (Furr & Carroll, 2003).

Consultant Role

The second category is the consultant role (Furr & Carroll, 2003). Under this role, the supervisor functions to review cases, monitor the counsellor, offer counselling to the therapist regarding their job performance, and at the same lime, assess the counsellors. In addition, under this role the supervisors provide alternatives to case conceptualizations, and offer oversight to the supervisee's work in order to achieve the mutually agreed objectives. The supervisor at this stage can also recognize and address supervisee impairment (Furr & Carroll, 2003).

Coach Role

The third category is the coach role (Furr & Carroll, 2003). Under this role, the supervisors offer morale building, prevent burnout, cheerlead, suggest clinical approaches, assess strengths and needs, and offer support.

Mentor Role

The fourth category is the role model/mentor role. In other words, the supervisor acts as the pace setter; the supervisee ought to look up to the supervisor for career development as they advance their career (Furr & Carroll, 2003).

Additionally, the clinical supervision is anchored on two concepts, 1) parallel processes, and 2) isomorphism (Kolutz, Odegard, Feit, Provost, & Smith, 2012).

Parallel Process

The parallel process accounts for the interpersonal relationship between the supervisor and supervisee. It is an intrapsychic phenomenon that tends to occur unconsciously on the part of the supervisee. It normally originates in one setting but is reflected in another setting (Klotz et al., 2012). With respect to the supervisor, this phenomenon occurs as a characteristic of the client portrayed by the supervisee in the context of supervision. The process is normally generated in the course of work when the client and the counsellor are working together. Interestingly, it is not under the awareness of either the client or the therapist. This phenomenon can be manifested in a number of ways. For example, the client may exhibit anger in the course of the therapy when requested to do a given task. On the other hand, in the course of the supervision, the supervisee may get angry when requested by their supervisors to undertake a given action (Koltz et al., 2012). But how can the supervisor and supervisee handle such situations?

First, in on order to successfully handle this issue, there is a need to understand that supervision aims to protect client welfare, as well as promote supervisee's professional development. Once the supervisor has understood this, they are likely to navigate past this challenge with ease. In order to manage this case, the supervisor must examine both the client and the supervisee and check for similarities in the forms of their parallelism. Once a commonality has been identified, the supervisor must now assess its cause and work towards resolving it with both the client and the supervisee, but in an amicable manner that does not make the situation even sorer. Here, the supervisor should be the role model and inspire both the client and the supervisee.

Isomorphism

On the other hand, isomorphism is inter-relational. In other words, patterns of isomorphism can emerge in two forms: from counselling into supervision or from supervision into counselling (Koltz et al., 2012). This phenomenon occurs in replicating structural patterns between supervision and counselling. The supervisor and the therapist might find themselves in an awkward situation whereby their roles are being replicated on the client. The supervisor finds himself or herself doing the counselling role, which is the duty of the therapist. To avoid this, the supervisor should define their roles and objectives from the beginning so that no conflict of interest emerges in their supervisory role (Koltz et al., 2012).

There are central principles that govern clinical supervision (UDHHS, 2009). First, clinical supervision is an integral aspect of clinical practice. It integrates evidence-based practice, clinical theory and treatment philosophy, and the organization's goals and mission. Second, it enhances counsellor morale and staff retention. Third, all employees (counsellors) have a role in supervision; in addition, supervisors have a right to being supervised as well. The most important aspect of supervision is to offer custom made supervision to each counsellor.

Fourth, supervision must be supported by the organization in which counsellors are working. Having that support builds counsellor-supervisor-administration relationship. Clinical supervision is a skill and for that matter, it must be developed (UDHHS, 2009). It is vital to note that culture and contextual factors affect the supervision process, and for that matter, caution must be taken so that these factors do not hinder the process in a negative way. Furthermore, in order to become better counsellors, there is a need to have ongoing supervision (Jacobsen, 2007). Last but not least, the clinical supervision process must always involve direct observation methods and act as a gatekeeper of the professional (Jacobsen, 2007).

Working with clients who experience(d) IVP: Best practices

Safety first: Make the client's safety and well-being of the utmost importance (Bray, 2014). Safety should also be the first and foremost consideration when choosing interventions (Bray, 2014). Create and talk through a safety plan with clients (Bray, 2014). For victims of intimate partner abuse, a safety plan might include keeping an extra house key and change of clothes in the car in case their spouse or partner throws them out during an argument (Bray, 2014).

Treading gently: Clients who experienced abuse may have been traumatized, and discussions about the abusive situation can trigger PTSD-like symptoms (Bray, 2014). Counsellors should talk through the client's emotions, use trauma-informed care and allow the client to control the pace of therapy (Bray, 2014).

Assessment: Ask behaviour-specific questions: Has your partner ever called you names? Who makes the decisions in the relationship? Does your partner check up on you? Have you ever been injured in a fight with your partner?

Be holistic in your approach: All aspects of the client's life — from physical and mental health to parenting, finances and housing — can be affected by abuse (Bray, 2014). Look at all areas of the person's life that have been influenced and help her work toward recreating her life and build back a sense of self-worth (Bray, 2014).

Be interdisciplinary in your approach: Work with other agencies in your community (Bray, 2014). Become knowledgeable about violence services in the client's area—hotlines, shelters, school resource officers, women's clinics, victim advocate organizations, support groups, law enforcement personnel, and social workers (Bray, 2014). Learn the basics regarding how a client would file a police report or restraining order (Bray, 2014).

Storytelling and self-care: Abuse survivors typically enjoy an opportunity to tell their story, and talking through a client's story in counselling can help the person to heal and feel validated (Bray, 2014). Journaling can also be useful therapy tool (Bray, 2014).

Summary

In summary, this chapter has shown that clinical counsellors play an important role in helping clients overcome their psychological unrest. This gives a more accurate and effective therapy. Supervisors play an integral role in shaping the careers of their supervisees. For that reason, counsellors working with immigrant women who are victims of domestic violence can benefit from the supervision process. It will help them improve their careers, as well as client outcomes. In order to become better counsellors, it is essential to have ongoing supervision. The clinical supervision process must always involve direct observation and act as a gatekeeper of the profession.

CHAPTER 4: DISCUSSION

In this chapter, I will summarize main findings, outline scope and limitations of this study, and point at areas for future research.

The focus of this study was to explore literature regarding incidence, nature and impact of intimate partner violence (IPV) on women's health. I outlined statistics on IPV, as well as described the nature and impact of IPV. I have addressed immigrant women's experiences with IPV in particular. The lens through which I explored these topics was feminist theory.

Main Findings

IPV has serious physical, emotional and socioeconomic effects not only for the victims, and their family, but also creates major problems for public health.

The prevalence of IPV is difficult to gauge, but in 48 WHO population based surveys from around the world, between 10 and 69% of women reported being physically abused by an intimate partner at some point in their lives (Krug et al., 2002).

Epidemiological and clinical research shows that IPV is consistently associated with a broad range of negative health outcomes (Ellsberg, Janse, Heise, Watts, & Garcia-Moreno, as cited in Wong & Mellor, 2014).

Prior exposure to child abuse, indulgence in alcohol and drugs, witnessing parental violence and adhering to patriarchal values contributes to intimate partner violence at the individual level (Lee & Hadeed, 2009). At the community level, wife-beating behaviour, exposure to violent crime, isolation and lack of social support systems are contributory factors. Cultures that fostered rigidity in gender roles and ascribed to male dominance, and poverty contributes towards intimate partner violence at the societal level (Lee & Hadeed, 2009).

Poverty, alcohol and substance abuse, and family dynamics (power and control issues) also increase the prevalence of IPV directly or indirectly.

Immigrant women are especially vulnerable to abuse by their intimate partners due to a myriad of reasons. Financial insecurity makes immigrant women dependent on their male partners or spouses, in addition to fear of deportation back to their home countries, language barriers and lack of awareness of the availability of services in the new country. Shetty and Kaguyutan, (2002) delve into these social and economic factors that create barriers for immigrant battered women. For example, if an immigrant woman's only means of support is an abusive husband, leaving him means losing financial support and possessions, but also the extended family or community (Erez, as cited in Shetty & Kaguyutan, 2002).

Immigrant women are often also not allowed to legally work and they may face a constant threat of deportation or other immigration related threats by their abuser (Narayan; Abraham; Dasgupta, as cited in Shetty and Kaguyutan, (2002). Dutton, Orloff and Aguilar Hass (as cited in Shetty & Kaguyutan, 2002) found that 72.3% of the battered Latinas surveyed in their 2000 study reported that their spouses never filed immigration petitions for them, even though over half of them (50.8%) qualified. The abusers who did file petitions for their spouses took almost four years to do so, and "fear of deportation is a very powerful tool used by abusers to prevent battered immigrant women from seeking help and to keep them in violent relationships" (Shetty & Kaguyutan, 2002, par. 7).

Turning points that motivate women to change their situation are (1) protecting others from the abuse/abuser; (2) increased severity/humiliation; (3) increased awareness of options/access to support and resources; (4) fatigue/recognition that the abuser was not going to change; and (5) partner betrayal/infidelity (Chang et al., 2009).

Recommendations for clinical counsellors included:

- **Clinical Supervision**
- Consider **PFEC** as an approach, as research has shown that PFEC is helpful in term of healing the psychological wounds of abused women (Sharma, 2001; Theinkaw and Rungreangkulkij, 2013).
- **Safety first:** Make the client's safety and well-being a priority and make safety first and foremost consideration when choosing interventions (Bray, 2014). Create and talk through a safety plan with clients (Bray, 2014).
- **Treading gently:** Talk through the client's emotions, use trauma-informed care and allow the client to control the pace of therapy (Bray, 2014).
- **Assessment:** Ask behaviour-specific questions: Has your partner ever called you names? Who makes the decisions in the relationship? Does your partner check up on you? Have you ever been injured in a fight with your partner?
- **Be holistic in your approach:** All aspects of the client's life — from physical and mental health to parenting, finances and housing — can be affected by abuse (Bray, 2014). Look at all areas of the person's life that have been influenced and help her work toward recreating her life and build back a sense of self-worth (Bray, 2014).
- **Be interdisciplinary in your approach:** Work with and familiarize yourself with other agencies in your community (Bray, 2014).
- **Storytelling and self-care:** Offer **your client** an opportunity to tell her story, and you may encourage her to journal as well (Bray, 2014).

Scope and Limitations

This thesis is limited in a few ways. I have used CityU library's data base as well as online data bases EBSCO, Directory of Open Access Journals, ERIC, Global Health, Google Scholar, Indian Citation Index, JSTOR, and JournalSeek, which may have limited search results. My search terms may have also limited results. In addition, I have not used which limits this study to a review of existing research. Qualitative research with women that includes women's voices would have enriched this work and offered a more nuanced glimpse into the experiences of women who are or were subject to IPV.

Areas for Future Research

I believe that much more research is needed into the lived experiences of women with experiences of IPV, in particular the voices of exceptionally vulnerable women such as new immigrants who don't speak the local language or who have limited command of it. These women are, as research in this study has shown over and over, most vulnerable not only to IPV, but also sexual abuse, physical abuse, and abuse of their status as autonomous person by their husband's family members (Anitha, 2008). As the research also shows, these women struggle to find help, despite numerous efforts—indeed, in Anitha's study, many women had attempted to reach out, often on more than one occasion, before finding the help they needed—more work is needed to see to it that these women get help and protection, despite their status as new immigrants with perhaps an ambiguous citizenship status. Scholars could help in the effort to better help these women in outreach and participatory research, which would yield new insights into these women's experiences this could also be empowering for the women participants. In addition, such research could be a factor in saving the Canadian government resources of money. Earlier I cited a Justice Canada study that revealed the cost of one type of intimate partner

violence, spousal violence, on Canadian society to be $7.4 billion in 2009 (Stats Canada, 2013). In addition, children who witness domestic violence are at increased risk of anxiety, depression, low self-esteem and poor school performance, among other problems that harm their well-being and personal development. Children, both girls and boys, who have witnessed or suffered from gender-based violence, are more likely to become victims and abusers later in life.

The United Nations Universal Declaration of Human Rights and the Declaration on the Elimination of Violence, as well as many international agreements against women have recognized women's fundamental human right to live free from violence (United Nations General Assembly, 2006). I believe that the academic community has a moral obligation to recognize this right and to actively work to improve the plight of the many women who do not enjoy this right yet. Attaining equality and being free from discrimination and violence are fundamental human rights (UN 2014). Yet women around the world regularly suffer violations of their human rights throughout their lives, and realizing women's human rights has not always been a priority (UN 2014). Achieving equality between women and men requires a thorough understanding of the ways in which women experience discrimination and are denied equality so that appropriate strategies and interventions can be developed to eliminate such discrimination, inequality, violence, and suffering (UN 2014). In establishing this thorough understanding is where I see the academic community to have work ahead of itself.

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