

## Appendix 13: Intimate partner violence: evidence review for newly arriving immigrants and refugees

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### ABSTRACT

**Background:** Intimate partner violence is a significant worldwide public health problem. We conducted an evidence review to determine effectiveness for screening, prevention, and treatment that primary care practitioners can offer to prevent/reduce morbidity and/or mortality from intimate partner violence in newly arriving immigrants and refugees.

**Methods:** Using the Grading of Recommendations Assessment, Development and Evaluation (GRADE) Working Group approach, we systematically assessed evidence on screening, prevention, and interventions for intimate partner violence, including barriers to care for newly arriving immigrants and refugees to Canada.

**Results:** Recently-settled immigrant women appear to have lower rates of intimate partner violence than longer-term immigrants and Canadian-born women. Immigrant women from developing countries report a higher prevalence of intimate partner violence compared to those from developed countries or Canadian-born women. Screening for intimate partner violence among women in the general population does not reduce intimate partner violence recurrence. Immigrant and refugee women may be particularly vulnerable to the consequences of false positive screens and may be wary of the screening process. An advocacy and counseling intervention program, administered to women who have spent at least one night in a shelter, can decrease intimate partner violence. Other individual, group or legal intervention programs or approaches provide poor or conflicting evidence of effectiveness.

**Interpretation:** Practitioners should stay alert to signs and symptoms associated with intimate partner violence and assess after patient disclosure or when reasonable doubt exists. Advocacy programs and strategies aimed at alleviating migration and family stress may be effective for recently-settled immigrant and refugee women who are living in precarious conditions or experiencing integration difficulties.

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### Box 1: Recommendations on intimate partner violence from the Canadian Collaboration for Immigrant and Refugee Health

Do not routinely screen for intimate partner violence. Be alert to potential signs and symptoms related to intimate partner violence and assess when reasonable doubt exists or after patient disclosure. Currently, there is insufficient evidence to recommend screening of immigrant and refugee women for intimate partner violence.

#### Basis of recommendation

- **Balance of benefits and harms:** Current evidence does not demonstrate clear benefits from screening women for intimate partner violence, and harms have resulted from screening. Compared to the general population, there may be greater risk among immigrant and refugee women for harm directly related to screening (e.g., risk of loss of migration status and sponsorship agreements). Harm may incur indirectly due to impaired rapport and barriers to disclosure, which may lead to less use of general medical and mental health services.
- **Quality of evidence:** Moderate
- **Values and preferences:** The guideline committee attributed more value to evidence of harms and lack of evidence of benefits and less value to recommending uncertain interventions, even in face of significant concerns.

## The cases

A Child Protection Services worker brought a 25-year-old Indian woman, Gita, to the emergency department. The worker indicated that the patient was suffering from depressive symptoms and expressed suicidal thoughts. When questioned, Gita said that her life has no meaning now that her family has been destroyed.

A 33-year-old pregnant Moroccan woman, Mariam, attends a pre-natal follow-up appointment with her doctor. During the check-up procedures, Mariam requests an ultrasound for her fetus, and mentions being worried. She has been having some leg and abdominal pain due to a slip while walking on the icy street three days ago.

How would you approach these patients?

## Introduction

Intimate partner violence, defined as physical, emotional, financial and/or sexual abuse perpetrated against the victim by his or her intimate partner,<sup>1</sup> is a significant, worldwide public health problem,<sup>2,4</sup> both in terms of prevalence<sup>5</sup> and multiple acute and chronic physical and

mental health consequences.<sup>1,6-13</sup> Tjaden and Thoennes (2000) estimate that medical care (mostly hospital-based) is required in one-third of all cases of intimate partner violence.<sup>14</sup> A ten-country study conducted by the World Health Organization (WHO) from 2000 to 2003<sup>13,15</sup> revealed rates of sexual and/or physical abuse by a partner on ever-partnered women between 15% and 71%, with rates varying substantially between countries and between urban and rural regions within any one country.

In Canada, the 1999 General Social Survey with a nationally representative sample of 26,000 participants reported 8% intimate partner violence against a female and 7% against a male by a previous or current partner in the past five years.<sup>16</sup> Women, however, are more likely to be the victims of serious violent acts such as sexual abuse, beatings (25% vs. 10%), being choked (20% vs. 4%) or being threatened or having a weapon used against them (13% vs. 7%).<sup>17</sup> They are also more likely to be injured during the violent act (40% vs. 13%) and to be fearful for their lives (40% vs. <10%).<sup>17</sup> This review aims to determine whether existing screening tools and approaches for intimate partner violence are appropriate for immigrant and refugee women and to identify care barriers for these populations.

## Methods

We used the 14-step approach developed by the Canadian Collaboration for Immigrant and Refugee Health (CCIRH) team.<sup>18</sup> A Clinical Summary Table was used to highlight the populations of interest, the epidemiology of intimate partner violence, population-specific clinical considerations and potential key clinical actions (Appendix 2).

### *Search strategy for systematic reviews and population-specific literature*

We designed a search strategy in consultation with a librarian scientist to identify relevant systematic reviews and guidelines from MEDLINE, PsycLIT, CINAHL, Embase and Cochrane Database of Systematic Reviews. We further hand-searched websites including National Guideline Clearinghouse (<http://www.guideline.gov/>), Public Health Agency of Canada (<http://www.phac-aspc.gc.ca>), United States (US) Preventive Services Task Force (<http://www.ahrq.gov/clinic/USpstfix.htm>), Canadian Task Forces on Preventive Health Care (<http://www.ctfphc.org/>), the Task Force on Community Preventive Services, the Presidential Task Force on Violence and the Family

(<http://sogc.medical.org/guidelines/public/157E-CPG-April2005.pdf>), the National Institute for Health and Clinical Excellence (NICE) (<http://guidance.nice.org.uk/PHG/Wave20/60>) and the World Health Organization (WHO) (<http://www.who.int/en/>). The first search covered English and French articles from 1 January 1995 through November 2008.

Two reviewers screened the eligible papers for relevance to the key question: Should Canadian primary care practitioners routinely screen for intimate partner violence in all immigrant and refugee women and refer women to an appropriate intervention program to prevent or stop further abuse and reduce its consequences on women? We appraised eligible systematic reviews using the National Institute for Health and Clinical Excellence (NICE) critical appraisal tool to assess systematicity, transparency, quality of methods and relevance and appraised relevant guidelines using the Appraisal of Guidelines Research & Evaluation (AGREE) Instrument. Inclusion criteria included: 1) outcome studies or outcome reviews or systematic reviews on screening, prevention or intervention programs for intimate partner violence; and 2) full-length articles published in peer-reviewed journals and written in English or French. We excluded manuscripts providing only descriptions of screening instruments/methods, prevention or intervention programs. A reference systematic review was chosen for each clinically important outcome. We updated the literature search from 1 November 2008 to 31 December 2010 to determine if there were any recent publications that would change the position of the recommendation.

Using the same databases as the first search (through December 2010), we conducted a third literature search to identify quantitative and qualitative studies on intimate partner violence, focusing on the immigrant and refugee population and discussing: 1) baseline risk or incidence and prevalence; 2) risk of clinically important outcomes; 3) genetic and cultural factors (e.g., preferences, values, knowledge); and 4) compliance variation.

#### *Synthesis of evidence and values*

We synthesized evidence using the Grading of Recommendations Assessment, Development and Evaluation (GRADE) Summary of Findings tables which assesses both relative and absolute effects. We also used GRADE to appraise study limitations, directness, precision, consistency, and reporting bias across all studies (Box 2). We identified both clinically-relevant considerations and implementation issues relevant to our

population. Finally, we identified gaps in the research and evidence-based literature.

## Results

The initial and update searches found no systematic reviews or evidence-based guidelines on screening, prevention or treatment for intimate partner violence in recently settled immigrants or refugees. The literature search thus focused on general and ethnic minority populations and identified 409 titles with reference to intimate partner violence. Twenty-three citations were selected for critical appraisal, and reviewers retained two key reviews as background evidence.<sup>19-20</sup> After the search update, two additional key reviews and one randomized controlled trial (RCT) were selected.<sup>21-23</sup> (Appendix 1) Studies conducted with general population and ethnic minority samples also provided evidence that informed our clinical recommendations.

### **What is the burden of intimate partner violence in immigrant populations?**

Three studies provided results from secondary analyses of the 1999 Statistics Canada General Social Survey. Women born in developing countries reported the highest prevalence rates of intimate partner violence (5.1%,  $p < .05$ ;  $n = 534$ ), followed by Canadian-born women (3.7%;  $n = 5,737$ ) and immigrant women from developed countries (2.4%;  $n = 844$ ). However, when all other variables in the model were controlled for, logistic regressions showed that recently-settled immigrant women (i.e.,  $< 10$  years) had significantly lower odds of intimate partner violence victimization than longer-term immigrants and Canadian-born women.<sup>24</sup> Hyman (2006) also showed that intimate partner violence rates were lower in recently-settled immigrant women (Odds Ratio=0.57; 95% Confidence Interval=0.38 to 0.87;  $n = 389$ ) compared to non-recently-settled immigrant women ( $n = 1,207$ ).<sup>25</sup>

Risk for intimate partner violence varied as a function of age, marital status and country of origin, the strongest factor being marital status. Single, divorced, separated or widowed immigrant women were ten times more likely to report intimate partner violence than immigrant women married or in a common-law relationship.<sup>25</sup> Conversely, Ahmad (2005) found no significant difference between Canadian-born ( $n = 3,548$ ) and Canadian immigrant women ( $n = 313$ ) in terms of physical abuse (4.5% vs. 3.3%). Immigrant women, however, reported higher rates of emotional abuse (14.7% vs. 8.7%), with the strongest risk factor being their partner's low educational level.<sup>26</sup>

Although results tend toward recently-settled immigrant women having lower odds of physical intimate partner violence, the overall results are inconclusive, due to mixed findings, the impact of non-controlled for sociodemographic factors and methodological limitations of the studies. The representativeness of the General Social Survey is limited by the fact that only English or French-speaking women participated. This may have excluded a significant subsample of recently-settled immigrant women who may be more vulnerable to intimate partner violence. None of these studies examined rates of intimate partner violence for refugee women.

Unofficial surveys on intimate partner violence have yielded higher rates. For example, MacMillan et al. (2006) reported rates that ranged from 4.1% to 17.7% among a sample of 2,461 women (all English-speaking aged 18 to 64, 12.6% foreign-born). Ahmad et al (2009) reported a 22% rate of intimate partner violence following computer screening.<sup>27</sup> Prevalence rates also vary in relation to the health care setting (highest prevalence in emergency departments).<sup>28</sup> Finally, women in war zones, disaster zones, during flight or displaced in refugee camps in countries of asylum may be at higher risk for intimate partner violence.<sup>12</sup>

### **Does screening for intimate partner violence decrease morbidity and mortality?**

#### *Screening*

Screening for intimate partner violence differs from traditional screening for medical disorders because the target of clinical concern is a behavioral event, which women usually recognize as a problem, but may not view as appropriate for medical attention.<sup>12, 29</sup> No studies have assessed physical examination of women as a screening strategy; however, several self-report or interview instruments have been developed to assess women's experience with intimate partner violence.<sup>30</sup> Guidelines are available from the Canadian Task Force, the US Task Force, and two recent reviews from the United Kingdom (UK).<sup>12,20-21,23,30</sup> According to the recent reviews,<sup>20-21,23,30</sup> four short self-report questionnaires have received the most study: 1) the *Hurt, Insulted, Threatened, or Screamed at* (HITS, 4 items)<sup>31</sup> yields sensitivity ranging from 30% to 100% and specificity from 86% to 99%; 2) the *Partner Violence Screen* (3 items)<sup>32</sup> provides sensitivity from 35% to 71% and specificity from 80% to 94%; 3) the *Women Abuse Screening Tool* (8 items)<sup>33</sup> yields 47% for sensitivity and 96%, for specificity; and 4) the *Abuse Assessment Screen* (5 items)<sup>34</sup> yields sensitivity ranging from 32% to 94% and specificity from 55% to 99%.

In a Canadian randomized controlled trial (RCT), MacMillan and colleagues (2006) compared three screening methods (a face-to-face interview with a health care provider, a written self-completed questionnaire, and computer-based self-completed questionnaire) and instruments (Partner Violence Screen, Women Abuse Screening Tool, Composite Abuse Scale) among 2,461 women (all English-speaking, ages 18 to 64, 12.6% born outside Canada; immigration status unknown) visiting emergency departments (n=2), family practices (n=2), or women's health clinics (n=2). The authors reported similar sensitivities and specificities for screening tools, but found that women preferred the self-completed approaches on all measures of acceptability (ease of responding, likeability, and privacy).<sup>28</sup> However, other studies on or comparing administration methods of screening instruments (e.g., face-to-face interviews, computer screening, written screens) have shown inconsistent results.<sup>27,35-38</sup> Furthermore, it is unknown whether these results apply to recently-settled immigrant and refugee women. Indeed, lack of direct questioning in intimate partner violence has been reported as a disclosure barrier in culturally diverse women.<sup>12</sup>

#### *Relative benefits and harms from screening*

In a unique RCT on the effect of screening on intimate partner violence, MacMillan et al. (2009) recruited 6,743 English-speaking women (ages 18 to 64 years) from 11 emergency departments, 12 family practices, and 3 obstetrics/gynecology clinics in Ontario. The final sample consisted of 411 women; 53 were born outside Canada, immigration status unknown. After controlling for the high sample attrition rate (43% of screened and 41% of non-screened women), there were no statistically significant differences between women screened and not screened at 6, 12, or 18 months follow-up for recurrence of intimate partner violence (e.g., at 18 months: Odds Ratio = 0.88; 95% Confidence Interval 0.43 to 1.82), positive post-traumatic stress disorder screens, alcohol problems, drug problems, quality of life, depressive symptoms, physical health or mental health. (Table 1) The study did not find any harms related to being screened. More than half of the women who disclosed being victims of intimate partner violence on screening did not discuss the violence with their practitioner during the health care visit. An important study limitation was that no specific intervention was provided to women who disclosed or screened positive.<sup>22</sup>

In Feder's systematic review of 13 qualitative and 19 quantitative studies with ethnically diverse samples (immigration statuses unknown), and in two additional studies, most women found routine screening for

**Table 1:** Summary of findings on screening for intimate partner violence to reduce morbidity due to intimate partner violence

Patient or population: English-speaking female patients

Settings: Health care settings in Ontario

Intervention: Screening for intimate partner violence

Comparison: No screening

Source: MacMillan HL et al. Screening for Intimate Partner Violence in Health Care Settings. A Randomized Trial. JAMA. 2009;302(5):493-501.

Outcomes	Absolute effect			No of participants (studies)	GRADE quality of evidence	Comments
	Risk for control group	Difference with screening for intimate partner violence	Relative effect (95% CI)			
Intimate partner violence – 18 months Composite Abuse Scale Follow-up: 18 months	530 per 1000	74 fewer per 1000 (159 fewer to 32 more per 1000)	RR 0.86 (0.70– 1.06)*	379(1)	Moderate†‡	NNT 14 (not statistically significant)
Post-traumatic stress disorder screening – 18 months SPAN (startle, physically upset by reminders, anger, and numbness) Follow-up: 18 months	601 per 1000	162 fewer per 1000 (246 fewer to 66 fewer per 1000)	RR 0.73 (0.59– 0.89)*	379(1)	Moderate†‡	NNT 7 (95% 5–16)
QOL – 18 months WHO Quality of Life-Bref Follow-up: 18 months	The mean quality of life in the control groups was 52.7	The mean quality of life in the intervention groups was 5.8 higher (2.14 higher to 9.46 higher)		379(1)	Moderate†§	
Depression – 18 months Follow-up: 18 months	The mean depression in the control groups was 24.4	The mean depression in the intervention groups was 3.4 lower (5.8 lower to 1.0 lower)		379(1)	Moderate†§	

Note: CI = confidence interval, GRADE = Grading of Recommendations Assessment, Development and Evaluation, NNT = number needed to treat, RR = relative risk.

\* RR calculated using Review Manager based on observed counts

† Only one study.

‡ Dichotomous outcome: total number of events is less than 300

§ Continuous outcome: total population size is less than 400

violence in pre- and post-natal settings<sup>21,39-40</sup> or computer screening<sup>27</sup> acceptable, although it made a few uncomfortable.<sup>21</sup> The authors reported screening benefits such as recognizing violence, decreasing isolation, increasing support, relief, breaking the silence and validating their feelings.<sup>12,41-42</sup> However, these same studies identified several harms, including feeling: the practitioner is too busy or not interested; judged and being disappointed by the practitioner response; increased anxiety and that the intervention was cumbersome or intrusive; concerns around privacy,<sup>27</sup> breaches of confidentiality and legal repercussions; fear of being reported to child protective services;<sup>12,43</sup> and concern around or actual increased risk of retaliation or further harm from partner<sup>12,42</sup> (for 43% of 202 women;<sup>44</sup> and 25% of 95 women in trauma centers).<sup>45</sup> These potential harms may make immigrant and refugee

women particularly wary of screening and may constitute significant disclosure barriers.<sup>46</sup> According to Rodriguez et al., immigrant and refugee women may have additional fears related to their immigration status and family sponsorships. Thus, compared with Canadian-born women, there may be greater risk among immigrant and refugee women for harm directly related to screening and indirectly due to impaired rapport and disclosure barriers, which may reduce use of health services.

*Relative benefits and harms of treatment*

The individual studies and reviews that have included ethnic minority women have not provided information on participant immigration status. Four systematic reviews synthesized evidence on prevention efficiency and intervention programs, mostly advocacy, for intimate partner violence.<sup>1,19,21,30</sup> Advocacy interventions aim to

provide abused women with legal, housing and financial advice, facilitate their access to and use of community resources (e.g., shelters, emergency housing, psychological interventions), and provide safety planning advice.<sup>1</sup> The eligible RCTs selected by the four reviews showed significant heterogeneity in type of advocacy programs, instruments used, outcomes measured, sample composition, and recruitment source. Most findings were contradictory, mixed, or indicated a positive outcome but with wide confidence intervals.

In the Wathen and MacMillan (2003)<sup>19</sup> and the Ramsay (2009)<sup>1</sup> reviews, the strongest evidence came from the studies on the Experimental Social Innovation and Dissemination (ESID) program,<sup>47,48</sup> in terms of decreased physical and emotional abuse at 12-24 months follow-up (Odds Ratio= 0.23; 95% Confidence Interval 0.23 to 0.80) and improvement of women's quality of life at 12-months follow-up (Weighted Mean Difference 0.23; 95% CI 0.00 to 0.46). The Experimental Social

Innovation and Dissemination program (ESID) continued to have positive effects on women's quality of life and social support levels three years after intervention<sup>49</sup> (Table 2). Ramsay et al. (2009) reported that, while promising, the results were inconclusive.<sup>1</sup> MacMillan and Wathen (2003) found low quality evidence for the efficacy of the Experimental Social Innovation and Dissemination (ESID) advocacy and counseling intervention program in decreasing incidence of intimate partner violence<sup>19</sup> in an ethnically diverse sample of women who have spent at least one night in a shelter. Feder et al. (2009) report the strongest evidence for advocacy services for women victims of intimate partner violence in antenatal services, while the weakest is for women identified through screening.<sup>21</sup>

Interventions designed to treat couples show no clear benefits.<sup>19</sup> Data on psychological interventions for women victims of intimate partner violence provide evidence that most individual therapy programs are

**Table 2:** Summary of findings on advocacy programs for preventing further intimate partner violence

Patient or population: Women in a Midwest shelter program for women with abusive partners. Women were eligible for the project if they (a) spent at least one night in the shelter and (b) planned on staying in the general vicinity for the first 3 months postshelter.

Settings: Community setting

Intervention: Advocacy programs

Comparison: No advocacy program

Source: Wathen et al. Interventions for Violence Against Women. Scientific Review. *JAMA*. 2003;289:589-600.

Sullivan et al. Reducing Violence Using Community-Based Advocacy for Women With Abusive Partners. *J Consult Clin Psych* 1999;67(1):43-53.

Outcomes	Risk for control group	Absolute effect		No of Participants (studies)	Quality of the evidence (GRADE)	Comments
			Difference with advocacy programs (95% CI)			
Self-reported severity/frequency of abuse Frequency-Severity Scale of Violence. Scale from: 0 to 3. Follow-up: 24 months	The mean self-reported severity/frequency of abuse in the control groups was 0.85	The mean self-reported severity/frequency of abuse in the intervention groups was 0.15 higher		265 (1§)	Low*†‡	
Effectiveness in obtaining community resources Effectiveness in Obtaining Resources Scale. Scale from: 1 to 4. Follow-up: 10 weeks	The mean effectiveness in obtaining community resources in the control groups was 2.7	The mean effectiveness in obtaining community resources in the intervention groups was 0.50 higher (0.34 higher to 0.66 higher)		265 (1)	Low*†‡	
Quality of life Scale from: 1 to 7. Follow-up: 24 months	The mean quality of life in the control groups was 4.94 **	The mean quality of life in the intervention groups was 0.25 higher (0.02 lower to 0.52 higher)		265 (1)	Low*†‡	
Depression Scale from: 0 to 3. Follow-up: 24 months	The mean depression in the control groups was 2.00	The mean depression in the intervention groups was 0.08 lower (0.24 lower to 0.08 higher)		265 (1)	Low*†‡	

Note: CI = confidence interval, GRADE = Grading of Recommendations Assessment, Development and Evaluation.

\* Only one study

† Concerns re: directness; only applies to those women seen in primary care who have been in a shelter

‡ < 300 events

§ Sullivan et al. An Advocacy Intervention Program for Women with Abusive Partners: Initial Evaluation. *American Journal of Community Psychology* 1992;20(3):309-32.

\*\* Post-intervention scores

efficient in reducing symptoms of psychological distress, such as depression or post-traumatic stress disorder. Other intervention programs or approaches (e.g., emergency department interventions or home visits by police and social workers) provide very low quality or no evidence of their effectiveness in reducing intimate partner violence or enhancing awareness or use of services.<sup>19</sup> Evidence is conflicting regarding effectiveness of batterer intervention programs, either with or without partner participation, in decreasing the rate of further intimate partner violence.<sup>19, 50</sup>

## Clinical considerations

*Does screening for intimate partner violence occur during the migration process?*

All migrants to Canada complete an immigration medical examination. However, screening for intimate partner violence is not part of this examination.

*What are potential implementation issues?*

Signs and symptoms of intimate partner violence differ significantly among women. They may be absent in some women or be of psychological (depression, anxiety, suicidal ideation, alcohol or drug abuse), social (social isolation) and/or physical (injuries, bruises and aches) nature in other women. Patient-physician rapport thus remains a key element in the detection of intimate partner violence.

Recently-settled immigrant women in Canada are more likely to report intimate partner violence to the police than both non-recently-settled or general population women (50.8%, 26.0%, and 29.5% respectively), but less likely to use social services (30.8%, 52.8%, and 50.5% respectively).<sup>46</sup> Barriers to help seeking were legal, contextual, or cultural and included fear of losing sponsorship agreements, deportation or not accessing Canadian citizenship, lack of knowledge of services/language-specific services, experiences of racism or discrimination, culture-specific belief systems, and recourse to non-biomedical strategies.<sup>46</sup>

Cultural variations in intimate partner violence definitions and related domains such as culturally-specific perceptions of spousal relationships, gender roles, gender obligations, parental authority, aggression, and abuse may impact reporting and disclosure.<sup>12</sup> Like other women, immigrant and refugee women may choose - or be pressured- not to disclose the intimate partner violence and to stay with their abusive partners.<sup>51-53</sup> The reasons for these choices may include: shame; privacy; obedience to husband; woman's role to preserve harmony and unity, often for the sake of children; belief in accepting

fate; need to uphold the "model minority" image vis-à-vis the larger society; and the husband's prerogative or sexual entitlement.<sup>54-55</sup>

*Linguistic and Socioeconomic factors:* Age at migration, time since migration, and linguistic barriers may constitute significant barriers to disclosure, treatment negotiation and adherence to interventions, and also may diminish a patient's sense of self-efficacy.<sup>12,51,56</sup> An immigrant or refugee woman may not want to disclose intimate partner violence if her partner solely supports her and her children financially.<sup>12</sup> Thus, interventions that reduce migration stress and enhance women's socioeconomic conditions may decrease their risk of intimate partner violence.<sup>57</sup>

Lacking knowledge about services and laws on intimate partner violence and fearing punitive institutional power (police, child protection services, courts) constitute disclosure barriers.<sup>12,46</sup> Involvement with police or criminal proceedings may put immigrant and refugee women at risk of losing their sponsorship agreements, or may put their partners at risk of deportation to countries of origin or having applications for Canadian citizenship denied.<sup>12,46</sup> For migrants, concern about these barriers is heightened by negative past experiences with institutions both in countries of origin and the host country.

Given that intimate partner violence is now considered a form of child maltreatment, women's fear of losing custody of their children (reported reason by Child Protection Service is most often mother's failure to protect children) is another important disclosure barrier.<sup>12,46</sup> Some women feel coerced into staying in a shelter to keep custody of their children. Although this may protect them from further intimate partner violence, it may also isolate them from extended family and community networks and increase their socioeconomic vulnerability. Deficiency-oriented approaches that aim to protect but not empower women may neglect the victim and perpetrator's other competencies and ignore available supports that might otherwise be integrated effectively into the intervention plan.<sup>58</sup>

Services that can defuse conflict situations and reduce family stress include: social welfare, health insurance, affordable and reliable childcare, affordable and safe housing, affordable clothing and transportation, language classes and other educational and vocational training opportunities. Community grassroots organizations can provide information and support groups in appropriate languages and in a culturally-competent manner.<sup>51,54-55,59-62</sup> Recent research is showing significant benefits in terms of intimate partner violence recurrence outcomes and child outcomes when screening and interventions

target general population and ethnic minority women with specific conditions, for example pregnancy, mental illness, and substance abuse, but this work has yet to consider the immigrant women context.<sup>42, 63</sup>

## Recommendations from other groups

National clinical preventive screening committees, the Canadian Task Force, the US Task Force, and Feder et al. 2009 have not found sufficient evidence that screening offers more benefits than harms to recommend for or against screening all women for intimate partner violence in the periodic health exam.<sup>20,21,22</sup> The UK national screening committee concluded that “Screening for domestic violence should not be introduced” in periodic health examinations.

Screening proponents argue that intimate partner violence is a prevalent public health problem with significant health costs for women and their families, and that screening has been found to be generally acceptable for women.<sup>22</sup> The American Medical Association, the American Academy of Pediatrics, the American Academy of Family Physicians, the American College of Obstetricians and Gynecologists and the American College of Emergency Physicians recommend routinely screening all women for intimate partner violence.<sup>23</sup> However, these organizations have not based their recommendation on systematic reviews of effectiveness.

## The cases revisited

Gita reported that she had gone to a shelter with her children, as recommended by child protection services,(CPS) following disclosure of intimate partner violence. However, after a week, she returned to her husband. Consequently, her two daughters have been placed in foster care for “failure to protect the children from intimate partner violence”. Gita felt she had destroyed her family and regretted having disclosed the violence. Given the importance of preserving her couple and family unity, the practitioner referred her and the child protection services (CPS) worker to a community agency and worked on a safety plan. The community agency offered couples intervention, as the husband was willing and mediated between the couple, the child protection services (CPS) worker and the foster family, establishing conditions for the children’s safe return.

Upon further questioning and examination, the practitioner informed Mariam that the bruises did not seem accidental. After guaranteeing confidentiality, he asked her whether occurring problems might explain the bruises. Mariam started crying and said she had been hit

and pushed by her husband, which made her fall. The violence began after migration when her husband experienced repeated workplace discrimination, and it became worse with her pregnancy. She confided that she wished to end the relationship, keeping her child, but had no support network. Together, Mariam and the practitioner made a three-step intervention plan. First, the practitioner referred Mariam to an immigrant women shelter. Second, the practitioner offered a more intensive follow-up for her pregnancy, with weekly visits. Third, a social services professional from the shelter devised an advocacy program with Mariam. This included helping her complete registration for language classes, preparing her curriculum vitae and looking for employment, applying for inexpensive housing and seek child care services, and assisting with legal divorce procedures. The worker also supported Mariam in explaining her situation to her extended family and in gradually reestablishing a social network.

## Conclusion and research needs

There is a striking lack of evidence on the prevalence, screening and intervention for intimate partner violence among immigrant and refugee women in Canada. Research is also needed on the impact of migratory and settlement stressors on this phenomenon’s prevalence. Detection and assessment of intimate partner violence requires knowledge of cultural variations in normative spousal interactions, the causes of interpersonal conflict and the consequences of help-seeking and disclosure. Because of the diversity between and within immigrant groups, epidemiological surveys and quantitative studies must be supplemented with qualitative research and case studies.

Research is needed on the impact of various institutional intimate partner violence interventions (e.g., police, youth courts, criminal, courts, Child Protection Services) on immigrant or refugee women and their families. Due to current intervention strategy limitations, research must not only address the impact of more traditional interventions (e.g., shelter) on immigrant and refugee women, their children, their families and their relationships with their cultural communities, but also assess the potential value of advocacy programs and other culturally-based interventions that can mobilize resources for prevention, detection, and intervention within specific communities.

## Key points

- Recently-settled immigrant women appear to have lower odds of intimate partner violence than longer-term immigrants and Canadian-born women.
- Linguistic barriers, financial dependency, lack of knowledge of laws and health services, fear of losing custody of children, and threats to immigration status of sponsorship agreements due to police involvement or criminal proceedings, may constitute significant barriers to disclosure and adherence to interventions among immigrant and refugee women.
- Practitioners should refer women who have spent at least one night in a shelter to a structured program of patient-centered (advocacy) support services to decrease rate of abuse.

### Box 2: Grading of Recommendations Assessment, Development and Evaluation Working Group grades of evidence ([www.gradeworkinggroup.org](http://www.gradeworkinggroup.org))

**High quality:** Further research is very unlikely to change our confidence in the estimate of effect.

**Moderate quality:** Further research is likely to have an important impact on our confidence in the estimate of effect and could change the estimate.

**Low quality:** Further research is very likely to have an important impact on our confidence in the estimate of effect and is likely to change the estimate.

**Very low quality:** We are very uncertain about the estimate.

## REFERENCES

- Ramsay J, Carter Y, Davidson L, et al. Advocacy interventions to reduce or eliminate violence and promote the physical and psychosocial well-being of women who experience intimate partner violence. *The cochrane collaboration*. 2009(3):1-93.
- World Health Organization/London School of Hygiene and Tropical Medicine. Preventing intimate partner and sexual violence against women: taking action and generating evidence. Geneva, World Health Organization, 2010.
- Prevention of violence. 1997; [http://www.who.int/violence\\_injury\\_prevention/resources/publications/en/WHA5019\\_fre.pdf](http://www.who.int/violence_injury_prevention/resources/publications/en/WHA5019_fre.pdf).
- Djeddah C, Facchin P, Ranzato C, Romer C. Child abuse: Current problems and key public health challenges. *Social Science & Medicine*. 2000;51:905-915.
- Statistics Canada. Family Violence in Canada: A Statistical Profile. In: CCFJS, ed. Ottawa: Statistics Canada; 2005.
- Briere J, Jordan CE. Violence against women: Outcome complexity and implications for assessment and treatment. *Journal of Interpersonal Violence*. 2004;19(11):1252-1276.
- Chrisler JC, Ferguson S. Violence against women as a public health issue. *Annals New York Academy of Sciences*. 2006;1087:235-249.
- Eisenstat SA, Bancroft L. Domestic violence. *The New England Journal of Medicine*. September 16, 1999;341(12):886-892.
- Fischback RL, Herbert B. Domestic violence and mental health: Correlates and conundrums within across cultures. *Social Science & Medicine*. 1997;45(8):1161-1176.
- Plichta SB, Duncan MM, Plichta L. Spouse abuse, patient-physician communication, and patient satisfaction. *American Journal of Preventive Medicine*. 1996;12(5):297-303.
- Xu Q. In the "best interest" of immigrant and refugee children: Deliberating on their unique circumstances. *Child Welfare*. 2005;LXXXIV(5):747-770.
- Cherniak D, Grant L, Mason R, Moore B, Pellizzari R. Intimate Partner Violence Consensus Statement. *SOGC Clinical Practice Guidelines*. April 2005 2005(157):365-388.
- Ellsberg M, Jansen H, Heise L, Watts CH, Garcia-Moreno C. Intimate partner violence and women's physical and mental health in the WHO multi-country study on women's health and domestic violence: an observational study. *The Lancet*. April 5 2008;371:1165-1172.
- Tjaden PT, Thoennes N. Full report of the prevalence, incidence and consequences of violence against women: Research report. In: National Institute of Justice, ed. Washington, DC: NCJ; 2000.
- Garcia-Moreno C, Jansen H, Ellsberg M, Heise L, Watts CH. Prevalence of intimate partner violence: findings from the WHO multi-country study on women's health and domestic violence. *the lancet*. 7 october 2006;368:1260-1269.
- Canadian Centre for Justice Statistics. A Profile of Criminal Victimization: Results of the 1999 General Social Survey. 2000; <http://www.statcan.gc.ca/pub/85-553-x/85-553-x1999001-eng.pdf>.
- Statistics Canada. Family Violence in Canada: A Statistical Profile. In: CCFJS, ed. Ottawa: Statistics Canada; 2002.
- Tugwell P, Pottie K, Welch V, Ueffing E, Chambers A, Feightner J. Evaluation of evidence based on literature and formulation of recommendations for Clinical Preventive Guidelines for Immigrants and Refugees in Canada. *CMAJ*. (in press).
- Wathen NC, Mac Millan HL. Interventions for violence against women: Scientific review. *Journal of American Medical Association*. February 5, 2003 2003;289(5):589-600.
- Nelson HD, Nygren P, McInerney Y. Screening for family and intimate partner violence: Systematic evidence review. In: Services USDoHaH, ed. Rockville: Technical Support of the U.S. Preventive Services Task Force; 2004:1-76.
- Feder G, Ramsay J, Dunne D, et al. How far does screening women for domestic (partner) violence in different health-care settings meet criteria for a screening programme? Systematic reviews of nine UK National Screening Committee criteria. *Health Technology Assessments*. 2009;13(16).
- Mac Millan HL, Wathen NC, Jamieson E, et al. Screening for Intimate Partner Violence in Health Care Settings: A Randomized Trial. *Journal of the American Medical Association*. 2009;302(5):493-501.
- Rabin RF, Jennings JM, Campbell JC, Bair-Merritt MH. Intimate Partner Violence Screening Tools: A Systematic Review. *American Journal of Preventive Medicine* 2009;36(5):439-445.
- Brownridge DA, Halli SS. Double jeopardy: Violence against immigrant women in Canada. *Violence and Victims*. 2002;17(4):455-471.

25. Hyman I, Forte T, Du Mont J, Romans S, Cohen MM. The association between length of stay in Canada and intimate partner violence among immigrant women. *American journal of public health*. April 2006;96(4):646-659.
26. Ahmad F, Ali M, Stewart DE. Spousal-abuse among Canadian immigrant women. *Journal of immigrant health*. 2005;7(4):239-246.
27. Ahmad F, Hogg-Johnson S, Stewart DE, Skinner HA, Glazier RH, Levinson W. Computer-Assisted Screening for Intimate Partner Violence and Control: A Randomized Trial. *Annals of Internal Medicine*. 2009;151:93-102.
28. Mac Millan HL, Wathen NC, Jamieson E. Approaches to screening for intimate partner violence in health care settings: A randomized trial. *Journal of American Medical Association*. August 2, 2006 2006;296(5):530-536.
29. Taket A, Wathen NC, MacMillan H. Should Health Professionals Screen All Women for Domestic Violence? *Plos medicine*. October 2004 2004;1(1):7-10.
30. Mac Millan HL, Wathen NC, Canadian Task Force on Preventive Health Care. *Prevention and treatment of violence against women: systematic review and recommendations*. London, Ontario 2001.
31. Sherin KM, Sinacore JM, Li X-Q, Zitter RE, Shakil A. HITS: A short domestic violence screening tool for use in a family practice setting. *Family Medicine*. 1998;30(7):508-512.
32. Feldhaus KM, Koziol-McLain J, Amsbury HL, Norton IM, Lowenstein SR, Abbott JT. Accuracy of 3 brief screening questions for detecting partner violence in the emergency department. *The Journal of the American Medical Association*. 1997;277(17):1357-1361.
33. Brown JB, Ryan BL. *The Women Abuse Screening Tool: A Ten-Year Program of Research*. London: University of Western Ontario; 2001.
34. Soeken KL, McFarlane J, Parker B, Lominack MC. The Abuse Assessment Screen: A clinical instrument to measure frequency, severity, and perpetrator of abuse against women. In: Campbell JC, ed. *Empowering survivors of abuse: Health care for battered women and their children*. Thousand Oaks: Sage Publications; 1998:195-203.
35. Nelson HD. Screening for domestic violence—bridging the evidence gaps. *Medicine, Crime, and Punishment*. 2004;364:22-23.
36. Glass N, Dearwater S, Campbell J. Intimate partner violence screening and intervention: Data from eleven Pennsylvania and California community hospital emergency departments. *Journal of Emergency Nursing*. 2001;27(2):141-149.
37. Furbee PM, Sikora R, Williams JM, and Derk SJ. Comparison of domestic violence screening methods: A pilot study. *Annals of Emergency Medicine*. 1998;31(4):495-498.
38. McFarlane J, Christoffel K, Bateman L, Miller V, Bullock L. Assessing for abuse: Self-report versus nurse interview. *Public Health Nursing*. 1991;8(4):245-250.
39. Stenson K, Saarinen H, Heimer G, Sidenvall B. Women's attitudes to being asked about exposure to violence. *Midwifery*. March 2001 2001;17(1):2-10.
40. Webster J, Stratigos SM, Grimes KM. Women's responses to screening for domestic violence in a health-care setting. In: Wickam S, ed. *Midwifery: Best Practice 2: Book for Midwives*; 2004:59-66.
41. Chang J, Martin S. What happens when health care providers ask about intimate partner violence? A description of consequences from the perspectives of female survivors. *J Am Med Women's Assoc*. 2001;58(2):76-81.
42. Spangaro JM, Zwi AB, Poulos RG, Man WYN. Six Months After Routine Screening for Intimate Partner Violence: Attitude Change, Useful and Adverse Effects. *Women & Health*. 2010;50:125-143.
43. Dowd DM, Kennedy C, Knapp JF, Stallbaumer-Rouyer J. Mothers' and health care providers' perspectives on screening for intimate partner violence in a pediatric emergency department. *Archives of Pediatrics & Adolescent Medicine*. August 2002 2002;156(8):794-799.
44. Gielen AC, O'Campo PJ, Campbell JC, et al. Women's opinion about domestic violence screening and mandatory reporting. *American Journal of Preventive Medicine*. 2000;19:279-285.
45. Weinsheimer RL, Schermer CR, Malcoe LH, Balduf LM, Bloomfield LA. Severe intimate partner violence and alcohol use among female trauma patients. *Journal of Trauma*. 2005;58:22-29.
46. Hyman I, Forte T, Du Mont J, Romans S, Cohen MM. Help-seeking rates for intimate partner violence (IPV) among Canadian immigrant women. *Health care for women international*. 2006;27(8):682-694.
47. Sullivan CM, Bybee DI. Reducing violence using community-based advocacy for women with abusive partners. *Journal of Consulting and Clinical Psychology*. February 1999 1999;67(1):43-53.
48. Sullivan CM. Using the ESID Model to reduce intimate male violence against women. *American Journal of Community Psychology*. December 2003 2003;32(3/4):295-303.
49. Bybee D, Sullivan CM. Predicting re-victimization of battered women 3 years after exiting a shelter program. *American Journal of Community Psychology*. 2005;36(1-2):85-96.
50. Smedslund G, Dalsbø TK, Steiro AK, Winsvold A, Clench-Aas J. *Cognitive behavioral therapy for men who physically abuse their female partner* 2007.
51. Dutton MA, Orloff LE, Aguilar Hass G. Characteristics of help-seeking behaviors, resources and service needs of battered immigrant latinas: Legal and policy implications. *Georgetown Journal on Poverty Law and Policy*. 2000;7(2):245-305.
52. Bauer HM, Rodriguez MA, Szkupinski Quiroga S, Flores-Ortiz YG. Barriers to health care for Latina and Asian immigrant women. *Journal of Health Care for the Poor and Underserved*. 2000;11(1):33-44.
53. Rodriguez MA, Sheldon W, Bauer HM, Perez-Stable E. The factors associated with disclosure of intimate partner abuse to clinicians. *Journal of Farm Pract*. 2001;50(4):338-344.
54. Bhuyan R, Mell M, Senturia K, Sullivan M, Shiu-Thornton S. Women must endure according to their karma": Cambodian immigrant women talk about domestic violence. *Journal of Interpersonal Violence*. 2005;20(8):902-921.
55. Bhuyan R, Senturia K. Understanding domestic violence resource utilization and survivor solutions among immigrant and refugee women: Introduction to the special issue. *Journal of Interpersonal Violence*. 2005;20:895-901.
56. Hass GA, Dutton MA, Orloff LE. Lifetime prevalence of violence against Latina immigrants: legal and policy implications. *Domestic Violence: Global Responses* 2000;7(1-3):93-113.
57. Pronyk P, Kim J, Hargreaves J. Microfinance and HIV prevention perspectives and emerging lessons from a community randomized trial in rural South Africa. *Small Enterprise Development*. 2005;16:26-38.
58. Morh WK, Tulman LJ. Children exposed to violence: Measurement considerations within an ecological framework. *Advances in Nursing Science*. September 2000 2000;23(1):59-68.
59. Boiko P, Katon W, Guerra JC, Mazzoni S. An audiotaped mental health evaluation tool for hispanic immigrants with a range of literacy levels. *Journal of Immigrant Health*. 2005;7(1):33-36.

60. Crandall M, Senturia K, Sullivan M, Shiu-Thornton S. "No way out": Russian-speaking women's experiences with domestic violence. *Journal of Interpersonal Violence*. 2005;20(8):941-958.
61. Sullivan M, Senturia K, Negash T, Shiu-Thornton S, Giday B. "For us it is like living in the dark": Ethiopian women's experiences with domestic violence *Journal of Interpersonal Violence*. 2005;20(8):922-940.
62. Kasturirangan A, Krishnan S, Riger S. The impact of culture and minority status on women's experience of domestic violence. *Trauma, Violence & Abuse*. 2004;5(4):318-332.
63. Kiely M, El-Mohandes AAE, El-Khorazaty MN, Gantz MG. An Integrated Intervention to Reduce Intimate Partner Violence in Pregnancy: A Randomized Controlled Trial. *The American College of Obstetricians and Gynecologists*. February 2010 2010;115(2):273-283.

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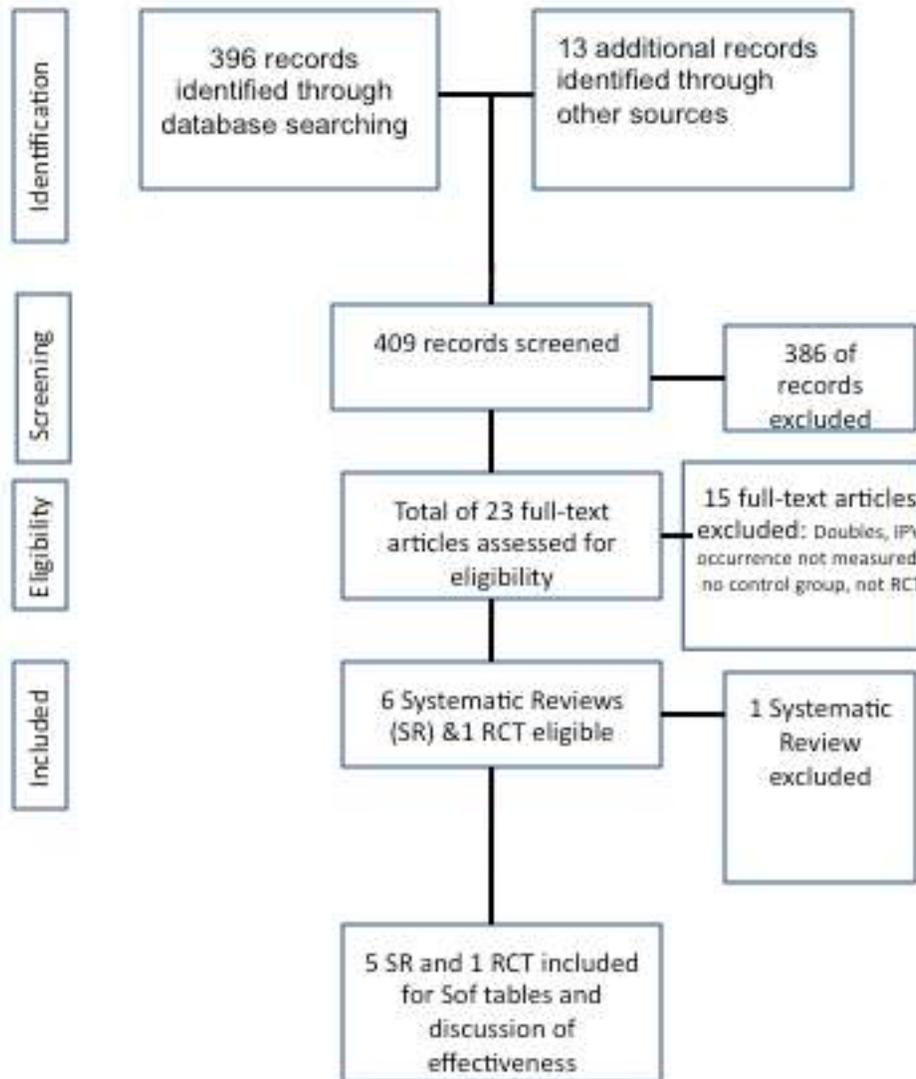
**Clinical preventive guidelines for newly arrived immigrants and refugees**

This document provides the review details for the CMAJ CCIRH Intimate Partner Violence paper. The series was developed by the Canadian Collaboration for Immigrant and Refugee Health and published at [www.cmaj.ca](http://www.cmaj.ca).

More detailed information and resources for screening, assessment and treatment of depression can be found at: [www.mmhrc.ca](http://www.mmhrc.ca).

Appendix 1: Figure 1

Figure 1: Search and Selection Flow Sheet 1999 to 2008 and 2008-2009



## Appendix 2: Intimate Partner Violence Evidence Based Clinician Summary Table

Do not routinely screen for intimate partner violence. Be alert to potential signs and symptoms related to intimate partner violence and assess when reasonable doubt exists or after patient disclosure.

**Prevalence:** Women born in developing countries reported the highest prevalence rates of intimate partner violence (5.1%), followed by Canadian-born women (3.7%) and immigrant women from developed countries (2.4%). However, recent immigrant women (i.e. <10 years) reported significantly lower rates of intimate partner violence victimization as compared to longer-term immigrants and Canadian-born women.

**Burden:** Women are more likely than men to be the victims of serious violent acts such as sexual abuse, being beaten (25% vs. 10%), being choked (20% vs. 4%) or being threatened or having a weapon used against them (13% vs. 7%). They are also more likely to be injured during the violent act (40% vs. 13%) and to be fearful for their lives (40% vs. <10%).

**Access to Care:** Barriers to care are legal, contextual and cultural in nature and include: linguistic barriers, economic strain, lack of knowledge of services and laws on intimate partner violence, racism experiences, fear of punitive institutional power, the fear of losing the custody of their children (reported reason by Child Protective Services is most often mother's failure to protect children), risk of losing their sponsorship agreements, fear of deportation or not accessing the Canadian citizenship, issues of confidentiality and fear of stigma, shame or exclusion from community.

**Key Risk Factors:** Immigrant women who are single, divorced, separated or widowed were ten times more likely to report intimate partner violence than immigrant women who were married or in a common-law relationship. Risk factors for intimate partner violence during pregnancy include: violence prior to pregnancy, unplanned pregnancy, unemployed partners or lower SES, fewer years of education of mother, younger age, fewer years in the relationship, being unmarried, partner not father of the baby, more negative interactions with baby's father, and mother's alcohol and drug use.

**Screening Test:** Shorter instruments, such as the *Hurt, Insulted, Threatened, or Screamed at* (HITS, 4 items); the *Partner Violence Screen* (3 items); *Women Abuse Screening Tool* (8 items), and the *Abuse Assessment Screen* (5 items) perform equally well or better than longer instruments and are faster to administer. Screening instruments have acceptable psychometric properties (sensitivity 30-100% and specificity 55-99%), including internal consistency reliability and convergent validity.

**Treatment:** Refer women who have spent at least one night in a shelter to a structured program of patient-centered advocacy support services to decrease rate of abuse. The program consists of a ten-week, 4-6 hour/week intervention carried out by trained paraprofessional advocates who assist women to devise individualized safety plans and advocate in the community to obtain resources (e.g. employment, transportation, housing, education, assistance in child care and services for children, health, legal and material assistance) and increase their social supports. Such programs do not yet exist in Canada.

### **Special Considerations:**

- Cultural variations in perceptions of spousal relationships, gender roles, gender obligations, parental authority, and cultural definitions around aggression and abuse, may impact reporting and disclosure of intimate partner violence.
- An immigrant or refugee woman may choose or be pressured not to disclose the intimate partner violence and to stay with her abusive partner, especially if her partner is her only source of financial support.
- Signs and symptoms of intimate partner violence differ significantly among women. They may be absent in some women or be of psychological (depression, anxiety, suicidal ideation, alcohol or drug abuse), social (social isolation) and/or physical (injuries, bruises and aches) nature in other women. Patient-physician rapport thus remains a key element in the detection of intimate partner violence.