# Making Sense of a Global Pandemic: Relationship Violence & Working Together Towards a Violence Free Society

# Making Sense of a Global Pandemic: Relationship Violence & Working Together Towards a Violence Free Society

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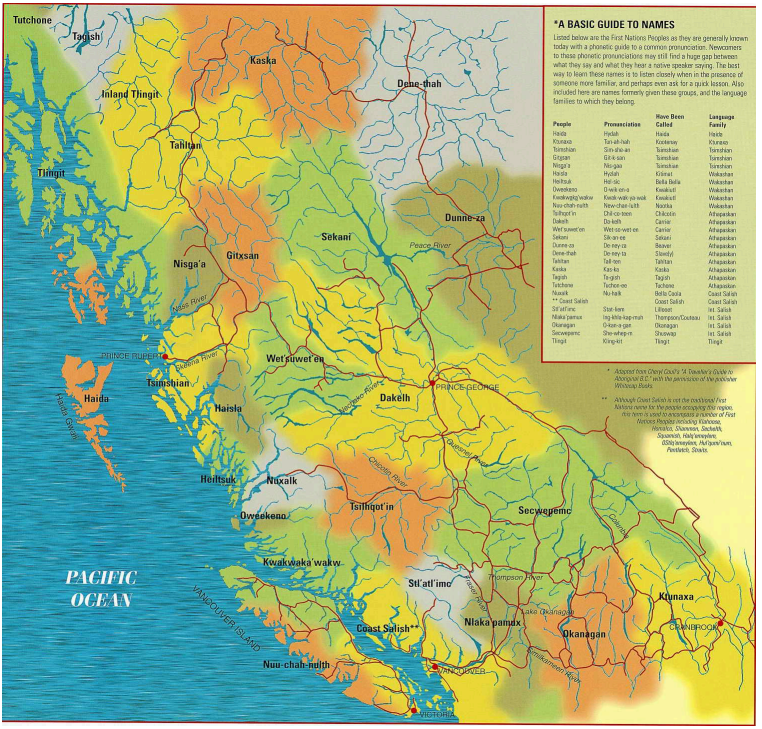
## Project Team

# Territorial Acknowledgement

We are grateful to work and live on Turtle Island, on the Coast Salish Territory. We thank the Coast Salish people for access to this beautiful unceded land!



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# Review

A. ALEXON

I have approached the reading of this book as a survivor of relationship violence. My evaluation of its value is based on certain questions: Does the book provide a comprehensive understanding of relationship violence? Does it recognize the challenges survivors face in accessing help? Does it provide ideas and tools to community support providers and organizations and others working in the field for how they may help survivors?

After reading this book, I can say in a word, yes. I went through the book with a fine-toothed comb because as a survivor I am looking to see if anything is missing when it comes to an understanding of relationship violence and the response to it, for example, at the community level and in terms of educating the public. This is the first book that I've read that covers everything my heart desires. I think everything is there that needs to be.

Those who have contributed to the formation of this book recognize the complexity of relationship violence, and furthermore, recognize the comprehensive, multifaceted, needs-based response that is required to help survivors so that they may recover, heal, and rebuild their lives. They also recognize that in addition to intervention, prevention is key and that educating and changing attitudes about relationship violence within our communities and society as a whole is essential.

What I appreciate about this book is that it is based on multiple "ways of knowing" and that the information provided here is built on, for example, empirical, emancipatory, aesthetic, and personal knowledge and experience. Too often in the past, survivors' voices have been overshadowed by others telling them that their perspectives are less valid or not valid at all. This book clearly contains the voices of survivors in its content; their voices and their concerns are heard, included, and responded to here. Furthermore,

this book recognizes the diversity of our survivor voices. Voices that have often been ignored in previous discussions about relationship violence are present here as evidenced through chapters that directly respond to survivors who identify, for example, as LGBTQ2SAI+, indigenous, immigrant, refugee, or male. Balbir Gurm and colleagues, in creating this book, recognize the often unique cultural, social, and personal challenges survivors face.

Survivors face a multitude of challenges in accessing help in their communities; often assistance is presented to them in a fragmentary, incoherent, and partitioned way, which can lead survivors to feel unsupported, vulnerable, and unsafe. The writers of this book recognize that relationship violence is a highly complex problem that requires a comprehensive response through a multi-agency, multi-sectoral, and multi-level effort, that is, in a multi-faceted and intersectional way, whether it is toward building a support network to help survivors through a crisis phase once they leave their abuser, addressing inequities in the legal system that require governmental or legal reforms, or changing social attitudes toward relationship violence in our communities. Balbir Gurm and colleagues, through this book, and by use of a socio-environmental framework, demonstrate how the collective and collaborative efforts of service providers and community organizations can be framed in a way that provides a coordinated and cohesive community support system that will meet the needs of relationship abuse survivors through a continuum of services and supports. Therefore, this book is a useful learning tool for outlining the ways community supporters can advocate for and help the survivor through an integrative community response. As a survivor, I find this reassuring.

The book's strength lies in the diversity of knowledge that it brings together and in how that information is presented. A reader can access information through clearly laid out chapters and sections, and within each chapter, also click on various salient supplementary links to, for example, news articles, personal testimonies, research studies, illustrative graphs, statistics, videos,

slide presentations, and tool kits. It is structured in a way that a reader can see the interconnectedness of the issues, or they can go directly to the chapter that provides information they need on a specific problem or issue. Thus, a reader can view the information from different angles, depending on need. It is written in a clear and cohesive way that makes it accessible, navigable, and readable.

The creators of this book acknowledge the necessity of evaluating and re-evaluating "what works" in intervention and prevention. One of the things I appreciate about this book is that it is created as a "living book;" that is, it allows for additional information to be added to the existing information already provided. The benefit of this is that as new information for understanding relationship violence and dealing with relationship violence comes to light, this can be applied to strengthen resources and responses for helping survivors.

As a survivor of relationship violence, I wholeheartedly, and gratefully, recommend this book. This is the first book that I've read that covers everything my heart desires. I think everything is there that needs to be. I rest easy.

Andrea Alexon

# Review

SONIA ANDHI BILLKHU

I have just finished reading "Making Sense of a Global Pandemic: Relationship Violence & Working Together Towards a Violence Free Society", authored by Dr Balbir Gurm and her team from NEVR (Network to Eliminate Violence in relationships). It is a compendium of resources, terminology and understanding of relationship violence. As a social worker, family counsellor and community organizer, I cannot say enough about how valuable this is for all practitioners, be it child protection workers, law enforcement, physicians, nurses, teachers and the general public.

This book is also a comprehensive resource with the latest research and statistics that can be utilized for community projects and initiatives. When you see the following numbers on paper, they offer a stark reminder of the cost of relationship violence and the need for early intervention. "... in a report for Justice Canada, estimates of the economic cost of relationship violence against adults may be as high as $15 billion. This estimate does not include "cumulative, compounding, long-term institutional costs—educational, workplace-related, medical and mental health, drug and alcohol therapeutic, legal— when we fail to intervene early and effectively in RV cases (Neilson, 2013). The Canadian Department of Justice (2012) estimated the financial cost of spousal violence in 2009 to be $7.4 billion."

This is a thoroughly researched book that provides the most current understanding of relationship violence. It offers clear and unbiased descriptions of various forms of relationship violence, whether it is spousal, against children, in the workplace or against older adults. I was particularly impressed by the approach that Dr. Gurm has taken to address the difficult subject of violence against women and its positioning in contrast with violence against men, as there is growing concern about the incidence of men experiencing

violence in relationships and how the same issues of stigma, fear of retaliation and consequences prevent the victims from coming forth. She also encourages the reader to ensure there is "Fair representation of gender violence and critical interpretation of the statistics and numbers reported".

While most front line workers in this field are aware of services and protocol, this book is a detailed source for knowing exactly what to expect from the time you make a crisis call to making a court appearance or exploring other avenues of remediation. (Chapter 10- Navigating the System). It is an easy to read book with sufficient references and links to enrich our learning and understanding of violence in relationships. This book is so rich in information that as I was reading it, I was taking notes and highlighting areas for my own practice and thinking of how each chapter would make an informative presentation in itself.

This is a living document, not only in terms of the extensive list of the most current services being provided but also as a testament to the work of NEVR and its members as a collaborative community effort to end violence in relationships. "At NEVR meetings the facilitator ensures each individual at the meeting is respected and provided an equal opportunity to voice their opinion and the decisions are made from an inclusion perspective." I have seen this practiced by Dr. Gurm at NEVR meetings and it is a reminder for us to translate theory into practice by creating true safety and respect for all. The book is also an invitation for practitioners to see how equity, cultural safety, AI (Appreciative Inquiry) and PAR (Participatory Action Research) can be incorporated into all our roles. I appreciated how the role of the service provider was acknowledged as essential to reducing relationship violence and also how the needs and vicarious trauma of the service provider have to be acknowledged. "

From the cultural safety perspective when working with survivors, one of the goals of NEVR is to ensure no harm is done to the service provider, and their specific current situation and any historical oppressions are considered. Although originally

developed to work with individuals, cultural safety applies to work between groups, organizations, and communities. Emphasis is placed on the desires of the service provider, and where they are positioned in terms of family, workplace, and community roles and dynamics. This is respectful and empowering to the service providers who may also face their own institutional or political challenges and oppression. It is recommended that this approach also be carried out with survivors and offenders."

There are countless nuggets in this book. Two that particularly stood out for me were:

"There are many reasons for not reporting. It is time to switch the question from why do victims not leave to why do people abuse? And why does society continue to normalize and accept relationship violence? Society still continues to blame the victim and question their behaviour." (Chapter 8).

"Drawing on the work of Foucault (1977), there is an interplay between what is considered true or knowledge, and power and privilege. Quite often those with power and privilege decide what is truth and perpetuate that truth. Then, this truth is internalized and reproduced by all of society (including legislation) at which point it becomes an accepted fact" (Chapter 25).

The book has been masterfully created by Dr. Gurm and other respected contributors so that while dealing with the heavy topic of relationship violence, you are left with a sense of inspiration and hope that you can seek solutions through self-reflection, collaboration, advocacy and action.

I would highly recommend that this resource becomes a part of all front line workers', academics', policy makers' and community groups' toolkit for effective work in the area of relationship violence.

Sonia Andhi Bilkhu

Social Worker, Fraser Health Authority and Project Parent Fraser South

Founder and President Shakti Society

# Review

CJ ROWE

I straddle two worlds as an academic and a practitioner, and an effective resource like *Making Sense of a Global Pandemic: Relationship Violence & Working Together Towards a Violence Free Society* is what I look for to bridge the range of work that I do. This book helps demystify the complexities inherent in understanding, responding and preventing relationship violence. This collaborative multi-authored and edited text provides a balance between academic research and providing hands on tools to support service providers in their work. The authors provide readers with balanced perspectives while recognizing the inherently complex personal and social issue that relationship violence plays in our communities and society. Drawing on a critical literature review, [they] have created an accessible resource for any reader, at any point along their learning journey—for those beginning to explore these issues to those who are deeply entrenched in working to end relationship violence.

I appreciate the thought behind the book's structure; all of the chapters speak to one another, and yet each chapter can also be used as stand-alone resource. Each chapter has also been conceptualized with different readers in mind. There is a mix of hands on tools for survivors and those supporting individuals impacted by relationship violence, explorations of policy and investigations of the interconnected nature of theory and practice, and learning opportunities from those working within unique and diverse networks of service providers. I could see using this book as a tool in the classroom, as a pre-reading for a workshop and as an easy to access tool to support staff and service providers in linking them with promising practices from across the country.

In addition to the above, I see this book as a celebration of all the work that the NEVR group have been involved with and have

been spearheading since their inception. This book provides us with many road maps, one of which includes how to bring a meaningful organization and community together to engage in important, timely and relevant work—building connections, developing learning opportunities, co-creating toolkits and resources, supporting events and initiatives that promote a society free of relationship violence. This is dynamic work that moves and changes over time. I'm excited to see where this living and breathing book can move and change given current and future conversations within the anti-violence movement.

Dr. CJ Rowe

Director, SFU's Sexual Violence Support & Prevention Office

# Dedication

## We dedicate this resource to:

**NEVR members**
**Service providers**
**Students**
**Victims/survivors**
**Allies of the anti-violence sector**

# Acknowledgements from Project Lead

**BALBIR GURM**

I want to thank Maryam Majedi (who was at Surrey Women's Centre) and Pardeep Sahota (who was at Progressive Intercultural Community Services (PICS), who encouraged and assisted me to start the Network to Eliminate Violence in Relationships (NEVR). For without their support, NEVR would not have been formed.

Members of NEVR, past and present, thank-you for helping us learn about the work being done at the front-line and in policy and legislation, and allowing us to share academic understandings of Relationship Violence (RV). PICS, DIVERSEcity, Delta Police Department, and Options, thank-you for hosting our meetings.

I also thank the former Provincial Office of Domestic Violence (2012-2017), the BC and Canadian government and local MLAs and MPs for your ongoing support, willingness to attend conferences and listen to our concerns. To the past and present mayors of Surrey and Delta for your unrelenting support, thank-you.

Our students have been our biggest resource, for they have helped create toolkits, conduct literature reviews, write reports, plan and host conferences. Thank you for being our biggest asset.

My project team writers & self-editors (Jennifer Marchbank, Glaucia Saldago & Sheila Early) and editors (Sobhana Jaya-Madhavan, Gary Thandi, Julie Czek, Daljit Gill-Badesha & Jim Cessford), thank you for your time, support and knowledge sharing.

I want to thank Kwantlen Polytechnic University for providing me with my education leave (sabbatical) and providing technology and communication support, and meeting and conference space for NEVR (Network to Eliminate Violence in Relationships). Thank you Karen Meijer-Kline for answering all my technology questions, Lana Radomsky for making sure that our tables and figures are sharp and

clear, Monica Le for layout assistance and Marketing department for creating our cover page. Also, a big thank-you to Rajiv Jhangiani for all your advice and support.

To Sobhana Jaya-Madhavan, Associate Vice-President External Affairs, SFU, and her team, thank-you for hosting a virtual launch of the book.

I want to thank our reviewers (A. Alexon, Sonia Andhi and CJ Rowe) for taking the time to truly shape this into a useful resource. To Amarjit S. Sahota, thank-you for taking the time to carefully digest the resource and write a foreward.

To my family, thank you for your support and for picking up tasks on days when I spent 16 hours on the computer.

I want to acknowledge that the victims/survivors of relationship violence have inspired me to put a team together to create this resource. I hope this will help improve prevention efforts, programs and services for the anti-violence sector.

To all of you, I am sincerely grateful!

# Preface

BALBIR GURM AND JENNIFER MARCHBANK

This project brings together a common understanding of relationship violence (RV) across the lifespan and resources/links on one site.

Dr. Balbir Gurm, the facilitator of the Network to Eliminate Violence in Relationships (NEVR) and a faculty member at Kwantlen Polytechnic University (KPU) led the development of this online resource while on educational leave (sabbatical) from her teaching and service duties, with key writing support from Glaucia Salgado, Professor Jennifer Marchbank and Sheila Early.

Professionals from multiple fields/perspectives provided review, input and feedback as the book evolved to ensure that key information was captured. This interdisciplinary team included: Gary Thandi, Daljit Gill-Badesha, Julie Czeck, Sobhana Jaya-Madhavan, Jim Cessford, Andrea Alexon, Sonia Andhi, CJ Rowe and Amarjit Sahota.

This process has allowed the emergence of a publication which includes multiple perspectives and resources to provide a comprehensive overview of relationship violence. This online platform is intended to be a living resource that is useful to all readers, but particularly British Columbians. If you would like to contribute to this work, please email NEVR@kpu.ca.

## A note on content and use

Chapter one includes summaries on chapters that follow. As well, each chapter identifies key messages that may help you decide which chapter you want to give more time and attention too. We anticipate that readers will use this book to 'dip' into different topics

to develop their understandings of specific areas or to simply access the resources. As such, we have repeated some material in certain chapters and also refer readers to other chapters to further develop a theme. So, if you read each chapter in turn you will find duplicate or similar material in more than one place – this is intentional.

Also, there are many hyperlinks to resources. Some references can only be accessed through a library so are not linked. You will find the full citation at the end of the chapter and you can use it to request the resource from the KPU library or find it at another library.

This book is available under a Creative Commons licence, this means that you can use any materials in your classes and/or to provide services, but please make sure that you give due credit to the authors. If you adapt/update the material, please email a copy to NEVR@kpu.ca.

# Foreward

AMARJIT S. SAHOTA

I have had the immense pleasure of working with Dr. Balbir Gurm for close to a decade.

I first met her when I was working with the Ministry of Children and Family Development and was attempting to affect practice change in my organisation's approach to child protection domestic violence situations. Right from the outset, I was impressed with her balanced outlook and ability to engage individuals at all levels. Her inclusive approach and willingness to engage stakeholders across sectors was readily apparent. As the founder of the Network to Eliminate Violence in Relations (NEVR) and it's driving force, Balbir has been a strong advocate in raising awareness about this issue and in bringing about systemic change. Her credibility in the community is such that she is regularly sought out by others in the field for her insights.

This on-line book provides a wealth of information on relationship violence focusing amongst other things on definitions; the scope of the problem, theoretical frameworks, interventions and prevention strategies. It provides information on legal statutes (Provincial; Federal and International) and contains numerous links to additional resources to inform the reader. The book also highlights some emerging issues such as the importance of cultural safety; relationship violence in the work place and on post-secondary campuses. I was also interested to read the section on male victims and the dearth of services available to this segment of the population. Similarly, the importance of engaging male perpetrators if we are to effect meaningful and lasting change at a societal level.

This on-line resource will be of value to all practitioners that work in the area of relationship violence and emphasizes the importance of collaboration across sectors. It will also be of interest to others that may have a general interest in learning more about this

phenomena. The book is easy to read; extremely well researched and covers an array of related issues and concepts. It is indeed rare to find so much useful information on a given topic in one "publication" and Dr. Gurm and her fellow writers should be commended for this.

Finally, our understanding of and efforts to respond effectively to the issue of relationship violence continues to evolve. The format of this book lends itself well to providing relevant updates as they become available and engaging others that have an interest in this pandemic. It will therefore be a valuable tool in ensuring that our knowledge remains current and informs our approach to meeting the service needs of victims.

Amarjit S. Sahota
Vice President
Sophie's Place, Child and Advocacy Centre

# MAKING SENSE OF A GLOBAL PANDEMIC

This book brings together multiple perspectives and resources to provide a comprehensive overview of relationship violence. This online platform is intended to be a living resource that is useful to all readers. We invite you to read, take away key messages and let us know what else needs to be included or make a submission for inclusion by emailing nevr@kpu.ca.

# Chapter 1: An Introduction to Relationship Violence

**BALBIR GURM**

*Key Messages*

- Relationship violence is a critical issue that greatly impacts the health of individuals; RV is recognized as any form of violence that happens among individuals who have some form of relationship with each other.
- For many years, violence in relationships was largely ignored as a public health issue; however, more and more studies have analyzed and affirmed the social determinants of health (SDOH) indicating its relevance and critical role especially in developing health promotion interventions for RV.
- Since RV affects so many different people, it is an issue that cannot be addressed by one organization or a government alone. It requires a response from many sectors in the community (education, housing, justice, service providers both public and private) while taking into consideration the intersectional identities of both victims/survivors and perpetrators. Since no single factor can explain RV, responses need to be tailored according to the needs within and across groups of victims based on sound research

(i.e., feminist, intersectionality, health theory and others) and informed by best evidence practices.
- Summaries of the key themes in each chapter are broken down below; this book does not attempt to provide an entire and thorough literature review; rather, it brings critical literature review pieces forward that offer an overview of understandings to help demonstrate the complexity of RV.

## A Social Challenge & Health Issue

Societies around the world face many social challenges that influence the lives and health of populations. A critical issue that greatly impacts the health of individuals is relationship violence (RV). RV has been recognized as any form of violence that happens among individuals who have some form of relationship with each other. But why would RV impact the health of people? According to the World Health Organization (WHO, 1946), health includes the physical, mental and social well-being of individuals, and it involves going beyond the absence of health ailments. To have good health is a basic human right of all individuals and everyone should have the opportunity to do so "without distinction of race, religion, political belief, economic or social condition" (World Health Organization, 1946). This basic human right is understood as a collective effort and responsibility among individuals, families, communities and government. However, health is more complex than well-being at the individual level; rather, it is interconnected between the individual and the state (community/government). WHO (1946) indicates that health is "fundamental to the attainment of peace and

security" of individuals and nations. As health involves the interplay between individuals' biological, psychological and social factors, the way people interact with each other and act within their relationships becomes critical to determine one's health state. This is how relationship violence has become an important factor that affects people's health.

For many years, violence in relationships was largely ignored as a public health issue; however, more and more studies have analyzed and affirmed the social determinants of health (SDOH) indicating its relevance and critical role especially in developing health promotion interventions. Therefore, RV has become a recognized public health issue, similar to the broad-sweeping impacts of a pandemic problem. RV, like a pandemic, affects people worldwide. RV is a systemic global issue that has been around for a very long time, but it was not recognized as having negative impacts until the women's movement in the 1970s. Besides being a problem affecting nations, it is a problem with local impact and it is has been shown to be a very present issue in Canada. Estimates published by WHO indicate that globally 1 in 3 (30%) of women worldwide have been subjected to either physical and/or sexual intimate partner violence or non-partner sexual violence in their lifetime. Most of this violence is intimate partner violence (WHO, 2021). Worldwide, almost one third (27%) of women aged 15-49 years who have been in a relationship report that they have been subjected to some form of physical and/or sexual violence by their intimate partner (WHO, 2021). Pain (2014) affirms that "domestic violence does not receive the levels of attention and resourcing that it merits" (p. 532). He suggests that there are not enough services available to support those who experience this type of violence, which in comparison with other forms of aggression, is minimized and overlooked. The Frontier Centre for Public Policy (FCPP) that analyzes public policy in Canada and makes recommendations has links to the most current policies, Part 1 of 2: Gender-Based Violence in Canada, Part 2 of 2: The Status of Gender-Based Violence in Canada.

A more recent and critical fact related to relationship violence

in the domestic environment is the realization and acceptance that intimate partner violence does not only affect women in a heterosexual relationship; men are also victims who suffer similar health consequences as women victims. To know more about intimate partner violence against men, please check the Sky News United Kingdom documentary (Male Domestic Violence Is Very REAL Measells, 2015). Besides intimate partner violence among heterosexual partners, the literature indicates that same-sex partners also experience intimate partner violence. Finneran and Stephenson (2013) show through a systematic literature review that gay males experience intimate partner violence at similar rates to heterosexual women, especially young gay males.

Additionally to issues related to intimate partner violence, people experience violence in other types of relationships such as within the family circle (i.e., parents, siblings, etc.), between neighbours and in the community, school, workplace and gangs. Among the groups of people affected are children (violence against children), women, men, older adults (City News reporting a study about elder abuse), and LGBTQ2SIA+ (lesbian, gay, bisexual, transgender, queer, two-spirited, intersex and asexual plus) (Government of Canada, 2020; City News, 2016). Unfortunately, relationship violence spares no one. It cuts across people of all ages, income status, sexuality and gender identity, ethnicity, race and geography.

Canada's Department of Justice has modified the definition of **family violence** as "any form of abuse, mistreatment, or neglect that a child or adult experiences from a family member, or from someone with whom they have an intimate relationship" (Department of Justice Canada, 2017), partly in order to address these together. We use the term RV and expand this definition to include perpetrators that are known to the survivor and not just intimate partners. Therefore, RV is any form of violence (physical, emotional, financial, spiritual) that is inflicted from conception to death by someone that is known to the victim/survivor. RV includes neglect – the failure to provide care. Since RV affects so many different people, it is an issue that cannot be addressed by one organization or a

government alone. It requires a response from many sectors in the community (education, housing, justice, service providers both public and private) while taking into consideration the intersectional identities of both victims/survivors and perpetrators. Since no single factor can explain RV, responses need to be tailored according to the needs within and across groups of victims based on sound research (i.e., feminist, intersectionality, health theory and others) and informed by best evidence practices.

## Who This Book is For?

In this online "living" book, we share our experience of creating a multi-sectoral committee—Network to Eliminate Violence in Relationships (NEVR)—to address RV, with a focus on the Surrey/Delta/Langley area of British Columbia, Canada. Without any major grants or funding, this grass-roots project has provided practicum and research placements for students from various post-secondary institutions. This book can be used by any academic that wishes to work on a real world problem with students by engaging the community.

This work can be used as a textbook resource by educators in various disciplines to teach about issues related to RV. This publication is also meant to be a living document for people who work in the RV sector, all service providers, those who research and teach on RV and the general population who wants to help address the issue. This is a result of an extensive and participatory action research (PAR) approach (PAR is research determined by the community being researched and involves their participation to inform the research process). This approach was used to develop NEVR's strategic plans (2013) that have become the "…central resource centre or database which acts as a guiding map for the committee to provide information about community resources, systems in place, and information about how to access them" (Gurm

et al., 2013). Also, hopefully, this work can serve as one more stimulus, among so many others, to motivate and create change. This online resource brings together multidisciplinary and community knowledge on RV; it is what academia would call loosely a knowledge translation project.It is meant to be one local platform that provides space to bring together academics and service providers, to highlight current understandings, effective programs and organizations involved in this issue, identify the laws and policies that impact RV, and inform on the context and environment in which the relationship violence cycle takes place. Each one of the components mentioned might be useful to support the working knowledge to address RV.

## A Multi-Disciplinary/Multi-Paradigm Approach to Understanding RV

We address RV across the lifespan because our NEVR members work with all age groups. In fact, having a diverse team is one of the reasons that we bring together models from different disciplines as particular theories may explain prevalence for certain groups, but they do not necessarily apply to every or any particular single individual in a given group. A multidisciplinary and multi-paradigm approach is needed to unpack and address the multiplexity of RV. For example, the feminist lens explains heterosexual relationships and the use of male power and privilege. However, this approach does not necessarily apply to all heterosexual couples because we know that females can also be perpetrators of RV. That is why we may need to draw on other rationales like Intersectionality Theory to understand, explain and intervene. We believe that practitioners need to have an understanding of the complexity of RV as background knowledge in order to ask appropriate questions to assess and understand their client which in turn will help them

to refer or provide services and programs that meet the client's particular need(s).

You will notice that this resource does not aim to provide an entire and thorough literature review; rather, it brings critical literature review pieces forward that offer an overview of understandings to help demonstrate the complexity of RV. In this book, we show the complexity and the multiple factors and their influences. As you read it, you will find the synthesis of understandings from different fields and hyperlinks to organizations, programs and prevention campaigns to help you get to the main sources of information, which serves an applied focus for the reader. Each chapter is written to be independent, in case the reader has one particular focus.

We would like to acknowledge that RV is so complex that it is very difficult to bring together everything known because the literature is so vast and dynamic. Therefore, the chapters you will read bring a work in progress, for even our own understandings evolve as we read and discuss ideas with NEVR members and communities. We see this as a beginning to help with understanding the issue and hope that we can count on all of you to dialogue with us, to keep improving and deepening the knowledge on relationship violence in order to help create effective interventions to create a violence-free society.

It is our sincere hope that this book will become a living resource that is continuously updated by academics, service providers, government, police, justice, health and support workers, and basically anyone that considers themselves a stakeholder. We hope you will gain an understanding of RV and how government and service organizations and community members can work with academics to leverage resources to address complex challenges. We see this resource as a beginning and not an end. If you wish to contribute please email your thoughts/comments/ideas to NEVR@kpu.ca.

## Content Summaries

**Chapter 2** we share the community action framework that has emerged through the Network to Eliminate Violence in Relationships Committee (NEVR) to address relationship violence. This unique action framework can be used to address many social issues. We share what NEVR has been able to accomplish since its inception.

**Chapter 3** demonstrates how our community action works, and we provide a case study of NEVR. This chapter outlines the collaborative and inclusive process of NEVR. We describe the participatory action research (PAR) used to develop and maintain the committee focus and actions. Inclusion, cultural safety, and successful elements of collaboration are identified. The intersectionality and interconnections of issues of culture and other factors of RV are identified and how the NEVR committee uses principles of ways of knowing, cultural safety and humility, in order to empower clients and service providers working in the RV domain.

**Chapter 4** we provide a definition of relationship violence and the most discussed types of violence. This chapter describes all the forms of violence, which are listed above and are included in our broad definition of relationship violence (RV) as well as a broad range of terminology used to describe RV. It highlights how RV impacts across the life span and how different sectors/ environments need to be brought together so communities can act together. It describes the collective, multidisciplinary and multi-modal action that is required to reduce the impact of RV on victims, perpetrators and our communities.

**Chapter 5** presents statistics and the consequences of relationship violence. This chapter describes the scope of the issue, which is impacted by variations in reporting that leads to inconsistent data and a lack of a true understanding of the depth and scope of RV. Furthermore, information is provided on the reporting of the experiences of men and women in intimate

violence, along with the impact and consequences on children/youth who experience or witness violence. Risk factors are provided and behaviour and health consequences are identified to help understand how the impact of RV can manifest in survivors.

**Chapter 6** shows relationship violence models, risk factors among individuals and actions. This chapter describes the integrated model of NEVR that incorporates multiple ways of knowing in a constructivist framework. It incorporates current knowledge that is brought together into the NEVR action framework, which draws from multiple overlapping frameworks presented, recognizing the diversity of perpetrators and survivors. A comprehensive understanding of the complex web of RV needed to drive changes in laws, policies and helpful actions that can reduce the risk for all affected groups is described.

**Chapter 7** provides information on the action and prevention of relationship violence (RV). It starts with the underlying principle of understanding the 16 social determinants for Canadian society in order to identify how to take a holistic approach for action and prevention in this domain. The chapter provides recommendations from NEVR and years of experience of service providers as well as a listing of programs in Canada, government resources and community-based tools available for further information and action.

**Chapter 8** provides information on an important aspect of relationship violence that is often not understood or misjudged by family and community, which is to identify some of the reasons why a survivor may not report the abuse/violence. As this can be a frequent question asked by society and others, why the person did not leave abusive relationships, this chapter unpacks this further and also asks us to question, why do we not ask the more important and underpinning questions, why does the perpetrator abuse or why does society accept relationship violence? Two major theories of help-seeking – survivor theory and process model—are described to explain how survivors cope with their experiences of violence and make attempts to reduce or end the violence. The reasons why men or women stay in violent relationships are described and

the overlapping experiences are identified. These reasons underpin the need to make changes at individual, family, community and institutional levels in order to reduce and end violence in intimate relationships.

**Chapter 9** legislation and policy related to relationship violence in Canada are discussed. RV is articulated as a Human Rights violation and is identified as a criminal and ethical offence. This chapter identifies the links to statues and resources, including the national policies and outlines the international conventions to which Canada has made a commitment. These conventions often require Canada to report on progress made on actions and on the resolutions. Canada is part of international efforts to combat violence against women and promote the rights of children and older persons. The legislation to charge perpetrators of relationship violence is outlined through detailed information on the Criminal Code of Canada. Information related to children, youth and adults are provided, particularly situated in the legislation that impacts British Columbians.

**Chapter 10** provides information on the process for a survivor to seek help and details a case example to help show the steps the survivor would go through and the range of professionals that can be involved. Further, the tasks of these professionals and what they do in their roles are articulated. As many survivors do not formally report the abuse and may turn first to family or friends for support, information is provided on how to help in this case. There are resources available for the helper, and it is important we all take a champion role to assist the survivor with appropriate information and resources in order that they can make the right choice for them. This can be to leave the partner or to stay (with a safety plan) and the steps and resources are provided. Additionally, the role of the police and court system is described so you can learn what to expect and what the survivor will go through as well as the consequences a perpetrator will face. It outlines the ability to go through an alternative dispute resolution process as many cases do not go to court and this restorative justice or mediation

process provides the opportunity to repair harm, make amends and talk about the crime from multiple perspectives to create trust. It outlines why it may be helpful to include cultural perspectives and Indigenous perspectives in restorative justice processes. Many links to resources are included.

**Chapter 11** provides the reader with the historical perspective of Forensic Nursing and its role in changing the healthcare response over the last five decades. The particular role development of the Forensic Nurse Examiner highlights how a change in healthcare response to the individual who has been subjected to sexual violence, has led to changed responses in RV (child maltreatment, elder maltreatment, intimate partner violence, interpersonal violence, human trafficking, death investigation and care of perpetrators of violence and trauma) is described. It predicts the future will have increased emphasis on the value of forensic nursing science and forensic science for training professionals to address RV.

**Chapter 12** provides information about and links to active campaigns on relationship violence in Canada and internationally. It highlights components that may be included in a national healthy relationship campaign.

**Chapter 13** provides information on the empirical evidence surrounding the development and implementation of risk assessments for survivors (adults, older adults and children). The research on why it is important to understand risk is identified. Information on risk assessment tools used in Canada including how local police/RCMP can respond is provided. It notes that there is increased risk due to: mental illness, history of complaints by the victim, violation of no-contact order, and continued contact with the offender. It highlights that assessing risk is important to the safety of the survivor and the children, and the use of these tools can aid the professional in their response.

**Chapter 14** explains how there may be different actions that can be taken to reduce the acceptance of relationship violence based on different theories. It explains how the process of change occurs

and suggestions on how to create healthy relationships. It provides steps of how to make personal change and steps to consider in community change.

**Chapter 15** focuses on relationship violence against women, commonly called IPV. It explains the many theories that have been presented over the years to explain relationship violence, including psychological, psychopathological, sociological, structural, and others. It describes the socio-environmental model that draws on them all as well as the cycle of abuse and the power and control wheel. It reviews the risk factors and lists actions.

**Chapter 16** provides information about relationship violence involving children (child abuse and neglect or mistreatment), and the consequences of experiencing this type of trauma early in life and preventive actions. It reviews literature that indicates correlations between RV among children and impacts on children's brain development and bio-psycho-social development from the time of conception throughout their life span. As well, systematic reviews that identify resilience factors in preventing or reducing adverse effects are provided. It lists effective prevention programs include parenting programs that strengthen the family unit and minimize harm to the child through education to the parent(s)/caregiver(s) through the introduction of alternative punishment strategies and parental self-management.

**Chapter 17** summarizes relationship violence among older adults, risk factors for relationship violence and actions against it. In Canada and around the world, elder abuse is increasing and older adults have their own unique set of vulnerabilities in these situations. Elder abuse is recognized as a public health and pervasive social issue and how often relatives, friends and caregivers are the perpetrators of elder abuse. Risk factors and protective factors are identified in this chapter. Resources on how to recognize elder abuse, how to help and supports available are provided.

**Chapter 18** provides literature on relationship violence against men, the most discussed types of relationship violence among this

population and their risk factors. It highlights large scale studies that indicate the most prevalent type of RV experienced by men is psychological and physical violence. It lists barriers to seeking help such as fear of disclosure, the challenge to masculinity, commitment to relationship, diminished confidence/despondency that inhibits action and invisibility/perception of services. It discusses how male survivors may experience distress and secondary victimization when professionals and services are not prepared to provide support to this population group. It points out that access to support services among male victims of intimate partner violence is typically considerably lower than services for women. It states that if RV against males is not acknowledged or treated, it can result in alcohol and drug abuse, family violence, suicide and social dysfunction.

**Chapter 19** discusses information on the experiences of Indigenous peoples in relationship violence. While traditionally among Indigenous communities, women were valued and held leadership roles, now there is violence against women in these communities. With the arrival of colonizers, over time, Indigenous communities got disconnected from their culture and this history is an important context for understanding relationship violence. While this group has commonalities with other groups, there are specific differences and these are discussed. It provides the higher rates of RV that exist in the Canadian Indigenous population. The statistics highlight the importance of paying attention to the impact of relationship violence amongst different groups and populations and this will impact practitioner knowledge development and needed policy changes to end relationship violence in Indigenous groups. As well, risk factors, a list of initiatives, programs and resources to end violence and national inquiries are provided to inform our perspectives and advocacy to eliminate relationship violence. It states in order for programs for Indigenous peoples to be helpful, culturally appropriate and safe practices that build on Indigenous knowledge and experiences, and are informed by Indigenous practitioners and elders need to be developed.

Connection to traditional beliefs and restoring connections to Indigenous identity, spirit and spirituality are encouraged through the research. The chapter notes the disconnect between how written policies are not always enacted, change takes generations and how everyone has a role in advocacy and supporting culturally appropriate and safe policies and practices.

**Chapter 20** provides information about relationship violence against LGBQT2SIA+ (youth, adults and older adults), rates within this group and services available. Forms of abuse specific to LGBTQ2SIA+ communities include a perpetrator: questioning their partner's sexual or gender identity and right to be in the LGBTQ2SIA+ community; using transphobic, biphobic or homophobic slurs; controlling their partner's expression of their gender or sexual identity; forcing personal displays of affection (PDAs) in non-safe spaces; forcing PDAs in public to 'out' their partner; withholding hormones from their transgender partner; using their partner's identity as ammunition in child custody cases; threatening to 'out' their partner to children, family, employers, friends; engaging in financial abuse through identity theft; isolating their partner from the LGBTQ2SIA+ community; reinforcing internalized trans/bi/homophobia; and forcing them to have sex in ways that do not match their identity. The chapter includes how RV among youth is a public health concern and illustrates how critical it is that schools, educators, youth service providers, and mental health practitioners educate and support diverse youth regarding healthy romantic relationships. Also, how LGBTQ2SIA+ elders lived through decades of outright discrimination and persecution and these experiences have taken a toll on their mental health is mentioned. It highlights that lack of research and data on RV in LGBTQ2SIA+ communities has resulted in programs that offer limited benefits and support or even further marginalize victims within LGBTQ2SIA+ communities.

**Chapter 21** is a summary of relationship violence among immigrants and refugees, risk factors and programs available to this population. While the act of migration itself does not cause

RV, some specific factors that may increase the risk of abuse are discussed. These may include post-migration strain and stigma, the stress associated with migration, geographic and social isolation, changes in socioeconomic status, power imbalances between partners; change in social networks and supports, loss of culture, family structures, and community leaders, economic insecurity resulting from non-recognition of professional/educational credentials, changes in gender roles and responsibilities, and unresolved pre-migration trauma. Some protective factors such as the history of religious practices (e.g., Buddhist beliefs) have been identified and resources listed.

**Chapter 22** provides a discussion about relationship violence in the workplace, the risks of RV, symptoms and impacts, and legislation available to protect workers. It describes how relationship violence at home can carry into the workplace. RV in the workplace has been described as any type of abuse, threat, intimidation or assault that occurs in a place of employment with the most common forms mentioned as physical, sexual, emotional, spiritual and financial. Research on workers experiencing harassment in the workplace, surrounding legislation and initiatives to end workplace violence are identified.

**Chapter 23** summarizes some of the RV incidents on Canadian post-secondary campuses that lead some Canadian provinces including BC to create legislation that directed post-secondary institutions in the province to create sexual assault policies. Good policy needs to include RV against all employees and address the violence that occurs to students even when they are not on campus. As well, there needs to be clear procedures that are easy to communicate, a definition of consent, and support for survivors. A legislative framework that can be used on campuses is provided along with links to resources.

**Chapter 24** describes how to care for the caregiver. This is an important aspect of all of the work done by service providers. Our intent is not to review the myriad ways to prevent compassion fatigue (CF) but to offer a few insights from the literature on

definitions and effective interventions. Since we know that CF can occur, it is best to take action to prevent CF in the first place.

**Chapter 25** is a broad philosophical understanding that underpins our knowledge. The chapter provides examples of some collaborations in Canada and future direction for work on addressing RV to create a violence-free society.

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# Chapter 2: What is NEVR?

JENNIFER MARCHBANK AND BALBIR GURM

*Key Messages*

- The Network to Eliminate Violence in Relationships (NEVR) was established in 2011 as a grass roots movement representing 200 dedicated cross-sector professionals and service providers (representing over 100 organizations) in the lower mainland, who champion and advocate for social justice change pertaining to relationship violence.
- Facilitated and hosted at Kwantlen Polytechnic University – as a neutral facilitator – the NEVR model is grounded in a social constructivist environmental framework in which the individual, family, and community all interact to establish a culture that accepts or rejects RV.
- NEVR activities include 8 meetings throughout the year, and an annual conference that brings together a cross-section of social sector professionals, students, and academics to discuss and advance issues of RV. Other activities have included the development of toolkits, public campaigns, academic outreach, community engagement, education and training, and systemic policy changes.

Relationship violence (RV) is any form of physical, emotional, spiritual and financial abuse, negative social control or coercion that is suffered by anyone who has a bond or relationship with the offender. In the literature, we find words such as intimate partner violence (IPV), neglect, dating violence, family violence, battery, child neglect, child abuse, bullying, seniors or elder abuse, male violence, stalking, cyberbullying, strangulation, technology-facilitated coercive control, honour killing, female genital mutilation, gang violence and workplace violence. In couples, violence can be perpetrated by women and men in opposite-sex relationships (Carney et al., 2007), within same-sex relationships (Rollè et al., 2018) and in relationships where the victim is LGBTQ2SAI+ (lesbian, gay, bisexual, transgender, queer, Two-Spirit, intersex and asexual plus) (The Scottish Trans Alliance, 2010; Rollè et al., 2018). RV is a result of multiple factors and impacts such as taken for granted inequalities, policies and practices that accept sexism, racism, ageism, xenophobia and homophobia. It can span the entire age spectrum. It may start in-utero and end with death. Although men are portrayed as the majority of perpetrators of RV, they can also be abused.

## NEVR – Network to Eliminate Violence in Relationships


NEVR is a committee of almost 200 individuals from over 100 organizations (www. kpu.ca/NEVR). Service providers, government officials, health, social services and justice professionals, educators, researchers and community members get together to collaborate, learn and advocate for changes to address relationship violence. In this chapter, we describe how we became NEVR, contributions we have been able to make to create change, and the resources that we have developed.

## NEVR Framework

The NEVR framework is grounded in a social constructivist environmental framework in which the individual, family, and community all interact to establish a culture that accepts or rejects RV. The individual response and reaction are mediated by their personal understanding of their resources and their abilities to take action. Survivors report or seek help based on their personal roles and positions in society. As well, those who provide services or create policy/law setting agencies do so through their own multiple intersectionalities. When creating NEVR, we paid attention to the power imbalances that exist and hegemonic practices that pertain.

Next, we will explain how we have become NEVR since it began in 2011.

## Becoming NEVR

In 2011, service providers approached Dr. Balbir Gurm, Nursing Faculty, KPU. Service providers requested that along with hosting yearly conferences with expert speakers, she provide a space for them to learn about other organizations and their programs, provide a voice to address issues that are faced by clients and find ways to advocate for change.

Dr. Gurm agreed to lead this initiative with one caveat. She wanted to understand what all those who work in addressing the cycle of abuse thought. In 2011, she facilitated a project with colleagues from the domestic violence sector to understand the perspectives of police, court personal, non-profit service providers, government services, educators and the healthcare providers, as

well as offenders and survivors. This step supported the community's call for advocacy and sharing amongst organizations. It was found that organizations did not fully understand what was happening in different departments within their own organization nor in other organizations, and there were many ideas on how to improve the system. See the full report (Gurm et al., 2013). This report was formally launched at a KPU media event and attended by about 100 service providers, educators, police, justice and health personal. In the first meetings, the idea was to name the committee and to create a strategic plan. This strategic planning session was led by KPU Vice-President Emeritus, Linda Coyle, who has been involved with equity and women's issues most of her adult life. Linda has served on many boards including Richmond Chamber of Commerce, Surrey Social Policy Advisory Committee, BC Labour Force Development Board, and the Coalition of Visible Minority Peoples of BC, to name a few. She was the founding (1991) president of WPSE-Women in Post-Secondary Education. The session was co-led by Maureen Shaw; a union activist and officer, a President of the College Institute Educators' Association (now FPSE), Vice-President (Negotiations/Grievances) of the Kwantlen Faculty Association (KFA), founding President of the National Union of the Canadian Association of University Teachers (NUCAUT), and a Vice-President of the Canadian Labour Congress. She was also a member of the BC Labour Relations Board. This half-day meeting created a mission and strategic plan. At the end of the day, the 60+ members who attended the meeting could not agree on a name. They wanted something that had a catchy acronym.

Dr. Gurm was declared the facilitator for the network because it was understood that in her position as KPU Nursing Faculty, she was not competing for services funding and would be a neutral facilitator without prejudice. Her first duty was to run a poll for a name. By a narrow margin of one vote, the Network to Eliminate Violence in Relationships or NEVR for short was created.

NEVR was established in 2012, as a committee that values everyone's opinion and is a safe space for all individuals to voice

their concerns. The committee is open to all, not exclusionary, welcomes diverse voices and allows those present to have a vote if consensus is not reached at meetings. It is agreed that anyone's particular knowledge/voice would not be privileged, and dialogue would be encouraged to increase understanding. Also, it is understood that the facilitator would advocate with different government bodies and organizations. Community organizations that are involved in NEVR include battered women's support services, police departments at a municipal and provincial level, health authorities, religious organizations, secondary and post-secondary education institutions and government ministries See the complete list of NEVR members and community partners (NEVR, 2020).

## Actions

NEVR has eight monthly meetings throughout the calendar year and at least one conference annually. Through NEVR, several

initiatives have been developed by its members in partnerships. These include academic partnerships in interdisciplinary fields (e.g., forensics, nursing, psychology, gender studies) manifested in conferences and research projects, increasing public awareness through media outreach, as well as policy change. Four subcommittees were initially established: conference, media, courts, and children. Each subcommittee was to work on their particular area of interest. The conference committee was supported by KPU nursing students and it remained the most active, organizing a yearly conference that started as a one-day symposium with presentations from experts. This format changed later to a two-day conference with experts and members sharing best practices to increase understandings of the state of knowledge but also the RV system as a whole.

The court committee continues to advocate for integrated courts, both criminal and family areas, as a one-stop-shop for services. The media committee was very active in the early days with a monthly hour-long radio program, media releases and articles about special events. The children's committee was active early on, lead by an executive director from the Vancouver area. After a phase of slowing down its practices due to issues related to distance and time, the children's committee work continued with the assistance of nursing students. Working together, Surrey community school staff members and high-risk girls created a toolkit for middle school children (Gurm et al., n.d.). Although this toolkit has not been evaluated, others (Walsh et al., 2016; Zwi et al., 2007) have found that school-based programs increase protective behaviour knowledge regardless of the type of intervention program. Similar findings have been suggested by Fitriana et al. (2018) who also assert that peer education models are effective in addressing relationship violence.

Other specific resources have been developed, including the Community Champions Toolkit; the Domestic Violence Toolkits tailored individually to Bartenders and Salon Professionals; and the Domestic Violence Toolkit for Healthcare providers in British Columbia (all available for free at www.kpu.ca/nevr).

These Toolkits focus on recognizing domestic violence and signs of abuse, as well as understanding why victims of abuse stay in abusive relationships. They include information about overcoming hesitation with helping which is adapted from the Centre for Research and Education on Violence Against Women and Children (e.g., feeling like it's none of your business vs. realizing that it could be a matter for life and death; violence is everyone's business) (Western Centre for Research and Education on Violence Against Women and Children, 2002). Toolkits also include action items for talking to the abuser, including what to do if they deny the abuse as well as safety planning. In addition, these toolkits offer cultural considerations and their influence on behaviour, specifically Aboriginal women, immigrant, and refugee women, and offer some legal considerations for intervention in RV.

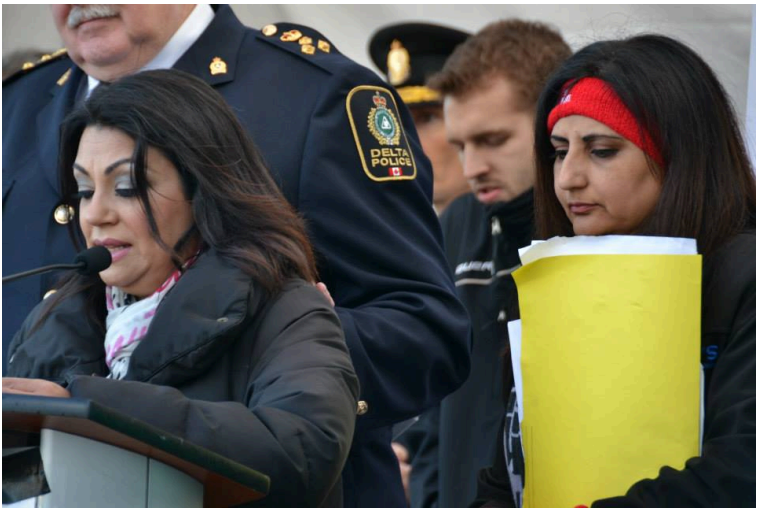
## Academic Outreach

In terms of academic conferences and partnerships, NEVR has hosted nine interdisciplinary conferences and three workshops

between 2012 to 2019. We estimate that these conferences had the collaboration of 1400 people and an audience of 120 participants each. NEVR has also presented at Kwantlen Polytechnic University's (KPU) first Teaching, Learning, Scholarship and Research Symposium in June 2017 and acts as a practicum placement for KPU nursing students and Adler University's graduate students. In addition, NEVR's framework was shared through an academic tour with university faculty in Thailand and Brazil. It was presented at international conferences for nursing professionals in Australia and an international forensic nursing conference in Vancouver, BC.

NEVR has also created partnership opportunities through which Simon Fraser University and Adler University graduate students can conduct and report on real-world research to bring social change to the community. As well, the KPU nursing program students have created a number of toolkits (NEVR and Community Resources list, 2020). Gender, Sexuality & Women's Studies students at SFU researched and wrote this report on LGBTQ2SIA+ refugee services for NEVR member organization DIVERSEcity.

## Increasing Community Awareness




Besides having its own campaign, NEVR also partners with other organizations working to eliminate relationship violence. NEVR has been active in the international mass action event to end violence against women, One Billion Rising since 2013, and NEVR is beginning to raise awareness about relationship violence against men. Additionally, NEVR was part of the Justice Summit on the family justice system in BC in 2014. In 2016, NEVR, using the performance of a specially commissioned play (funded by a corporate donation of $5000) held an information and fundraising event to educate the public on what happens when a 911 call is made covering events and actions from the time of the call until the judge adjudicates. In the play, NEVR members acted out their real-life roles, and service providers played the roles of offenders and survivors. The play educated the public on how to navigate the justice system. A question/answer period was also held. To see photos of the event click here.

## Education and Training

NEVR instituted a social media campaign utilizing the hashtags #nevrcampaign, utilizing social media pages on Twitter, Facebook, and creating a YouTube channel. Also, another hashtag was created (i.e., #saysomething) by NEVR's ally, the provincial government. Find more details about #saysomething at saysomethingbc.ca. In 2015, NEVR members made monthly appearances on a local radio station (REDFM, 93.1FM), in both English and Punjabi, and have been on radio and television programmes across a variety of talk shows and networks. NEVR developed a complete webpage with information about the organization, links to all of the Toolkits, as well as descriptions and contact information of other resources (www.kpu.ca/nevr). NEVR continues to actively present Toolkits in a variety of settings such as the National Emergency Nurses' conference in 2013, the Union of British Columbia Municipalities Annual General Meeting in 2016, the BC Crime Prevention Annual General Meeting in 2016, and the Police Victim Services of BC Annual General Meeting in April 2017. Toolkits were presented to seven nursing classes at KPU, resulting in 222 student nurses being trained in relationship violence awareness and prevention. Toolkits have also been presented at community organizations, union meetings and for the City of Surrey staff and the public resulting in the training of 60 adults total. Information tables and campaigning at KPU have also raised awareness about RV within the university community. NEVR has presented the "Salon and Bartender Toolkits" to two salons and six professionals and works actively with the police forces in BC regarding the issue of RV underreporting. A presentation on underreporting was made to the BC Police Chiefs at their 2016 annual meeting.

## Policy Change

November 2012 NEVR, along with the Provincial Office of Domestic Violence, hosted a forum that brought together seven provincial ministers and 90 community members resulting in the ministers signing an agreement to have ministries collaborate and break down silos when dealing with RV. This resulted in a slow thaw.

NEVR continues to advocate to the BC Provincial Office of Domestic Violence, Assistant Deputy Minister Public Safety, Minister of Justice, Minister of Social and Family Development, and Minister of Labour, as well as policy analysts in the above ministries. Over the years, the following changes to public policy have occurred:

- Person Fleeing Abuse (effective Dec. 2012), an alert is applied to each contact on each case;
- The Family Law Act has increased the ability of courts to deal with family violence; and in addition, a dedicated crown for each case file in the Surrey, B.C. courts.
- Change to rental legislation (2015), so that women fleeing violence are not required to provide 30 days' notice to end their tenancy.
- NEVR also advocated with union allies to local Surrey Ministers (provincial) and MLAs to push for workplace policy change and paid leave for survivors of domestic violence. The government passed legislation (2020) that allows survivors of domestic and sexual violence up to five days leave to deal with their trauma. This is a step towards addressing the world health pandemic of domestic violence. To see photos and press releases on the policy change, click here.

## Awards and Honours

NEVR was recognized by the City of Surrey as part of its 2016 Public Safety Strategy Taking Action Together. NEVR was also a nominee for the 2013 Provincial Nesika Award for Excellence in Cultural Diversity (Certificate received April 4, 2014). Sheila Early, NEVR member, was honoured with the Young Women's Christian Association's (YWCA) 2019 Women of Distinction Award in Health and Wellness. NEVR member Kamaljit Lehal was honoured with the 2019 Equality & Diversity Award for advocating for changes to laws and policies that compromise the safety of immigrant women in abusive relationships. Dr. Balbir Gurm, the founding member of NEVR, was honoured with the Ruby Award by the Soroptomist Society for her long term activism in improving the lives of women and girls and her work on relationship violence. Both, members Drs. Jennifer Marchbank and Balbir Gurm were honoured with Shakti Awards in Education. As the NEVR facilitator, Dr. Gurm was invited to attend the Justice Summit on better responses to domestic violence, provide a submission to the Cowper Report on justice reform and be part of the Death Review Panel on intimate partner violence (Justice BC, 2014; Cowper, 2012, BC Government 2016). Watch a video on the purpose of death review panels (Learning to End Abuse, 2017). As a result, the sector is more informed and increasingly interdisciplinary.

## Cycle

Each conference (8 to date) hosted by NEVR has a participant—cross-sectoral DV and ministry staff— consultation to find out what each organization deems important to inform future plans. This information is circulated widely to service providers and community members and is then provided to the government for

more informed planning by ministries and municipalities. Also, the information is used to inform NEVR's strategic plan and take action to improve the RV sector.

## Conclusion

NEVR is a committee based on community participatory action research aiming to eliminate relationship violence. Its goal is to create a society in which relationship violence is neither accepted nor tolerated. NEVR also aims to have research projects and organizing mechanisms that bring together stakeholders to identify and act on matters related to relationship violence, and a community clinical placement for nursing and other students. The continued process of creating and keeping this network is based on a broad framework encompassing a socio-ecological understanding of RV, intersectionality, appreciative inquiry, cultural safety, and multiple ways of knowing, see chapter 6. NEVR's initiatives thus far have included academic conferences and workshops, student practicums, graduate student research opportunities, community outreach and awareness-raising via social media, radio, and television. Also, NEVR has developed and presented toolkits that support the general public, service, and health professionals to intervene in RV, as well as advocacy for policy change. The partnership across and between community members and community services allows for dialogue, and the creation of effective change based on continual feedback and assessment of the initiative's success. This process may be useful with other social issues that are pervasive wicked problems.

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# Chapter 3: NEVR's Relationship Violence Framework of Working Together

BALBIR GURM AND JENNIFER MARCHBANK

*Key Takeaways*

NEVR committee's first action was to have common understanding of steps that are followed by a women when she reports RV.

- A forum for the community to learn and work together, academia, service providers/government/ community
- It has been through a series of cycles where members decide what to do, do it, and evaluate it (Participatory Action Research called PAR).
- The results of the first PAR grounded its actions (i.e. creating tookits, advocating for policy change, conferences)
- Based on principals of social construction, NEVR sees itself as an amoeba that is constantly changing it's understanding and as it learns together and operates on the understanding that everyone brings

different types of knowledge (multiple ways of knowing), has many characteristics and roles that make them unique and need to be equally valued (Intersectionality Theory), focus on strengths (Appreciative Inquiry) and creates an environment for open dialogue without repercussions (Cultural Safety)

- Sees the issue of RV as a complex health issue impacted by determinants of health (Socio-environmental model)
- Challenges of working together are inconsistent attendance and time
- Elements of trust, distribution of power, equal decision-making, shared ownership and accountability are all key to success

## Framework for Working Together

Relationship violence (RV) is any form of physical, emotional, spiritual and financial abuse, negative social control or coercion that is suffered by anyone that has a bond or relationship with the offender. In the literature, we find words such as intimate partner violence (IPV), neglect, dating violence, family violence, battery, child neglect, child abuse, bullying, seniors or elder abuse, male violence, stalking, cyberbullying, strangulation, technology-facilitated coercive control, honour killing, female genital mutilation, gang violence and workplace violence. In couples, violence can be perpetrated by women and men in opposite-sex relationships (Carney et al., 2007), within same-sex relationships (Rollè et al., 2018) and in relationships where the victim is

LGBTQ2SAI+ (lesbian, gay, bisexual, transgender, queer, Two-Spirit, intersex and asexual plus) (The Scottish Trans Alliance, 2010; Rollè et al., 2018). RV occurs as a result of multiple impacts such as taken for granted inequalities, policies and practices that accept sexism, racism, ageism, xenophobia and homophobia. It can span the entire age spectrum. It may start in-utero and end with death.

In this chapter, we continue the discussion on NEVR and explain our framework and how the community and academia can work together to address RV. We also describe how mentoring students allows service providers to share real-world experiences with students. It allows service providers and students to address a social issue with limited funding.

## NEVR – Inclusive Framework

The Network to Eliminate Violence in Relationships (NEVR) is a committee that was conceived by Dr. Balbir Gurm, Nursing Faculty at Kwantlen Polytechnic University (KPU), Surrey Women's Centre (SWC), and Progressive Intercultural Services Society (PICS). At its inaugural meeting, there were over 60 individuals from the community including Royal Canadian Mounted Police (Surrey, BC), the City of Surrey, DIVERSEcity, Sophie's Place, YWCA, Options Community Services Society, Kwantlen Polytechnic University (KPU), Surrey Women's Centre (SWC), Progressive Intercultural Services Society (PICS), etc. Below is information on the background and process.

### Background and Purpose

> [Everyone] is responsible for the continued assaults on women and in some cases their deaths; the friends and

> neighbours who ignore or excuse violence, the physician who does not go beyond the mending of bones and the stitching of wounds, the social worker who defines wife-beating as a failure of communication, and the police or court officials who refuse to intervene. The violence is meted out by one man, but the responsibility for that violence goes far beyond him (Dobash & Dobash, 1980 p. 222).

Dobash & Dobash (1980) are pointing to the responsibility of all members of society to prevent RV.

Recent research shows that women and girls are the most discussed victims of relationship violence; nonetheless, it is critical to recognize that there are other cohorts suffering from relationship violence. **Read chapter 5** for RV prevalence rates.

Data on RV is interdisciplinary in scope; it comes from academic, government, and community partnerships, in such professions as nursing, social work, psychology, gender studies and criminology. Violence in relationships not only results in physical harm, but also "undermines the social, economic, psychological, spiritual, and emotional well-being of the victim, the perpetrator, and the society as a whole" (Kaur & Garg, 2008, p. 74).

In the first RV participatory action cycle (Gurm et al., 2013) the first item of business was for service providers in the anti-violence sector to identify the steps that occur when a survivor calls the police for assistance.

The following are the potential steps and contact with services when dealing with domestic violence, in each case these are lists of possible outcomes and actions.

The first is to decide if the Incident is an emergency – call 911 if it is an emergency. For non-emergency – call or text 211, 7 days a week, 24 hours per day and get assistance in multiple languages in Metro Vancouver, Fraser Valley, Squamish-Lillooet and Sunshine Coast Regional Districts. In other areas of BC, call VictimLinkBC at 1-800-563-0808. You can also email VictimLinkBC@bc211.ca for assistance.

Figure 3.1 shows the process that is followed from when police

respond to a 911 call for relationship violence until the matter goes to court (if it goes to court).

**Figure 3.1 – Steps followed after a 911 call**

*An interactive H5P element has been excluded from this version of the text. You can view it online here: https://kpu.pressbooks.pub/nevr/?p=23#h5p-2*

As mentioned in chapter 1, health is a positive concept, emphasizing personal resources as well as physical capacities. In the case of RV in family circles, the family does not function in a healthy way and does not have personal resources to cultivate healthy relationships. Intervention, then, must take the form of health promotion, which can be approached either from a medical, behavioural, and/or socio-environmental lens. In this paper, an innovative, multidisciplinary program targeting reduction in RV is introduced. The program framework is outlined and discussed.

## Methods and Procedures

The Network to Eliminate Violence in Relationships (NEVR) originated as a result of an early (2011) qualitative research project conducted to provide an analysis of the scope of RV, its causes and definitions from multiple standpoints. You can click here to read the full report.

Here we discuss not the methods of any one project, but how NEVR developed as a series of continuous cycles of research and activism. The methods and procedures employed by NEVR are

informed by the Action Framework and an understanding of the Intersectionality framework, cultural safety, multiple ways of knowing and appreciative inquiry. In addition, the procedures employed in each PAR cycle are meetings, action, conference and evaluation.

The goal of the original project was to gain a better understanding of the effectiveness, and the efficiency of current resources and services available for individuals affected by the cycle of female domestic abuse within the community of Surrey and surrounding areas. It also made recommendations to address the gaps identified. Six cohorts of participants were interviewed via a semi-structured interview format along with demographic questionnaires. The six cohorts included 14 male offenders, 10 female survivors, 10 healthcare service providers, 17 community service providers, six police unit representatives, and four members of the crown counsel. In 2011, the findings of this research initiated a further research project involving twelve individuals. Through continuous PAR (participatory action research – PAR cycles) it has grown to a membership of more than 200 people from over 50 organizations. Perspectives include those of criminal justice system personnel, educators, medical services personnel, service providers as well as the clients of existing programs and services (the perpetrators of violence in relationships as well as the victims/survivors).

The recommendations from the first cycle were to:

- Strive for increased program funding and staff resources
- Provide treatment for all involved in the abuse cycle
- Improve and implement screening tools
- Increase interpreter services
- Improve collaboration and resource sharing among agencies
- Use personalized empowering models for clients
- Improve system efficiencies.

It was also concluded from this cycle that more transformative changes are needed such as:

- The establishment of a dedicated judicial system
- A community conflict resolution system
- A central resource centre
- Education and networking for service providers.

Recommendations from the first cycle created NEVR and continuing PAR cycles have shaped the role of NEVR. The goal of NEVR is to create a society where RV is neither accepted nor tolerated, and it is conceptualized as both a research project and a community clinical placement for nursing students. It is hoped that participants will be able to use this process and framework to address the issue of relationship violence in their communities through utilizing NEVR's action framework and the findings and resources that result from the continuous cycles of work. In PAR, the entire group (all stakeholders and allies) is involved in identifying the topic of focus in the real world setting, planning actions, taking actions, and analyzing and reflecting on the actions. After the analysis and reflection the process starts again because now the current situation is redefined and the cycle repeats.

## Figure 3.2 Participatory Action Research Cycle

*An interactive H5P element has been excluded from this version of the text. You can view it online here: https://kpu.pressbooks.pub/nevr/?p=23#h5p-3*

Source

## NEVR Action Framework

### Socio-environmental Model of Health

NEVR's action framework springs from a socio-ecological understanding of relationship violence. That is, the understanding that health is a positive state defined by connectedness to one's family/friends/community, being in control, having the ability to do things that are important or have meaning, as well as community and societal structures that support positive human development. In this approach, RV is defined in terms of psychosocial risk factors and socio-environmental risk conditions, such as poverty, homelessness, isolation, powerlessness, stressful environments, hazardous living and working conditions; and social factors such as race, gender, disability and normalizing and acceptance of RV by the community (Capaldi et al., 2012; Centers for Disease Control and Prevention [CDC], 2017; Kantor & Jasinski, 1998; Stith et al., 2004; Vagi et al., 2013). NEVR recognizes the broad framework for implementing the healthy public policy of the Ottawa Charter for Health Promotion (1986) which in addition to stating that "prerequisites and prospects of health cannot be ensured by the health (or any) sector alone," (p. 3) calls for action by all concerned: by governments, by health and other social and economic sectors, by non-governmental and voluntary organizations, by local authorities, by industry and the media…professional and social groups and health personnel have a major responsibility to mediate between differing interests in society for the pursuit of health. (Public Health Agency of Canada, 1986, p. 3).

The interventions and actions in the socio-environment model of health prevention are community development, coalition building, political action and advocacy and societal change. As such, the high-risk societal conditions are targeted and political and economic policies are introduced at the community level. NEVR works with

multiple stakeholders to address these societal conditions and reject the normalizing of relationship violence. Interventions are aimed at family, work/school, communities and society. Indeed, the benefit of viewing relationship violence from a socio-environment perspective is that it allows RV to be targeted at a family and community level, rather than an individual level. It allows for looking at circumstances and events rather than blaming individuals. For a fuller discussion on the socio-environmental model, see chapter 6.

## Intersectionality Framework

NEVR utilizes a socio-environmental framework, as well as an intersectional approach; intersectionality means utilizing the sociological insight that people are shaped by the interactions of different social concepts (i.e., all of the psychosocial risk factors and socio-environmental risk conditions) such as race, class, gender, sexuality, ethnicity, nation, age, and religion and that these interactions occur within a context of connected systems and structure of power (Collins, 2015). An individual can have power and privilege in one role and be oppressed in another role. This is experienced simultaneously, is dynamic and is influenced by context. Of note, the systems and power structures are of great significance for NEVR, particularly in regard to cultural safety. To learn more about Intersectionality, see chapter 6.

## Appreciative Inquiry

Cooperrider & Srivastva (1987) describe Appreciative Inquiry (AI) as a process used to develop positive change in organizations. Additionally, AI is a form of action research that attempts to create new theories, ideas, and images that aid in the developmental

change of a system. It is a strengths-based approach that allows for social change. Instead of viewing clients, families, and organizations as machines, it views them as organisms—that is, adaptive, and above all, interactive within themselves and with other organisms (systems).

The concept of social construction is inherent in the philosophy of AI. "Reality" is created by those in the system. Our ability to change is limited by collective will and imagination. To effect change from an AI perspective, it is imperative to be respectful of the experiences of the group members. AI does not view an issue as a problem, per se, and does not use a traditional problem-solving approach. Instead, it looks at the desire for something—it asks people to look into their past for successful experiences, locate how they felt, recall what they did in order to amplify that in the present (Cooperrider & Srivastva, 1987). For RV, this means asking clients, stakeholders, and communities to focus on their feelings when they are in control, free, and healthy, and to ask them to identify what they need currently to make the change. In these cases, images and language must be used with intentionality.

## Cultural Safety

When working with individuals in Canada, a diverse population with many cultural backgrounds, cultural safety is paramount, as misunderstandings can reduce the efficacy of care offered. When working in RV, an issue that is pervasive and normalized in different ways across cultures, it becomes even more important due to the connection between different cultures and RV. In fact, it is widely accepted that knowledge of culture is an important part of effective therapeutic communication that can improve health outcomes (National Institute for Children's Health Quality, 2005).

The concept of cultural safety was first used in nursing by Irihapeti Ramsden (1990), a registered Maori Nurse in New Zealand.

It is based on the premise that historical, social and political processes have a lasting influence on marginalized groups (e.g., the Maori in New Zealand, First Nations, Inuit, and Métis people in Canada), and must be recognized. Cultural safety accepts that we all belong to a culture, and unequal power relations exist within and between cultural groups at the family, community, and societal level. Also, cultural safety involves the recognition that stereotypes and negative attitudes exist in scientific literature, which can be carried then into practice (Ramsden, 1990).

Practicing cultural safety ensures that health care staff are respectful of nationality, culture, age, sex, sexuality, political and religious beliefs, and the position of their patients. Awareness of these intersecting systems has the potential (consciously or unconsciously) to influence the power balance between clinicians and patients, as well as between colleagues. In nursing, cultural safety is understood to mean there is no damage or harm by interactions between people, and that dignity and respect are maintained for all parties in an interaction (College of Registered Nurses of British Columbia, 2017). Creating a culturally safe environment requires practitioners to have cultural humility. It requires self-reflection on personal oppression and privilege as well as identification of biases to create respectful partnerships based on trust. This empowers all involved in the relationship and aims to equalize power in the practitioner-client relationship or colleague-colleague relationship.

At NEVR meetings the facilitator ensures each individual at the meeting is respected and provided an equal opportunity to voice their opinion and the decisions are made from an inclusion perspective. From the cultural safety perspective when working with survivors, one of the goals of NEVR is to ensure no harm is done to the service provider, and their specific current situation and any historical oppressions are considered. Although originally developed to work with individuals, cultural safety applies to work between groups, organizations, and communities. Emphasis is placed on the desires of the service provider, and where they are

positioned in terms of family, workplace, and community roles and dynamics. This is respectful and empowering to the service providers who may also face their own institutional or political challenges and oppressions. It is recommended that this approach also be carried out with survivors and offenders.

## Multiple Ways of Knowing

Carper's (1978) and Chinn & Kramer's (2008) framework of multiple ways of knowing was adapted to work within the NEVR context by Gurm (2013). The premise is that each individual has a unique personal understanding and view of the world based on their own experiences that are derived in multiple ways. These include empirical, ethical, personal, aesthetic, and emancipatory.

> **Empirical knowledge** provides the theories about conducting and applying knowledge—to date, there is much literature and many theoretical frameworks for why RV exists and how it is perpetuated, as well as programs on effective prevention and intervention—these theories and programs may not address the fact that there is much variation in RV at the group and individual levels. As such, general theories may not work in particular situations, such as when dealing with a multidisciplinary and widespread issue like RV (and NEVR, itself) because collaborations by definition are not closed systems; they are open.
>
> **Aesthetic knowledge** is the art of practicing. Aesthetic knowledge recognizes that knowledge can be derived by acting—the practical skills required to work with clients. Those who are driven by aesthetic knowledge tend to draw from previous experiences, rather than empirical frameworks. It requires a deep appreciation of the context and moves beyond surface elements of the situation to a greater understanding of the whole. It may involve an

intuitive, creative approach to action and decision. It is aesthetic—practical—knowledge that leads to transformation.

**Emancipatory knowledge** is built on understanding that aims to critically examine the context or the environment in which they practice, programme, or decision occurs; that is, the social and political process of the organization, province or state, and country. It is about understanding both the mission and goals of agencies, as well as the social barriers or challenges involved in achieving those goals. It includes a historical understanding of those involved in partnerships (e.g., historical oppression) to better understand the multiple roles of partners. It requires facilitators and leaders with the capacity to recognize oppressive hegemonic practices, as well as to recognize the changes that are required to "right the wrongs" that exist. Emancipatory knowing is developed through action with reflection.

**Personal knowledge** is knowledge of the self and participation in action. It is based on the assumption that interpersonal engagement and interaction must include personal experiences and understandings. In contrast to empirical knowledge, where the researcher aims for objectivity, good personal knowledge practice acknowledges subjectivity and authenticity. The team or group (in this case, NEVR) is an open system that interacts and moves toward what Maslow calls self-actualization, or growth of human potential (Maslow, 1943 in Huitt, 2007). For NEVR, the research aims to reconcile this personal way of knowing with the role of controlling and managing the study—that is, an accepted norm or a more standardized approach (Gurm et al., 2013).

These multiple ways of knowing are key components in NEVR's framework. Only through understanding the diverse ways that individuals and groups conceptualize the problems of RV can any solution be formulated to address it.

The NEVR framework was presented at the Sigma Theta Tau International Society's nursing conference (2018). Gurm et al Participatory Action Research Addressing Domestic Violence from a Constructivist Framework

Ragavan et al. (2019) outlined findings that were consistent with NEVR's experience in that collaboration varies in participatory action research as participation changes from meeting to meeting. Furthermore, the process is very time-consuming and elements of trust, distribution of power, equal decision-making, shared ownership and accountability are all key to successful outcomes. While we found that our members are inconsistent in attendance, there has been enough strength through the few committed and consistent members to keep the momentum going. Importantly, students are a key resource and addition to this process. We believe this framework of cooperation between university faculty and community organizations and local governments can be implemented in all areas where post-secondary institutions are present.

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# Chapter 4: What is Relationship Violence?

BALBIR GURM

*Key Messages*

- Relationship violence (RV) has no standard definition.
- It is broadly defined as any abuse within a relationship and is massively underreported.
- RV is also known as domestic violence, intimate partner violence, interpersonal violence, spousal abuse, elder abuse, bullying, social control, coercion, dating violence, workplace violence, female genital mutilation, etc.
- The **key** distinction between RV and other forms of violence is that **it occurs between people who know each other and there is usually an interplay of multiple impacts such as taken for granted inequalities, policies and practices that accept sexism, racism, xenophobia, homophobia and ageism.**
- Subcategories of RV including physical abuse, emotional abuse, sexual abuse, financial abuse, spiritual abuse, etc.
- RV may be experienced in-utero and across the life

span. It may be experienced inside the home, workplace, school, community and online.

- RV impacts all ages and genders.
- If RV is experienced by one of the parents at home, children and youth may also be victims of child abuse and/or neglect.
- RV impacts Indigenous women and girls, significantly.
- Check out the Community Champion's Toolkit for more tips and resources (NEVR, n.d.).

# What is Relationship Violence (RV)?

## Background

The understanding of violence and its consequences are critical topics in public health. Violence is a multifaceted phenomenon; it can occur among any age, gender, ethnicity, social and economic status. Also, violence has different types of offenders, such as familiar and unfamiliar individuals, governments and systems. This book discusses violence that happens between people who know each other, and the relationship involves some form of power and control that results from an interplay between the individual and the socio-environment and taken for granted systemic practices. We chose the term **relationship violence** (RV) to describe this phenomenon.

Relationship violence is a major human rights violation and a public health concern with serious long-term physical and mental

health consequences. Also, RV has significant social and public health costs. It increases the risk of health problems in multiple human body systems, including the nervous, cardiovascular, gastrointestinal, genitourinary, reproductive, musculoskeletal, immune and endocrine systems resulting in multiple physical conditions (Centers for Disease Control and Prevention (CDC), 2019; Hines & Douglas, 2015; Ulloa & Hammet, 2016; ). It is also related to many psychological conditions such as PTSD and drug use (Cameranesi et al., 2019; Prangnell et al., 2020).

## Relationship Violence Definition

Relationship violence is any form of physical, emotional, spiritual and financial abuse, negative social control or coercion that is suffered by anyone who has a bond or relationship with the offender. In the literature, we find words such as intimate partner violence (IPV), interpersonal violence (IVP), neglect, dating violence, family violence, battery, child neglect, child abuse, bullying, seniors or elder abuse, stalking, cyberbullying, strangulation, technology-facilitated coercive control, honour killing, gang violence, and workplace violence. In couples, violence can be perpetrated by women and men in opposite-sex relationships (Carney et al., 2007), within same-sex relationships (Rollè et al., 2018) and in relationships in which the victim is transgender (The Scottish Trans Alliance, 2010). Relationship violence is a result of multiple impacts such as taken for granted inequalities, policies and practices that accept sexism, racism, xenophobia, homophobia and ageism. It can span the entire age spectrum and it may start in-utero and end with the death of the victim.

**Relationship violence occurs between two people who know each other**. In families, violence can happen between adult and child, child and child or adult and adult. Violence can occur in the home setting behind closed doors. Also, RV can happen between

a caregiver and a person requiring care inside the house, and institutional settings. It can be with a dating couple, between peers or students in schools, and employers and employees in the workplace or in gangs. It can happen in a physical or cyber environment.

There are many forms of relationship violence (Alliance of Hope International, 2019; Canada Department of Justice, 2017; Canadian Resource Centre for Victims of Crime, n.d.; Family Justice Center, 2019; Friends and Family, 2019; Government of Canada, 2017; Nordic Co-operation, n.d.; Public Safety Canada, 2018; Queensland University of Technology, 2019; WorkSafe BC, 2020). Some of them have been listed below.

- Physical abuse
- Sexual abuse
- Emotional abuse
- Financial abuse
- Neglect
- Cyberbullying
- Stalking (Criminal harassment)
- Bullying
- Negative social control- restriction of freedom or coercive control or technology-facilitated coercive control
- Strangulation
- Genital mutilation
- Honour killings
- Workplace Violence
- Gang violence

Relationship violence in schools and playgrounds between children is commonly referred to as bullying. It includes physical or psychological harming behaviours such as name-calling, threats and hitting. It can be direct (face-to-face) or indirect (exclusion or gossip or through social media). The term bullying undermines the

fact that our society would call some of these behaviours criminal acts if occurring between adults.

Gang violence quite often refers to all criminal activity inflicted by gangs. In our definition, we only include the violence between members and/or associates known to them. Gang violence entails a group of people who are loosely associated with illegal activities such as human/drug/firearms trafficking that engage in violence against those who are known to them (Dandurand et al., 2019). RV connected to gangs happens with males and females in different ways. RV in gangs can be emotional, physical, spiritual or financial, but it makes the news when it is homicide.

There are other forms of RV that we have identified, such as intimate partner violence, which is presented as physical, sexual, emotional and financial abuse, genital mutilation, honour killing, and gang violence. Intimate partner violence can occur to any gender, and it has been receiving the most attention in the academic field. Acts of genital mutilation are often performed against girls, but there are cases of male genital mutilation. Genital mutilation is connected to social norms and religious beliefs, and it seems to be widely accepted among certain cultures. Although its health consequences are well-established, genital mutilation is controversial, for its practice is accepted and sometimes even performed by health professionals (WHO, 2020).

Honour killings more often affect women and girls. This violence tends to be an act perpetrated by a close family member who believes to be acting in honour of the family name and prestige. The behaviour is connected to highly patriarchal societies that monitor and judge women and girls on the basis of "immoral sexual practices," including conversing with a man who is not a close family member, to having sex outside marriage or even being raped (Korteweg, 2014). Honour killings are about saving face, so no shame is brought to the family. To read about honour killings in Canada, click here. According to the Government of Canada, honour killings are against the law. However, some groups think there are acceptable reasons for honour killing including:

- Adultery
- Pre-marital sex or having a child out of wedlock (although honour may be restored through a "shotgun wedding")
- Disobeying parents, or
- Patriotism/Personal Insult/Defaulting on Monetary Debts (typically between men) (Government of Canada, 2017)

None of these are acceptable reasons, for they are against the Human Rights Legislation and Human Rights Code.

This chapter has provided the multiple types of abuse, known by many names. It is what we call, relationship violence or RV.

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# Chapter 5: Scope of Issue: Statistics and Consequences

BALBIR GURM AND JENNIFER MARCHBANK

*Key Messages*

- Relationship violence is any form of physical, emotional, spiritual and financial abuse, negative social control or coercion that is suffered by anyone that has a bond or relationship with the offender.
- Relationship violence can span the entire age spectrum and all genders. Relationship violence is a global social and health problem.
- Women are considered common victims of physical relationship violence. Boyce (2016) states relationship violence occurs equally between men and women, though current researchers suggest that women are over-represented when the violence is most intense. Indigenous/immigrant/limited ability/language barriers/isolated women are at greater risk (COAG, 2016).
- Relationship violence is under-reported by all age groups. Reporting rates vary between 19-33%. When victims report RV to family, friends and health professionals, these individuals are not sure how to address the disclosure.

Relationship violence (RV) is any form of physical, emotional, spiritual and financial abuse, negative social control or coercion that is suffered by anyone that has a bond or relationship with the offender. In the literature, we find words such as intimate partner violence (IPV), neglect, dating violence, family violence, battery, child neglect, child abuse, bullying, seniors or elder abuse, male violence, stalking, cyberbullying, strangulation, technology-facilitated coercive control, honour killing, female genital mutilation gang violence and workplace violence. In couples, violence can be perpetrated by women and men in opposite-sex relationships (Carney et al., 2007), within same-sex relationships (Rollè et al., 2018) and in relationships where the victim is LGBTQ2SAI+ (lesbian, gay, bisexual, transgender, queer, Two-Spirit, intersex and asexual plus (The Scottish Trans Alliance, 2010; Rollè et al., 2018). Relationship violence is a result of multiple impacts such as taken for granted inequalities, policies and practices that accept sexism, racism, ageism, xenophobia and homophobia. It can span the entire age spectrum. It may start in-utero and end with death.

## Scope of Issue

There are multiple factors called social determinants (see chapter 6) that contribute to RV that are mediated by social norms and context. It is important that we don't only address individual factors but consider them as they interact together. Such intersectional considerations are necessary for both recognizing risks and for creating policy. Sometimes referred to as GBA+ (gender-based analysis plus), such considerations are part of the policymaking framework in Canada. Click here for details of federal and here for BC information on GBA.

Below are some factors that put people at risk:

- Social norms that:

    - Normalize heterosexual relationships and myths about male masculinity
    - Accept power and privilege
    - Accept violence
- Environments that support:
    - Inequity and exclusivity
    - Homelessness
    - Conflict
    - Low socio-economic status (though RV occurs in all social classes)
    - Violation of human rights
- History of abuse

## Counting Relationship Violence

The statistics included in this book come from a variety of sources and countries. So, occasionally the statistics contradict each other—this is due to the way they have been collected. Janice Ristock (2003) notes that a number of surveys of lesbians who have suffered violence are self-selected whilst others use survey tools that are not adapted for this particular demographic.

From the 1970s, there has been a debate on whoperpetrates violence and who is victimized. Feminists and others point out that the vast majority of violence in adult heterosexual relationships is conducted by men towards their female partners. Others have argued that there is gender symmetry in interpersonal violence (IPV).

Family theorists Straus, Gelles and Steinmetz (1980) conducted the first National Family Violence Survey in the USA and found that violence towards men and women was about the same. They developed the Conflict Tactics Scale (CTS) that continues to be used today. They stated that men had a greater stigma in reporting and that further study was needed. Straus & Gelles (1986) modified

the CTS and repeated the study and found similar results. When reporting, Straus & Gelles (1986) stated that they could not determine how much of the violence towards men was self-defence – this is due to the fact that the CTS does not ask for the context in which violence occurred.

As this is a popular measure—it is the measure used by Statistics Canada—it is not surprising that study after study using it has found gender symmetry, which is men and women reporting equal incidences of violence. Yet in contradiction, many other studies, including statistics on who turns up in the ER, police stations, shelters, report great gender asymmetry (i.e., women are victimized at much greater rates than men). These differences are not due to errors in surveying but in what is being measured. Critiques of CTS point out the following:

- Only asks about the violence of cohabiting couples in the past year
- Does not include statistics on people murdered by their spouses (as they are no longer cohabitating)
- Counts a push back in self-defence as one incidence as is a beating resulting in hospitalization – there is no measure of severity of the violence
- Does not count sexual assault and much IPV may include sexual violence
- Does not make clear the meaning, context and consequence of relationship violence

The exclusion of murdered spouses is an important omission as the Canadian Women's Foundation (2014) reports that almost half of female murder victims in Canada (49%) are killed by their current or former partner. For male murder victims, 7% are killed by their current or previous partners. Approximately every six days, a woman in Canada is killed by her intimate partner with violence against women costing Canadians collectively $7.4 billion to deal with the aftermath of spousal violence alone (Canadian Women's

Foundation, 2021). Most men are likely to initiate violence while women are more likely to use violence in self defense (Canadian's Women's Foundation, 2021). .

Straus himself later acknowledged that understanding the severity of abuse matters, and we can see this with figures from Statistics Canada provided in F*amily Violence in Canada. A Statistical Profile 2005 (*Statistics Canada, 2016). It seems that 2005 is the last time family violence figures were specifically and explicitly reported in Canada though other figures are available.

After conducting a meta-analysis of several studies on IPV, sociologist Michael Kimmell (2002) concludes that both men and women use violence, but he found that they use violence for different means:

> It is certainly possible and politically necessary to acknowledge that some women use violence as a tactic in family conflict while also understanding that men tend to use violence more instrumentally to control women's lives. Furthermore, these two types of aggression must also be embedded within the larger framework of gender inequality. Women' s violence toward male partners certainly does exist, but it tends to be very different from that of men toward their female partners. It is far less injurious and less likely to be motivated by attempts to dominate or terrorize their partners (p. 1355-1356).

So, when reading statistics, we ask that you keep in mind what was actually being counted and what counting methods were used for you will find contradicting reports.

## Relationship Violence against Women

Although RV occurs across cultures and genders, it is still normalized to heterosexual relationships in most of the literature. Internationally and locally, one out of three women is abused by

their partners (World Health Organization [WHO], 2017; Public Health Agency of Canada, 2018). Specific literature on gender and sexual diversity RV can be found in chapter 20. Many women that experience violence accept it as a normal cultural/family practice and do not recognize it as abuse.

Some key statistics of RV (IVP) against women:

- Among all types of violence, sexual and intimate partner violence against women is a major public health problem (WHO, 2017)
- 1 in 3 women has experienced intimate partner violence through acts of physical and/or sexual abuse (WHO, 2021)
- Globally, 38% of murders against women are committed by an intimate male partner (WHO, 2021)
- In Canada, 28% of all violent crimes are connected to relationship violence (Burczycka & Conroy, 2018)
- Women are two times more vulnerable than men to experience sexual assault, being beaten, choked or threatened with a gun or a knife (Public Health Agency of Canada, 2018)
- Increased risk of intimate partner violence among lesbian or bisexual women (11% versus 3%) (Public Health Agency of Canada, 2018)
- Women and girls between the ages of 15 to 24 years old represent 67% of all cases (Public Health Agency of Canada, 2018)
- 79% of police-reported relationship violence is against women and girls (Burczycka & Conroy, 2018)
- The homicide rate is four times greater among women versus men (David, 2017)
- Indigenous women are more vulnerable to experience physical abuse than non-aboriginal women (60% versus 41%) (Boyce, 2016)
- Pregnant women have an increased risk of relationship violence (Baird, 2015; Garcia-Moreno et al., 2006)
- Women were killed by an intimate partner (45 per million

population) – more than five times the rate at which men were killed by an intimate partner (9 per million population) (Canadian Femicide Observatory for Justice and Accountability, 2020).

A woman or girl is killed by a known male every 2.5 days in Canada (Canadian Femicide Observatory for Justice and Accountability, 2020). According to the report to the chief BC Coroner (2016) using results from 2010-2015, there were 75 fatal relationship violence incidents against adults resulting in 100 deaths (73 victims and 27 perpetrators). Some other findings from the report are:

- 78% were women, and 22% were men
- Most women were 25-59 years of age
- Two-thirds had a history of relationship violence
- Less than one third had reported the crime to the police
- Ten cases had protection orders
- 80% were killed in their home (Government of British Columbia, 2016).

Risk factors for men in heterosexual relationships who abuse women and girls from WHO (2017) and Neilson (2013) include:

- Low education
- History of child abuse
- Witnessed abuse of mother
- Alcoholism
- Unequal gender norms
- Acceptance of violence
- Male privilege
- See women as subordinate
- Situations of conflict, post-conflict and displacement (WHO, 2017)

Besides causing fear among survivors, violence can escalate to

homicide. According to Neilson (2013), the risk factors of violence to become homicide are:

- Pattern of any type of domestic violence
- Pattern of any type of abuse against other family members
- Violence against any non-family members
- Any type of coercive control
- Unstable lifestyle (unemployment, refusal to accept family responsibilities)
- Any type of conviction
- Failure to comply with previous court orders
- Escalation of frequency and severity
- Separation

Below are additional risk factors that have mixed results. Consider these in conjunction with the above and when those on the previous list are present:

- Mental health problems
- Other than PTSD, there is not a strong association with mental health, the presence of mental health problems does not cause RV
- Survivors may become offenders from stress due to repeated RV
- Insecure attachments in the family of origin and in intimate partnerships
- A new partner in the target person's life
- Prior arrest
- Assault during pregnancy linked to a lethal outcome
- Continuing conflicts relating to children. The presence of children increases opportunities for contact. Increased contact increases opportunities to harm (Neilson, 2013)

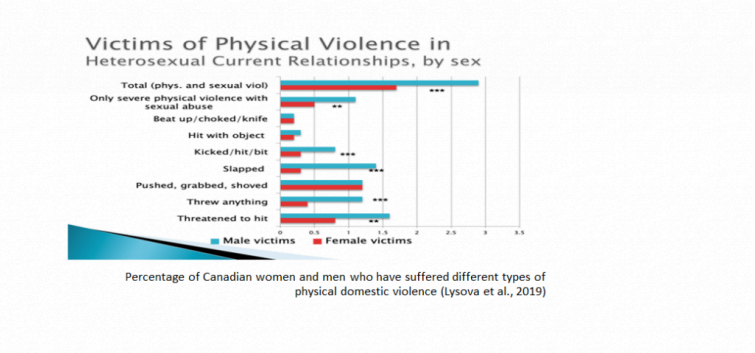
The Canadian government has started the family violence initiative to learn more click here. As well, more institutions are looking at

RV from a health promotion lens and gathering literature in one place. One example of this is the Canadian Femicide Observatory for Justice and Accountability, to visit their site, click here.

## Relationship Violence Against Men

In Canada, surveys from 1999 and 2016 show that the percentage of men who were abused were about the same as women (Burczycka & Conroy, 2018). In another analysis, data from the Canadian Survey shows that in most types of physically and sexually violent acts men experience higher rates of violence than women (Lysova et al., 2019). Figure 5.1 below reports that there are more male targets (victims) in severe physical violence with sexual abuse, hitting with an object, kicking, slapping, throwing things and slapping in heterosexual relationships. The same figure shows that being beaten/choked/ knifed and being pushed/ shoved/grabbed are equally prevalent for men and women in heterosexual relationships. Although this study contradicts previous research that indicated that women were the majority of victims, it is critical to acknowledge that regardless of incidence rates, any group of people can experience relationship violence and nobody should have to suffer in silence.

**Figure 5.1 – Victims of Physical Violence in Heterosexual Relationships (2019)**




Percentage of Canadian women and men who have suffered different types of physical domestic violence (Lysova et al., 2019)

Risk factors of intimate partner violence among men in heterosexual relationships:

- Risk of relationship violence among young men between 25 to 34 years old seems to be four to five times higher than among men 45 years old and more (4% versus 1%, respectively)
- Different percentage risk when categorizing groups in different age range groups. For instance, men between 18 to 29 years old show a risk of 21.8% versus 4.2% among men 65 years old and over
- Men in a common-law relationship are at higher risk than married (4% versus. 1%)
- Conflict increases abuse (Burczycka & Conroy, 2018)
- 25% lifetime prevalence of RV in the United States (Walters et al., 2013)

Conflict in other parts of lives is indicated as a risk factor associated with women who abuse men.

## Violence in Adult LGBTQ2SIA+ Relationships

LGBTQ2SIA+ rates of RV are similar to or greater than in heterosexual relationships. In 2014, Canada's rate of victimization

(of sexual assault, physical assault or robbery) was 69 per 1000 for heterosexual identified people; 142 per 1000 for lesbians and gay men and 267 per 1000 for bisexual people (Conroy & Cotter, 2017). A study from the United States provides prevalence rate comparisons for adults found that bisexual women had significantly higher rates than other adults. See table 5.2. below. The rates are significantly higher for bisexual women than heterosexual couples for all types of violence but are not statistically significant compared to lesbian women (Walters et al., 2013, p. 18). The rate for men was about 25% for all men (24.0% gay men, 27.0% bisexual men, and 26.3% heterosexual men). See chapter 20 for a deeper discussion.

**Table 5.2 – Prevalence Rates by Identity from the National Intimate Partner & Sexual Violence Study** (NISVS), 2010 Findings, USA (Waters, et al., 2013) IPSA (intimate partner sexual assault)

| | Lifetime IPV | Lifetime IPV | Lifetime IPSA | Lifetime IPSA |
|---|---|---|---|---|
| | Men % | Women % | Men % | Women % |
| General population | 28.1 | 32.9 | 8.0 | 15.9 |
| Heterosexual | 28.7 | 32.3 | * | 15.3 |
| Bisexual | 37.3 | 56.9 | * | 40.0^ |
| Gay, Lesbian | 25.2 | 40.4 | * | ** |

* Estimate not reported ** estimate not reported sample size too small

## Relationship Violence against Children (child abuse/maltreatment/neglect)

Children are also included in our definition of relationship violence. The World Health Organization (WHO) calls it child maltreatment.

> Child maltreatment is the abuse and neglect that occurs to children and youth under 18 years of age. It includes all types of physical and/or emotional ill-treatment, sexual abuse, neglect, negligence and commercial or other exploitation, which results in actual or potential harm to the child's health, survival, development or dignity in the context of a relationship of responsibility, trust or power. Also, exposure to intimate partner violence is sometimes included as a form of child maltreatment (WHO, 2016).

About 25% of adults state they were abused as children (1/5 women and 1/13 men, WHO). In Canada, 32% of adults state they were abused by the age of 16 (Public Health Agency of Canada). Some facts from the Public Health Agency of Canada related to the types of abuse children are exposed in Canada are below:

- Exposure to intimate partner violence (34%)
- Neglect (34%)
- Physical abuse (20%)
- Emotional abuse (9%)
- Sexual abuse (3%)
- Of police-reported cases:
  - Perpetrators were parents, siblings and extended family members
  - Girls are more likely to be victims compared to boys (four times more likely for sexual abuse, two times for other abuses) (Burczycka & Conroy, 2018)

Also, LGBTQ2SA+ youth are at higher risk than heterosexual peers (Martin-Storey, 2015). As well as minority status, of any kind (race/

gender/ability) is a risk for acceptance and thereby stigma that may also increase the risk of violence.

See chapter 16 for further discussion on children.

## Relationship Violence of Older Adults (elder abuse)

Relationship violence also includes older adults—see chapter 17. Relationship violence of older adults (elder abuse) is "a single, or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust that causes harm or distress to an older person" (WHO, n.d.). Older adults are 60 years of age and older according to WHO and 65 years and older according to Statistics Canada.

- Abuse rates are 4-10% (Burczycka & Conroy, 2018), 8-10% (Canadian Association for Retired Persons) and 15.6% globally (WHO, n.d.).
  - 61% of physical abuse
    - 21% involved threats
  - 34% of perpetrators were family members (33% spouse and 31% adult child)
    - For men, most perpetrators were adult children
    - Caregivers in senior's homes and hospitals may also be perpetrators
- In BC, 8% have been financially or emotionally abused (BC Centre for Elder Advocacy Support, n.d.)
- Couples are at risk when they have a conflict or as they transition to life stages such as retirement

## Underreporting

The statistics provided are estimates and the actual numbers are unknown. It is estimated that in relationship violence against women, only about 19% report the abuse to the police. Canadian Association for Retired Persons (n.d.), an advocacy group for seniors, agrees with the Public Healthy Agency that only about 20% of abuse is ever reported to police. It is theorized that one reason adults don't report RV is because of the stigma associated with it (see chapter 6 on Why do survivors not report). Children do not report it because they have limited contact outside the family whom they trust. Locally, in Surrey, British Columbia, one-half of the calls to the police are in regard to cases of relationship violence. RV is an international, national and local challenge. Although we have provided risk factors, keep in mind that these are averages and risk does not equate to causation.

We know that abuse happens across the lifespan, in many places and types of settings. It is often surprising when prominent men, who are very successful in their field, are charged with sexual abuse. The "Me Too" and "Time's UP" movements, which started in 2017, demonstrated how common sexual harassment is in workplaces, including the academic environment, breaking the myth that it only happens in low socioeconomic situations or to those with little education. For more details in academia read: *It's time to recognize how men's careers benefit from sexually harassing women in academia* (Mansfiled et al., 2019).

## Consequences of Abuse

The consequences of abuse are physical, psychological, financial and spiritual. For female victims, it can impact their reproductive health and for children, it can lead to neurological problems such

as learning disabilities and other health conditions. They also lead to decreased economic opportunities and decreased well-being. Consequences of abuse can last over the life-time and over generations.

High-level toxic stress from trauma has generational impacts. It results in neurological changes and physical ailments. Toxic stress can be from experiencing RV or witnessing RV and changes in cognitive, emotional and brain development may start in-utero (Mueller & Tronick, 2019). It results in changes in the brain (Center on Developing Child, n.d.) and the remainder of the neurological system and has huge social and health impacts (psychological, social, physical, and cognitive). A review by Howell et al. (2016) provides consequences for infants/children as a result of experiencing or witnessing violence. Some are listed below:

- Adjustment problems
- Delinquency
- Mental health challenges
- Intergenerational violence
- Detachment (leading to difficulty with social relationships)
- Irritability (fussy)
- Inability to self soothe
- Atypical behaviours (repetitive movement or making odd sounds)
- Post Traumatic Stress Disorder (even in infants)
- Premature birth
- Low birth weight
- Physical illnesses (For example, two times more likely to get asthma, gastrointestinal problems)
- Dysregulation in stress response leading to later adulthood difficulties
- Social withdrawal and anxiety
- Mood swings
- Poorer memory
- Decreased IQ

- Early-onset obesity

**Table 6.1 – Consequences of RV Across the Life Span** (MacMillan & Wathen, 2014). Research Brief: Interventions to Prevent Child Maltreatment. PreVAiL: Preventing Violence Across the Lifespan Research Network. London, ON.; Public Health Agency of Canada, (2015). Snapshot of Family Violence in Canada- Infographic. https://www.canada.ca/en/public-health/services/health-promotion/stop-family-violence/snapshot-family-violence-canada-infographic.html)

| Age group | Health Challenges |
|---|---|
| Infants | Injury, decrease in emotional control, parent-infant bonding challeng |
| Children | Anxiety disorders and PTSD, mood disorders, disruptive behaviour dis |
| Adolescence | Conduct disorder, alcohol & drug abuse, other risk-taking behaviours |
| Adults | Personality disorders, relationship problems Maltreatment of one's ov |
| Older Adults | Isolation, shorter life, dependence and financial problems |

Source: https://vegaproject.mcmaster.ca/docs/default-source/pdf/research-brief_-interventions-to-prevent-child-maltreatment-march-2014.pdf?sfvrsn=912afec1_0

Some of the behavioural signs can be found in the Early Childhood Expose to Domestic Violence years toolkit, (MacPherson et al., n.d. p. 8). Identification and treatment for children who witness abuse or are exposed to domestic violence need to start as early as possible, as there can be lifelong impacts on their development during formative developmental periods. See Toxic Stress and the Brain (Hall, 2019). Click to listen to the video about long-term impacts (Public Health Network Cymru, 2017).

For more on women, see chapter 15 and for more on children, see chapter 16.

## Economic and Social Costs of RV

Neilson (2013) in a report for Justice Canada estimates the economic cost of relationship violence against adults may be as high as $15 billion. This estimate does not include "cumulative, compounding, long-term institutional costs—educational, workplace-related, medical and mental health, drug and alcohol therapeutic, legal—when we fail to intervene early and effectively in RV cases (Neilson, 2013). The Canadian Department of Justice (2012) estimated the financial cost of spousal violence in 2009 to be $7.4 billion. Check out the table with the breakdown of the cost for spousal violence (Criminal Justice Canada, 2017). Bowlus et al. (2003) in a paper prepared for the Law Commission of Canada, estimated that the cost of child abuse in Canada is almost S6 billion. The Institute of Public Health in partnership with Children First Canada estimated the cost of child abuse at $23 billion in Canada (Prince Albert Daily Herald, 2018). The Circle Project (2016) estimated the cost of one child being abused causing broken ribs at $116,000 in Saskatchewan. The costs included only immediate costs (justice, social, health system and personal costs to the family such as loss of income and moving expense) see table, page 7 (The Circle Project, 2016). Cost estimates are difficult to obtain because families are hesitant to report, different definitions are used, and it is difficult to measure the impact.

The Centers for Disease Control and Prevention in the United States "estimates the lifetime economic cost associated with medical services for IPV-related injuries, lost productivity from paid work, criminal justice and other costs, was $3.6 trillion. The cost of IPV over a victim's lifetime was $103,767 for women and $23,414 for men" (Centers for Disease Control and Prevention [CDC], n.d.). This was just for intimate partner violence and not all relationship violence.

There are cost estimates calculated for child and spousal abuse, but no figures could be obtained for elder abuse and male violence

in Canada. It is safe to say that the cost of relationship violence is in the billions per year. This is a significant number. These costs only increase yearly, for rates of relationship violence appear to have not decreased significantly over the last few decades. Therefore, much work needs to be focused on prevention to bring these costs to society down and to increase the safety and well-being of individuals and society.

## Role of Media in Relationship Violence

Kohlman et al. (2014) in the article, Contribution of Media to the Normalization and Perpetuation of Domestic Violence explain how the media has normalized domestic violence. They note how news, TV shows, social and print media highlight acceptance and perpetuation of gender roles and use humour to minimize issues of relationship violence. Media highlights that good families cover up relationship violence and perpetuate stereotypical roles of males as aggressive, dominant and controlling while women are shown as subservient who will do anything to keep peace in the family. Quite often, sexist jokes are accepted by television characters normalizing a serious problem. The media, thus, plays a role in perpetuating stereotypes and contributing to gender myths and desensitizing the audience regarding relationship violence. As well, popular music has hits about toxic relationships such as Rihanna's Love on the Brain (Angel & Ball, 2016) and numerous others, Gangsta by Kehlani (Parrish, 2016) and Circus by Brittany Spears. (Gottwald et al., 2008).

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# Chapter 6: Relationship Violence Models and Risk Factors

BALBIR GURM AND GLAUCIA SALGADO

*Key Messages*

- Relationship violence is an extremely complex health and social issue that requires expertise in multiple fields such as health, sociology, psychology, criminology, and justice.
- Understanding what makes someone at risk of violence (contextual and environmental factors) strengthens the effectiveness of interventions.
- Risk factors are identified to develop appropriate services and programs in order to safely plan programs to prevent abuse. Risk factors are a combination of environmental and social conditions and individual's biology/genetics).
- Prevention and intervention programs need to be evidence-based, and the evidence can often come from practice.
- Other early intervention programs such as the Nurse-Family Partnership are also evidence-based strategies for intervention.

- Gendered violence will continue until there is a cultural shift about attitudes towards women and offender accountability (Iliadis, 2019).
- Relationship violence will continue until we recognize our own power and privilege and work toward creating equity and not oppression because violence exists against the whole spectrum of gender (Gurm, 2013).
- The world is becoming smaller and knowledge is shared freely through the internet. Therefore, in this section, we highlight what is known about relationship violence and successful initiatives from around the world.

Relationship violence (RV) is any form of physical, emotional, spiritual and financial abuse, negative social control or coercion that is suffered by anyone that has a bond or relationship with the offender. In the literature, we find words such as intimate partner violence (IPV), neglect, dating violence, family violence, battery, child neglect, child abuse, bullying, seniors or elder abuse, stalking, cyberbullying, strangulation, technology-facilitated coercive control, honour killing, gang violence and workplace violence. In couples, violence can be perpetrated by women and men in opposite-sex relationships (Carney et al., 2007), within same-sex relationships (Dixon & Graham-Kevan, 2011; Rollè et al., 2018) and in relationships where the victim is transgender (The Scottish Trans Alliance, 2010). Relationship violence is a result of multiple impacts such as taken for granted inequalities, policies and practices that accept sexism, racism, ageism, xenophobia and homophobia. It can span the entire age spectrum. It may start in-utero and end with death. Relationship violence impacts the physical, psychological,

economic and social well-being of those who are abused (see chapter 5).

Most of the literature is about violence against women and girls (Dixon & Graham-Kevan, 2011) from a feminist perspective, and the literature is in silos. It is also normalized to heterosexual relationships from this perspective where men are seen as perpetrators and women as survivors (Dobash & Dobash, 1984, 2004), even though studies indicate that it is perpetrated by females on males in heterosexual groups and by sexual and gender diverse groups ( Archer, 2000, 2006; Dixon & Graham-Kevan, 2011; Jones, 2018; Lien & Lorentzen, 2019; Straus & Gelles, 1986; Walters et al., 2013). Please also note that we are aware that there are debates around how statistics are counted, and what is counted, leading to contradictions in figures from different studies – see chapter 5 for a fuller discussion of this point.

Gender (male or female)/sexual and gender diversity (LGBQT2SIA+) is only one of the contributing factors because relationship violence is a multifactorial issue. We acknowledge that after decades of addressing RV from the feminist perspective, we have over time seen policy changes and a move towards equity. With this understanding, we believe that knowledge from women's programs and services may be adapted for use across genders, sexual and gender diverse groups. That does not mean services for women need to decrease, but all groups who suffer RV, with any prevalence, need to be served. However, we are also aware that Ristock (2002) argues that a simple, direct transfer of services without awareness of, and sensitivities to, the uniqueness of, in her case lesbian relationships, can have limited utility. See chapter 19 for Indigenous populations, chapter 20 for LGBTQ2SIA+ and chapter 21 for immigrants and refugees, for a fuller discussion of these nuances in serving the specific communities.

Our intent is to thaw the academic silos and offer practitioners, the public, governments, judiciary and academics more comprehensive ways to bring forward the complexities of RV. We

also aim to show the many interacting variables and acknowledge similarities and differences in addressing the issue. This might promote a better understanding, and hopefully the possibility of everyone working together on this global pandemic without arguing who is impacted the most. Since this is a living book, we see it as the beginning of sharing knowledge and wish for others to contribute their understandings. You can email NEVR@kpu.ca if you wish to contribute. Also, this is not meant to be an exhaustive literature review but a synthesis of understandings from various jurisdictions and fields. We present integrated models for understandings and actions.

# Integrated Models

## NEVR RV Model

Current knowledge related to RV is fragmented and in silos, but it needs to be brought together. The NEVR action framework draws from multiple overlapping frameworks. Each framework is discussed and the integrated NEVR RV Model presented. It is based on the fact that no two perpetrators or survivors are the same in any given group and there are similarities within and across groups. A comprehensive understanding of the complex web of RV needs to drive laws, policies and actions and reduce the risk for all affected groups.

**Multiple ways of knowing** – Multiple perspectives and understandings can help illuminate health challenges such as relationship violence. We draw on the adaptation by Gurm (2013) of Carper's (1978) and Chin & Kramer's (2008) framework of multiple ways of knowledge and knowing. This is based on the social constructivist theory that illuminates that each individual has a

unique personal understanding and view of the world based on their own experiences that are derived in multiple ways. These include empirical, ethical, personal, aesthetic, and emancipatory.

1. Empirical. The empirical knowledge/way of knowing is based on science; it is conscious reasoning and problem-solving, predicting, explaining, and describing. Empirical knowing is used to develop formal theories and descriptions about laws, theories, and explanations that are generalizable to other situations. This is what drives the academic literature.
2. Ethical knowledge/way of knowing is essentially a moral understanding of how to behave in multiple roles. This requires experiential and empirical knowledge of social norms and values, as well as ethical reasoning. Ethical knowledge can come from a professional code of ethics, social norms, or maybe philosophical positions including duty and social justice. Ethical knowledge must include judgment—that is, going beyond code to consider all actions that are deliberate and involve a decision of right and wrong. Ethical knowing involves understanding of different philosophical positions designed to deal with moral judgment and notion of service.
3. Personal knowledge/way of knowing is knowledge of the self and participation in action. It is based on the assumption that interpersonal engagement and interaction must include personal experiences and understandings. In contrast to empirical knowledge, in which the researcher aims for objectivity, good personal knowledge practice acknowledges subjectivity and authenticity. The team (in this case, NEVR) is an open system that interacts and moves toward what Maslow calls self-actualization, or growth of human potential (Huitt, 2007). For NEVR, the research aims to reconcile this personal way of knowing with the role of controlling and

managing the study (that is, an accepted norm or more standardized approach).

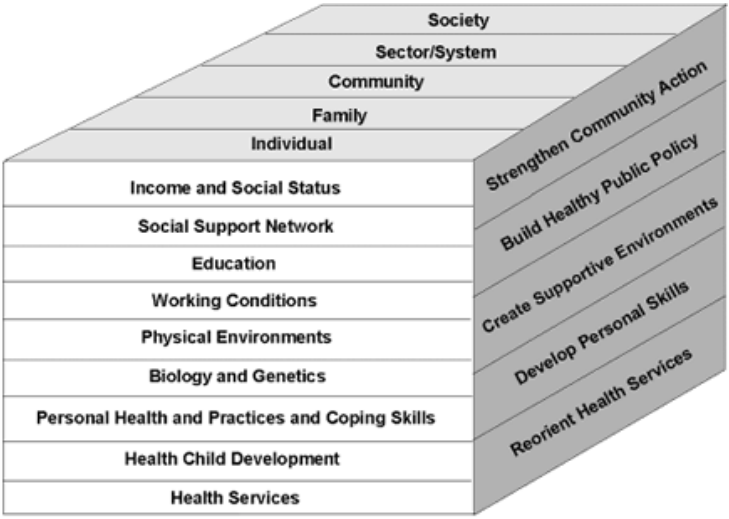
4. Aesthetic knowledge/way of knowing is the art of practicing. Aesthetic knowledge recognizes that knowledge can be derived by acting—the practical skills required to work with clients. Those who are driven by aesthetic knowledge tend to draw from previous experiences, rather than empirical frameworks. It requires a deep appreciation of the context and moves beyond surface elements of the situation to a greater understanding of the whole. It may involve an intuitive, creative approach to action and decision. It is aesthetic—practical—knowledge that leads to transformation.
5. Emancipatory knowledge/way of knowing is understanding that critically examines the context or the environment in which they practice, develop programmes, or decision occurs; that is, the social and political process of the organization, province or state, and country. It is about understanding both the mission and goals of agencies, as well as the social barriers or challenges involved in achieving those goals. It includes a historical understanding of those involved in partnerships (e.g., historical oppression) to better understand the multiple roles of partners. It requires facilitators and leaders with the capacity to recognize oppressive hegemonic practices as well as to recognize the changes that are required to "right the wrongs" that exist. Emancipatory knowing is developed through action with reflection (Gurm, 2013).

These multiple ways of knowing are key components in NEVR's framework for we value all our members and their understandings and perspectives on relationship violence. While empirical knowledge provides the theories about conducting and applying knowledge, to date, there is much literature and many theoretical

frameworks for why RV exists and how it is perpetuated, as well as programmes on effective prevention and intervention. These theories and programmes not always address the fact that there is great variation in RV at the group and individual levels. As such, general theories may not work in particular situations, such as when dealing with a multidisciplinary and widespread issue like RV, because collaborations by definition are not closed systems, but they are open and constantly changing.

**Socio-environmental framework** – As well as accepting that there are different ways of knowing, we accept the social-ecological framework for health promotion. That is, the understanding that health is a positive state defined by connectedness or relationship to one's family/friends/community, being in control, having the ability to do things that are important or have meaning, as well as community and societal structures that support positive human development. In this approach having control is seen as a major concept for a state of well-being (Lalonde, 1974). Also, RV is defined in terms of psychosocial risk factors and socio-environmental risk conditions, such as poverty, homelessness, isolation, powerlessness, stressful environments, hazardous living and working conditions; and social factors such as race, gender, ability and normalizing and acceptance of RV by the community (Capaldi et al., 2012; Centers for Disease Control and Prevention [CDC], 2016; Kantor & Jasinski, 1998; Stith et al., 2004; Vagi et al., 2013). Part of the reason why the feminist perspective that relationship violence is a gendered issue and only exists against women has explained RV well in the past is that most societies that the theories were developed from were on the extreme spectrum of patriarchy whilst today there is a range from more equitable societies in western nations to more patriarchal societies in less developed nations.

**Figure 6.1 – Health Promotion Model** (Government of Canada, 2001)




The socio-environmental model explains how relationship violence is a result of behaviours and social situations that occur in multiple interacting systems. It is a health promotion framework that looks at the individual, family, community and societal levels and is adopted by Health Canada (2001). The context may include demographic, neighbourhood, school or community (Capaldi et al., 2012). It looks at various elements in each system and incorporates individual and societal level theories. It indicates that health is a result between the combination or interaction of multiple factors (i.e., social determinants of health) and explains that actions need to be aimed at all systems. Social determinants that have been identified for Canadians are:

1. Aboriginal Status
2. Early Childhood Development
3. Education
4. Employment and working conditions
5. Food insecurity

6. Gender
7. Health care services
8. Housing
9. Income and its distribution
10. Social Exclusion
11. Social Safety net
12. Unemployment and job security
13. Disability (Ability)
14. Geography
15. Immigrant status
16. Race (Raphael, 2016; Mikkonen & Raphael, 2010)

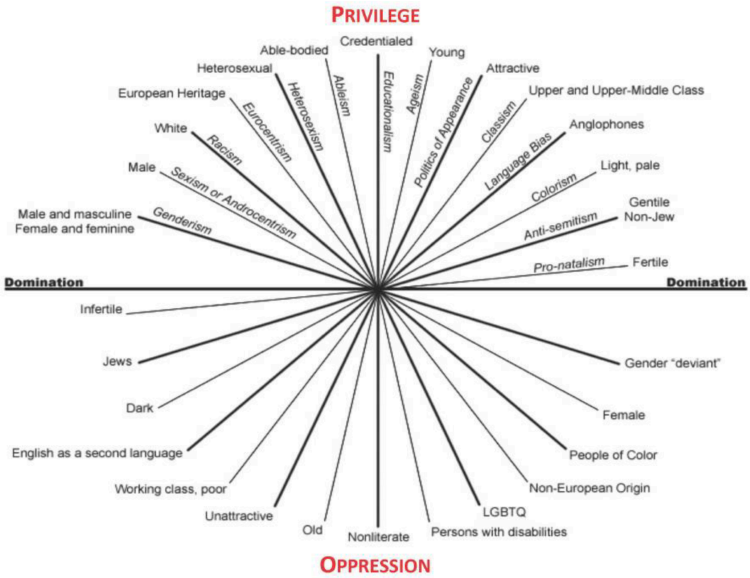
These 16 social determinants contribute to relationship violence, and they make up the risk factors identified. How much they contribute to a particular person is unique to the individual. NEVR recognizes the broad framework for implementing the healthy public policy of the Ottawa Charter for Health Promotion (World Health Organization [WHO], 1986) which in addition to stating that "prerequisites and prospects of health cannot be ensured by the health (or any) sector alone," (p. 3). It calls for action by all concerned such as governments, health and other social and economic sectors, non-governmental and voluntary organizations, local authorities, industry and the media. Professional, social groups and health personnel have a major responsibility to mediate between differing interests in society for the pursuit of health (Public Health Agency of Canada, 1986, p. 3). The interventions and actions in the socio-environment model of health prevention are community development, coalition building, political action and advocacy and societal change. We have been building coalitions and this living book is another way for us to build a coalition and develop ourselves and our colleagues to engage in advocacy and social change together.

To understand the complexity of RV, we have integrated the Intersectionality and Cultural Safety frameworks because within each system (i.e., individual, family, community, sector, society)

exists power and privilege and taken for granted internalized practices of power that may have been passed on for generations. Everyone within the system needs to be aware of their own social location, positionality and question received knowledge. There also needs to be an awareness of history and its impacts that are transferred through generations.

**Intersectionality Theory** – explains how identity, experience and positionality intersect to create oppression that underpins interactions and in turn relationship violence (Cramer & Plummer, 2009; Meyer, 2010). See the Intersecting axis of power and privilege below and place the survivor on the wheel to understand the totality of the person. Intersectionality theory explains that individuals have multiple roles and identities. Each individual life within systems of power and privilege is the sum of power/ privilege in a specific situation, that may contribute to RV. Also, it illuminates the diversity of populations and individuals to help create more specific and relevant programs.

**Figure 6.2 – Intersecting Axis of Power and Privilege** (Roberts et al., 2019)



Within systems, the risk may be increased due to historical, political, and socioeconomic realities, and the normalization and generational transmission of violence that leads to a culture that normalizes abuse. The history and impact of experiences and the code of silence to protect the family and community all contribute to increased RV.

Racism and gender inequality through many elements like barriers to voting and denying positions of leadership to minorities and women may also contribute to RV. In addition, economic dependency, poverty, lack of parenting skills, formal education, geographic isolation, government, and historical structures in remote communities increase the risk of abuse for some groups including immigrants, refugees and Indigenous peoples (Brassard et al., 2015). A collaborative framework, as well as an intersectional approach, is part of the model. Intersectionality means utilizing the sociological insight that people are shaped by the interactions of different social concepts (i.e., all of the psychosocial risk factors and socio-environmental risk conditions above) such as race, class, gender, sexuality, ethnicity, nation, age and religion. They all impact a person's positionality and either oppress or privilege them depending on accepted social norms. Also, these interactions occur within a context of connected systems, relationships and structures of power (Collins, 2015). An individual can have power and privilege in one role and be oppressed in another role. This is experienced simultaneously, and it is influenced by context. Context also determines power and privilege. Of note, the systems and power structures are of great significance, particularly regarding cultural safety.

**Cultural Safety (CS)** – Across Canada and in many nations around the world, there is a history of colonialism, racism and white privilege. For many years, practitioners were told to become culturally competent and many books and articles were written on how to deal with Indigenous and racialized populations. However, generalizations were published about groups leading all to believe that these groups were homogeneous. However, when

generalizations are applied to every single person of a given group, it leads to stereotyping. Cultural safety recognizes that stereotypes and negative attitudes exist in scientific literature, which carries into practice (Ramsden, 1990). This may explain why oppressed people feel that the system and its services revictimize them. This results in many individuals not having a sense of cultural safety. When working with individuals in Canada, a diverse population with many cultural backgrounds, cultural safety is paramount, as misunderstandings can reduce the efficacy of care offered. When working to address RV, an issue that is pervasive and normalized in different ways across cultures, it is more important still. This recognition of normalized as taken for granted practices that overlap with the concept of emancipatory knowing. Also, it is widely accepted that knowledge of culture is an important part of effective therapeutic communication that can improve health outcomes (Kreps, 2006).

Cultural safety accepts that all individuals belong to a culture, and unequal power relations and racism exist within and between cultural groups at the family, community, and societal level. In nursing education, cultural safety was first introduced by Irahapeti Ramsden, a Maori nurse in her doctoral dissertation, to address the historical oppressions that have led to higher rates of illness in the Maori population. It is based on the premise that historical, social and political processes have a lasting influence on marginalized groups (e.g., the Maori in New Zealand, First Nations, Inuit, and Métis people in Canada), and must be recognized (Ramsden, 2002). Cultural safety examines prejudice, power and bicultural relations. It can be applied to any person or group that differs on any axis of privilege, domination and oppression (age, ability, ethnicity, sexual orientation, migrant status, religious belief, socioeconomic status, education, etc.). It is about the unique bicultural relationship of two people and the focus is on the service provider/employer/educator/boss (privileged person) to create a trusting environment and equal partnership with the person who is in an oppressed position. Only the recipient (the oppressed person) can decide if

cultural safety has been achieved. The focus is on the one with the power to reflect on their power and assumptions in order not to stereotype but listen to and understand the other person. This can also be applied to multicultural relationships with three or more people.

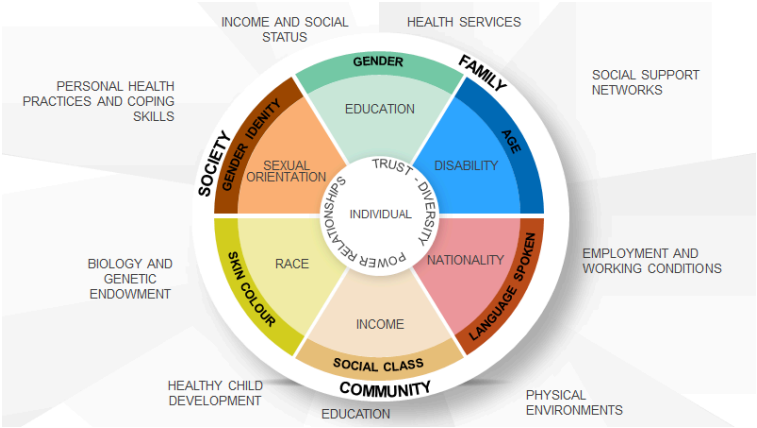
Cultural safety is practiced through cultural humility and the following occurs:

- Service providers become curious and reflective practitioners
- Listen to understand
- Practitioners reflect on their own biases and confront their prejudices
- Communicate in a respectful manner that recognizes historical and systematic (organizational/societal) oppression
- Create an equal partnership between those who are communicating with each other
- Create a trusting environment

Practicing cultural safety ensures that health care staff (all service providers) are respectful of nationality, culture, age, sex, sexuality, political and religious beliefs, and the position of their clients. Awareness of these intersecting systems has the potential (consciously or unconsciously) to influence the power balance between clinicians (service providers) and patients (recipients of care), as well as between colleagues. In nursing, cultural safety is understood to mean there is no damage or harm by interactions between people, and that dignity and respect are maintained for all parties in an interaction (College of Registered Nurses of British Columbia [CRNBC], 2010). Creating a culturally safe environment requires practitioners to have cultural humility. It requires self-

reflection on personal oppression and privilege as well as identification of biases and to create respectful partnerships based on trust. It is about creating equity in partnerships that is consistent with the concept of social justice.

**Figure 6.3 – NEVR Relationship Violence Model**

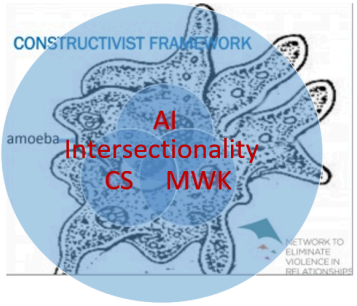



Using these overlapping frameworks, the high-risk societal conditions are targeted, and political and economic policies are introduced at the community level. We work with multiple stakeholders to address these societal conditions and reject the normalizing of relationship violence. Interventions are aimed at family, school, work, communities and society. Indeed, the benefit of viewing relationship violence from a socio-environment perspective is that it allows RV to be targeted at a family and community level, rather than an individual level. It allows for looking at circumstances and events rather than blaming individuals. The NEVR RV Model is used to understand the complex health global epidemic of RV. It shows that RV results from socio-environmental factors as well as individual choices. These choices are constrained by the individual's diversity and power within relationships and structures that operate within taken for granted practices. In this model, we are aware of these constraints so try to create equal power, engage in

a culturally safe manner to create trust. In order to collaborate and work with others, we add the change model of Appreciative Inquiry.

**Appreciative Inquiry (AI)** – Cooperrider & Srivastva (1987) describe Appreciative Inquiry (AI) as a process used to develop positive change in organizations. Additionally, AI is a form of action research that attempts to create new theories, ideas, and images that aid in the developmental change of a system. It is a strengths-based approach that allows for social change. Instead of viewing clients, families, and organizations as machines, it views them as organisms—that is, adaptive, and above all, interactive within themselves and with other organisms (systems). It is believed that they are all open systems. It overlaps with all the previous frameworks discussed for the concept of social construction is inherent in the philosophy of AI. "Reality" is created by those in the system; our ability to change is limited by collective will and imagination. To effect change from an AI perspective, it is imperative to be respectful of the experiences of the group members. AI does not view a problem as a problem, *per se*, and does not use a traditional problem-solving approach. Instead, it looks at the desire for something—it asks people to look into their past, locate how they felt, recall what they did when they experienced a positive state, and to amplify that in the present (Cooperrider & Srivastva, 1987). For RV, this means asking clients, stakeholders, and communities to focus on their feelings when they are in control, free of relationship violence, and healthy, and to ask them to identify what they need currently to have those feelings and make that change. In these cases, images and language must be used with intentionality and in programs on healthy relationships, parenting, employment skills, etc.

**Figure 6.4 – NEVR Collaboration and Action Framework**




At all meetings, the model on the left (**Figure 6.4**) is integrated by NEVR. In the constructivist framework, Cultural Safety (CS), appreciative inquiry (AI), Multiple ways of knowing (MWK) and Intersectionality theory interact and are constantly changing to address RV. We imagine NEVR similar to an amoeba system. Just like an amoeba changes its shape, so does NEVR because the committee is constantly evolving as it interacts with members (i.e., internal environment) and organizations/policies/law/allies (external environment). Each member has multiple roles and identities that interact to provide innovative perspectives and understanding (intersectionality). The committee values all members' ideas because it believes in multiple ways of knowing (MWK) creating equal power and trust which in turn results in cultural safety (CS). NEVR focuses on its mission (i.e., dream) of eliminating relationship violence and not on the statistics of today (AI). The facilitator ensures each individual at the meeting is respected and provided an equal opportunity to voice their opinion, and the decisions are made from an inclusion perspective. From the cultural safety perspective when working with survivors, one of the goals is to ensure no harm is done to the service provider, and their specific current situation and any historical oppression are considered. Although originally developed to work with individuals, cultural safety applies to groups, organizations, and communities. Emphasis is placed on the desires of the service provider, and where they are positioned in terms of family, workplace, and community roles and dynamics. Also, it is acknowledged that interactions are dynamic constantly change like the amoeba in the figure. It is recommended that this approach be carried out in all collaborations between individuals

and organizations and when working with survivors and perpetrators.

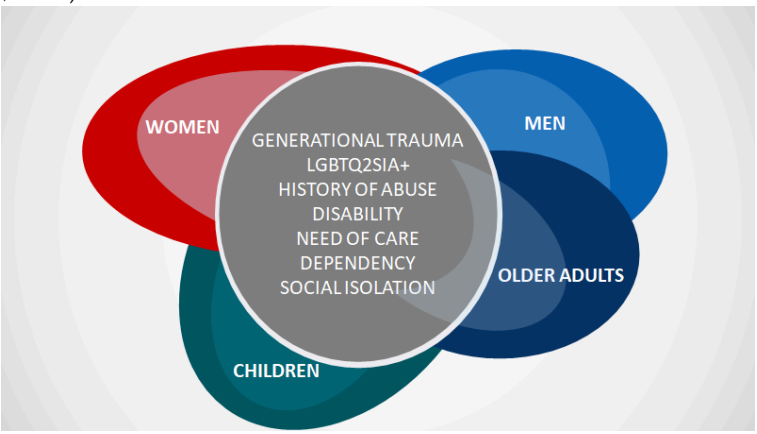
## Risk Factors for RV

The world is becoming smaller and knowledge is shared freely through the internet. We know that relationship violence occurs from conception to death and impacts all genders with a consensus that some groups are at greater risk than others. Identifying risk factors allows for the development of appropriate services and programs in order to safely plan programs to prevent abuse. Risk factors are a combination of environmental and social conditions and individual's biology/genetics).

In our literature review of Canadian studies, certain populations are identified as more vulnerable than the general population to RV; for instance, Indigenous, Northern and Remote Communities, children, older women, LGBQT2SIA+, immigrants and refugees, those who live with an impairment or disability (Jeffrey et al., 2018), low socioeconomic status (SES), low education, dependency, low control, oppression, witnessed abuse, suffered abuse or maltreatment (CDC, 2019). As well, the most severe form of RV like death is 4.5 times higher among women versus men. In addition, children considered one of the most vulnerable groups, face an extremely high risk of death, for they may be killed in a variety of situations including revenge or crossfire (Jeffrey et al., 2018). Although some groups might show higher risk depending on social situations, there is a great overlap in risk factors between groups. While much of the literature and our later chapters focus on each group across the lifespan separately, in this chapter we focus on bringing together the risks and successful initiatives and apply an integrative model. See chapter 15 for details about RV against women, chapter 16 for children, chapter 17 older adults, chapter 18 for men, chapter 19 for Indigenous populations, chapter 20 for

LGBQT2SIA+, chapter 21 for immigrants and refugees, and chapter 22 for workplace violence.

**Figure 6.5 – Common Risk Factors of RV among Children, Women, Men and Older Adults** (CDC, 2014; Renzetti, 1992; Stith et al., 2004)




We know that for all age groups the risk factors for being abused are disability (cognitive or physical impairment), LGBQT2SIA+ groups, need of care, dependency, social isolation (CDC, 2014) and intergenerational trauma (Franco, 2020; Stith et al., 2004). Notice there are overlapping risk factors across groups. Substance use, dependency, intergenerational trauma, relationship satisfaction (Renzetti, 1992; Stith et al., 2004) jealousy, anger, and/or control (Graham-Kevan & Archer, 2005) are risk factors for all adults (men, women, older adults). For example, young age is a risk factor for women and men and some authors believe abuse peaks at adolescents (Kim et al., 2008; Nocentini et al., 2010). Table 6.1 is created from available data on risk factors for different groups.

**Table 6.1 – Comparison of RV Risk Factors among Groups** (Derived from: CDC, 2014; Graham-Kevan & Archer, 2005; Kim et al., 2008; Nocentini et al., 2010; Renzetti, 1992; Stith et al., 2004)

| Cohort | Young Age | Low Level of Education | Low Income | Low Social Status | Substance use | Indigenous |
|---|---|---|---|---|---|---|
| Children & Youth | peaks at adolescents | inconsistent data | √ | √ | | √ |
| Women | √ | √ | √ | √ | √ | √ |
| Men | √ | √ | √ | inconsistent data | √ | |
| Older Adults | not applicable | | | √ | √ | |

| Cohort | Need of support | Control | High level of financial dependency | Lack of social support | Lack of formal support | History of violence in the family | Anger & hostility |
|---|---|---|---|---|---|---|---|
| Children & Youth | √ | | | | √ | √ | √ |
| Women | √ | √ | √ | √ | √ | √ | √ |
| Men | | √ | | | | √ | |
| Older Adults | √ | √ | √ | √ | √ | | √ |

Besides risk factors for victims/targets, there are risk factors for perpetrators to commit relationship violence. There are a number of already tested tools that are used to assess the risk to become an offender of RV. See chapter 13 on measurement tools to assess risk. The general risk factors for perpetration of RV that we can find data on are listed below in table 6.2 (CDC, 2020a; CDC, 2020b, CDC, 2020c).

**Table 6.2 – Relationship Violence Risk of Perpetration across Groups** (Derived from CDC, 2020a, b, and c)

| | Adult Against Children | Children Against Children | Adult Partners | Against Older Adults |
|---|---|---|---|---|
| Parents lack understanding of children's needs | x | | | |
| Experiencing or having poor parenting skills | x | | x | |
| Substance abuse | x | x | x | x |
| Mental health issues | x | x | x | x |
| Young age | x | | x | |
| Single parenthood | x | | | |
| Large number of dependent children | x | | | |
| Nonbiological parent | x | | | |

| | Adult Against Children | Children Against Children | Adult Partners | Against Older Adults |
|---|---|---|---|---|
| Emotions & views that justify maltreatment behaviours | x | | x | x |
| Low income | x | x | x | |
| Low education | x | x | x | |
| Exposure to abuse early in life | x | x | x | x |
| Attention deficits and learning disorders | | x | | |
| Low IQ | | x | x | |
| Inadequate coping skills | | x | x | |
| Deficits in social cognitive or information-processing | | x | | |

| | Adult Against Children | Children Against Children | Adult Partners | Against Older Adults |
|---|---|---|---|---|
| | | x | x | x |
| Low self-esteem | | | x | |
| Lack of healthy social problem social skills | | x | x | |
| History of experiencing physical discipline as a child | | x | x | |
| Financial dependency | | | x | x |
| Weak social policies | | | x | |
| Few friends & isolation | | x | x | x |
| Unemployment | | | x | |

| | Adult Against Children | Children Against Children | Adult Partners | Against Older Adults |
|---|---|---|---|---|
| Strict views about gender roles | | | x | |
| Desire of power and control | | | x | |
| Conflicts in the family | | x | x | |
| Unplanned pregnancy | | | x | |
| Poor caregiving training | | | | x |
| Lack of social support | | | | x |
| Lack of formal support | | x | | x |
| Emotional dependency | | | x | x |

| | Adult Against Children | Children Against Children | Adult Partners | Against Older Adults |
|---|---|---|---|---|
| Inadequate coping skills | | x | x | x |
| Poor and negative interactions | | x | x | |
| Community violence | x | x | | |
| Authoritarian child-rearing attitudes | | x | | |
| Inconsistent disciplinary practices | | x | | |
| Low parental involvement & monitoring of children | | x | | |
| Low emotional attachment | | x | | |
| Poor family functioning | x | x | x | |

| | Adult Against Children | Children Against Children | Adult Partners | Against Older Adults |
|---|---|---|---|---|
| Association with antisocial or aggressive peers | | x | x | |
| Involvement with gangs | | x | | |
| Social rejection by peers | | x | | |
| Lack of involvement in conventional activities | | x | | |
| Poor academic performance & School failure | | x | x | |
| Jealousy & possessiveness | | | x | |
| Poverty | | x | x | |
| Cultural norms that support aggression | | | x | |

| | Adult Against Children | Children Against Children | Adult Partners | Against Older Adults |
|---|---|---|---|---|
| Low level of community participation | | x | x | x |
| Socially disorganized neighbourhoods | | x | x | |
| Economic stress in the family | | x | x | |
| Lack of economic opportunities | | x | | |
| Hostility towards women | | | x | |
| Income inequality | | | x | |
| Assuming care-giving responsibilities at early age | x | | x | x |
| Family disruption | x | x | x | |

Several overlapping frameworks that help address RV have been outlined as part of the NEVR model. Also the risk factors that are common between groups identified. It is important to note that risk factors are just that, they are not causal.

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# Chapter 7: Actions and Prevention of RV

**BALBIR GURM**

*Key Messages*

- Although the total cost of relationship violence is difficult to estimate, the yearly cost of domestic violence and child abuse has been estimated as about $15 billion annually for adults and $23 billion for children in Canada.
- A significant way to address this cost is through investments in primary prevention initiatives, including strengthening strategies to prevent childhood exposure to RV, improving young people's relationship skills, supporting the development of healthy community norms and non-violent environments. On a more macro level, this includes prevention measures in legislation and policy and comprehensive data collection/monitoring systems.
- Action must be evidence-based and the evidence can come from multiple ways of knowing and developed collaboratively from multiple lenses.
- BC models that have had some success are the BC ICAT Model that brings together experts to address high risk clients and the DVU model that houses

social workers and support workers with police.

- There are a number of toolkits available to support an evidence-informed response to preventing RV, including The Early Childhood Exposure to Domestic Violence, the Community Champions Toolkit, and a Toolkit for Health Professionals. As well, several screening tools can be found on the NEVR website.
- A range of recommended resources can be found below including links to National Collaborating Centres created by the Public Health Agency of Canada.

Relationship violence is any form of physical, emotional, spiritual and financial abuse, negative social control or coercion that is suffered by anyone that has a bond or relationship with the offender. In the literature, we find words such as intimate partner violence (IPV), neglect, dating violence, family violence, battery, child neglect, child abuse, bullying, seniors or elder abuse, male violence, stalking, cyberbullying, strangulation, technology-facilitated coercive control, honour killing, female genital mutilation gang violence and workplace violence. In couples, violence can be perpetrated by women and men in opposite-sex relationships (Carney et al., 2007), within same-sex relationships (Rollè et al., 2018) and in relationships where the victim is LGBTQ2SAI+ (lesbian, gay, bisexual, transgender, queer, Two-Spirit, intersex and asexual plus ) (The Scottish Trans Alliance, 2010; Rollè, 2018). Relationship violence is a result of multiple impacts such as taken for granted inequalities, policies and practices that accept sexism, racism, ageism, xenophobia and homophobia. It can span the entire age spectrum. It may start in-utero and end with death.

Models and risk factors were presented in chapter 6. This chapter focuses on initiatives to prevent all types of RV.

# Actions

Although the total cost of relationship violence is difficult to estimate, the yearly cost of domestic violence and child abuse has been estimated as about $15 billion annually for adults (Neilson, 2013) and $23 billion for children in Canada (Prince Albert Daily Herald, 2018). Many children and adults suffer long-term health and social issues that could be avoided. Watch this video on the neurological impact of trauma (Ference, 2018). A significant way to address this is through primary prevention. Since doing this work over the last three decades, we have learned that there will never be enough resources to address all the abuse that occurs promptly. However, primary prevention addressing factors that increase resiliency and prevent relationship violence from occurring in the first place might be helpful.

Healthy relationships are formed from conception to early adolescence. As well, societal attitudes about women's work, the role of women, ideas about power and control contribute to relationship violence. Unfortunately, women and young girls continue to be blamed for the violence by such statements as "don't wear short shorts" and "don't provoke men." This misogynistic language not only shows the prevalent rape culture rooted in society, but it indicates the need to provide awareness and literacy about normalized violent behaviours among individuals (Inside Southern, n.d.). It is time to change the culture from one that blames girls and women to one that addresses the root causes of societal attitudes of gender inequality and privilege.

It is also important to engage men because the majority of the offenders may be men (mixed results from studies). Watch this video that discusses the importance of involving men, especially for heterosexual couples in which the male is the offender. It is important to reach men through social marketing and encourage them to attend programs (Learning to End Abuse, 2017). Click here to read a Canadian paper on engaging men in RV (Wells et al., 2013).

We need programs that change societal attitudes and make community members resilient, starting from an early age. Also, we need a whole community approach based on our model (see chapter 6). According to Raphael (2016), the 16 social determinants for Canadian society are:

1. Aboriginal Status
2. Early Childhood Development
3. Education
4. Employment and Working Conditions
5. Food Insecurity
6. Gender
7. Health Care Services
8. Housing
9. Income and its Distribution
10. Social Exclusion
11. Social Safety net
12. Unemployment and Job Security
13. Disability (Ability)
14. Geography
15. Immigrant status
16. Race

The literature is in silos but we think that actions conceived for domestic violence can be carefully adapted to address all sexual and gender diverse groups dyad or group relationships.

Wells et al. (2012) in *How Public Policy and Legislation Can Support the Prevention of Domestic Violence in Alberta* made six recommendations, see below. We believe that further additions can be made to these recommendations, our additions are in brackets. The full report can be accessed here.

1. Strengthen strategies to prevent childhood exposure to violence in the home (p. 9-13)

- Prohibit corporal punishment

- Prevent unplanned and teenage pregnancy
- Improve the parenting skills of at-risk parents (all parents)
- (Implement nurse-family partnership program at conception)

2. Improve young people's healthy relationship skills (p. 17-21)

- Introduce mandatory evidence-based anti-bullying and healthy relationships programming in all (pre-schools, schools, including post-secondary)
- Introduce trauma-informed/trauma-sensitive practices and principles into mental health, health, education and child welfare systems

3. Support the development of healthy community norms (p. 24-28)

- Engage men and boys in violence prevention
- Support immigrant, refugee and temporary foreign workers to enhance healthy family and community norms.
- Normalize equity in decision making for all family members

4. Support healthy, non-violent environments (p. 31-34)

- Foster healthy, non-violent workplaces
- Limit access to alcohol to reduce rates of violence
- Limit access to drugs

5. Include prevention measures in legislation and policy (p. 36-38)

- Include primary prevention in domestic violence-related legislation and policy frameworks
- Expand the definition of family violence in legislation to include dating relationships, as well as emotional and financial abuse. Instead, use NEVR's definition of relationship violence

6. Establish a comprehensive system for collecting data and monitoring domestic violence (p. 39-42)

- Develop a robust data collection system to more accurately track the prevalence of domestic violence (relationship violence)
- Develop an integrated and outcomes-based management and accountability framework that supports research, evaluation and continuous improvement
- Introduce social auditing to assess cultural safety in all organizations (Wells et al., 2013)

7. Apply social justice lens to all legislation and policy.

Action must be evidence-based and the evidence can come from multiple ways of knowing and developed collaboratively from multiple lenses. We suggest the following broad actions that are consistent with our model.

1. Approach RV as a pandemic issue (similar to COVID-19)
2. Create a provincial plan to address RV using a multisectoral/multidisciplinary approach
3. Implement a healthy relationship campaign
4. Implement cultural safety in all interactions and structures and use social auditing to measure success
5. Create hubs of (academics/service providers and community members) to formulate local policies and

actions

6. Utilize post-secondary faculty and students to create toolkits or synthesize literature (empirical knowing)
7. Provide training using interactive learning methods that address the knowing, being and doing (brain, hands, heart) for long-term retention
8. Implement programs to increase resilience across the lifespan (ie nurse-family partnership program, healthy relationships, mindfulness-based courses, and other successful courses/programs)
9. Implement health hubs (registered nurse, social worker, psychologist) in schools/workplaces/ community centres) to screen and provide knowledge and information across the life span
10. Provide person-centred services (i.e., counselling, employment training) and housing for all experiencing RV
11. Provide adequate resources and structures for the work required
12. Evaluate and share programs, so they can be adapted to specific context by others
13. Engage the community in learning and addressing RV
14. Build on successes

This approach includes integrating cultural safety into all interactions and organizational structures in order to create equity as well as building on successes. It requires organizations to practice the Human Rights Act and the Human Rights Code of their province.

Rothman et al. (2003) identified 74 international domestic violence intervention programs through snowball sampling. They reviewed various components such as definition, staff training effect on staff and effectiveness. Read the full report here. An excellent website for policy actions for sexualized violence can be accessed here.

## Multi-Agency Approach

There is some evidence for actions for a multi-agency approach, screening and school programs.More program evidence can be found in chapters dealing with specific populations.

Benefits for clients for multi-agency working together were **improved access to services, through speedier and more appropriate referral, and a greater focus on prevention and early intervention** and a holistic approach (Atkinson et al., 2007). It is also the most effective and efficient (NICE, 2018). There was also support for conferences that bring the whole sector together to learn together (Cleaver et al., 2019). In BC, NEVR has some success with two models, see chapter 3.

1. The BC ICAT model brings together service providers from various sectors such as police, victim services, probation, Ministry of Children and Family Development (MCFD), transition houses and others to share information, identify risks and create safety plans for specific high-risk domestic violence cases. ICATs do not involve physically co-locating partners but instead brings a team of subject matter experts together as and when required. ICATs do not involve physically co-locating partners but instead bring a team of subject matter experts together as and when required.(EVABC, 2015).

2. The Domestic Violence Unit (DVU) model brings together social workers and support workers together with police to address high risk offenders.

In the United Kingdom, the MARAC model is the collaboration model being used (Robinson, 2013). Some challenges noted with this multi-agency model that need to be considered are the unclear roles and responsibilities, competing priorities, communication, professional and agency culture and management, including professional silos and hierarchies, and lack of training across the workforce (Atkinson et al., 2001, 2002, 2005; Cleaver et al., 2019; Gasper, 2010; Laming, 2009; O'Carroll et al., 2016; Secker & Hill, 2001; Stevens, 2013; ). Another challenge is that it has changed

the culture of work from a feminist framework (power & control analysis) to that of judicial processes and bureaucratic political processes. It has resulted in dominance by the government sector over non-profit serving agencies (Harvie & Manzie, 2011). Governments control funding to non-profit organizations, and it is often men that create laws that further oppress women and the non-profit sector (Harvie & Manzie, 2011). This is consistent with what we hear from NEVR members. They would like to see a multi-agency approach, but with long-term funding, so that they can participate equally without having to worry about funding and spending hours writing grant proposals.

## Screening Tools

Early identification of issues allows for more opportunities to address them. With this thought, NEVR created a screening tool for health professionals. Here is a slide presentation that shows why **screening** for RV is absolutely necessary and how to assess in emergency rooms, dental offices and physicians' offices (FVPF, n.d.). Here are guidelines developed for registered nurses in Ontario that can be adapted by healthcare systems for use with all genders. Although a little bit old, 2012, it is still applicable today minus some resources that are only applicable to Ontario (RNAO, n.d.). This article in the American Family Physician journal recommends screening and provides some toolkits for screening (Dicola & Spaar, 2016).

School-based programs can be effective but NEVR members representing teachers state they are asked to take on too many social issues and there is no time for different programs. Therefore, we recommend that the teachers offer mindfulness over other programs since a meta-analysis found that these interventions decrease stress and anxiety (Dunning et al., 2018), so mindfulness may assist with improving the overall resilience of children.

## Integrated Prevention Interventions

We need to address relationship violence by addressing multiple factors. The lessons for British Columbia are that we need to be aware of what works, adapt it to our context, consistently evaluate outcomes and work toward eliminating the challenges of intersectoral work. We need to focus on integrated prevention interventions that start at conception right through to death.

The following are based on many years of our own work with the service providers in BC:

a) Increase offender accountability by establishing programs and paths that must be taken to change offender behaviour

b) Use cultural safety and intersectionality approaches in all programs and by all service providers in education, health and in the justice system

c) Require collaboration and integration of services across all agencies

d) Develop a National Plan with the integration of provincial and local services in order to avoid duplication and increase efficiency

e) Require evaluation of all government-funded programs and open access to programs and evaluations through a central website

f) Implement a national media strategy to normalize gender/race equality and equitable decision making

g) Require all health care provider and teacher training to include relationship violence screening

h) Require all primary health care providers to screen for relationship violence

i) Improve housing services, so emergency shelters are available when needed

j) Develop a national help-line for relationship violence similar to 911 that is currently used for emergency services

k) Fund only evidence-based programs

l) Provide timely interpretation services by encouraging a larger bank of interpreters

m) Change the judicial system so that survivors are not re-victimized

n) Allow other models of reporting and reconciliation

o) Fund psychologists, counsellors and social workers to work with all family members who are impacted by relationship violence even if they do not press charges

p) Encourage organizations to link to this platform in order to create a useful living document that provides working knowledge.

**Table 7.1 – Programs in Canada**

| Agency | Program | St |
|---|---|---|
| Simon Fraser University | Children's Health Policy Centre at SFU | A St th co ca In Pa re H N H |
| NEVR – Network to Eliminate Relationship Violence | Community Champion | A in re E la ba is Y b th T |
| The Canadian Centre for Gender+Sexual Diversity | LGBTQ2S+ Intimate Partner Prevention Program workshop | It d |
| Western Centre for School Mental Health | Primary Prevention of Violence Against Women and Girls | T pr S pr |

| | | |
|---|---|---|
| Ending Violence Association of Canada | Ending Violence Association of Canada | A<br>fe<br>h<br>(E<br>C |
| McMaster University | EDUCATE – The Centre for Evidence-Based Orthopaedics | T<br>re<br>in |

In BC, we have the FREDA Centre for research on domestic violence against women and children (n.d.). Their report on prevention describes current practices in BC and it recommends prevention initiatives. A large scale study in the US, the Adverse Childhood Experiences Study (ACES) found that resilience against all childhood abuse and neglect and household dysfunction may just require one stable adult (Centers for Disease Control and Prevention [CDC], 2020). Engage with Dr. Nadine Burke Harris TED talk on ACES about outcomes of childhood trauma (Harris, 2014).

The development of a program whereby nurses are attached to schools to screen children is recommended. For children, nurses are a safe adult as there is no stigma attached to their role. Nurses would work with the same schools throughout so that a relationship can be established with the children, that way they can become a stable adult in a child's life.

As nurses screen and realize that assistance is needed, they could refer to other healthcare team members such as counsellors and or social workers that need to be attached to schools. We are aware that high schools have counsellors but they are usually not trained in counselling for mental health, they mostly advise on educational matters.

> Therefore, one of the most important recommendations is to add school nurses and counsellors to our schools.

Globally, there are a number of programs for children that show evidence to be effective including school-based programs. They cannot just be an hour or two long assemblies but need to be part of a comprehensive program. The parameters are outlined in *What works in prevention*. These programs can be duplicated/adapted around the province (Nation et al., 2003). As well, in Canada, we have a centre that addresses bullying and healthy relationship resources (toolkits, videos, books) that can be found here (PREVNet, n.d.).

Another promising practice is the emergence of Foundry Centres as one-stop shops for youth ages 12-24. Foundry is a province-wide initiative supported by the Government of British Columbia, Graham Boeckh Foundation, Michael Smith Foundation for Health Research, Providence Health Care and St. Paul's Foundation.

There are eight Foundry Centres in British Columbia, with 11 more on the way, each providing unique resources for young people, and their families and caregivers to learn more about health and wellness. They can also access tools to manage and prevent challenges from getting in the way of their daily life. Through a team of healthcare professionals, counsellors, social workers and peer supporters, Foundry works with young people to match the support they receive to their need, whether it is for their mental or physical health, a substance use concern, or help to look for a job.

Working with over 140 partners from across British Columbia, Foundry Centres are operated locally by community organizations and are designed by young people for young people. Foundry's vision is to provide inclusive and easily accessible services for young people, their families and caregivers by simply coming through the doors of a Foundry Centre, or by exploring their services online.

While centres such as Foundry are a good first step, supports need to wrap around young people. Students need to be screened in schools and referrals made using a well-documented tool such as the ACES questionnaire (NCJFCJ, n.d.). The higher the score, the greater the risk for substance abuse, obesity, mental health issues, missed workdays, heart disease, cancer, stroke, COPD and broken bones. Since the estimated cost of childhood abuse is almost $6 billion in Canada, we cannot afford not to act.

## Pregnancy

Violence can start or be exacerbated during pregnancy. A place to begin prevention is at the time of conception. Programs for women at risk of abuse are essential. As well, interventions are necessary during the life span. In order to identify women at risk, it is key for healthcare providers to create an environment of trust and confidentiality with their patients. Tools for risk assessment are less important than creating a culturally safe environment. A health practitioner simply needs to screen and refer. Dr. Elaine Alpert, Director of Interpersonal Violence Programs, UBC states all family physicians have a responsibility to address relationship violence with their patients. They can simply use RADAR to remember.

R: Remember to ask
A: Ask directly
D: Document findings
A: Assess for safety
R: Review options, refer
F: Follow up

Dr. Alpert's full presentation is available.

## Other Resources and Programs

Trauma is experienced by individuals and by communities, affecting health and economics. The Prevention Institute (n.d.) provides a framework for protecting against community trauma that includes the need to "improve community health and wellness and resist the pressures of gentrification and dislocation**"** (p. 7) by providing education and access for all people. For details, read the complete report summary.

Knowing about successful programs is useful, and evaluations are a great way to check if a program brings positive, negative or even no results to the community to which it has been applied. Among many programs, we bring an overview of four programs assessed, two in Canada and two in the United States. You can see the results in the link program evaluation full report. Three (Fourth R, Safe Dates and Youth Relationships) of the four programs were successful in decreasing physical dating violence. "All three significantly reduced physical violence, while Safe Dates also significantly reduced sexual violence and emotional abuse. Only Ending Violence failed to reduce dating violence perpetration" (Children's Health Policy Centre (2013).

British Columbia government and a number of agencies have also created a toolkit for childhood exposure to relationship violence in the early years, 0-5. It covers statistics, legislation and reporting abuse and leaving an abusive relationship.

A number of toolkits have been created by NEVR for prevention. Using the whole community response model, the Community Champions Toolkit (NEVR, n.d.) provides statistics and explains the scope of the issue and how to identify, respond and get individuals to resources. This is a secondary prevention toolkit because you identify someone who is being abused and implement strategies for further prevention. The Network to Eliminate Violence in Relationships (NEVR) created a toolkit for health professionals

(Etheridge et al., 2014). As well, several screening tools can be found on the NEVR website.

NEVR has also created a theory based toolkit: Peer to Peer Manual: Healthy Relationships, Sexual Health, Drug Abuse, and Internet Safety (Sahota et al., n.d.). KPU nursing students worked with Safe Schools in Surrey staff Nancy Smith and KPU Nursing Faculty Balbir Gurm to create and test the toolkit. It was tested with the girls for ease of use and is currently being implemented in a Surrey School by leadership students. Evaluation data for long-term effectiveness is pending.

In addition, NEVR member Stroh Health Care in collaboration with the Ministry of Public Safety and Solicitor General and the Ministry of Education created resources called Respectful Futures based on the *Respectful Relationships program. It* is a BC Corrections, Ministry of Public Safety and Solicitor General program that has had success with male perpetrators of RV. Just like the Peer to Peer Manual above, the evaluation data is pending. They can be accessed at Respectful Futures (n.d.).

A network of NGOs, trade unions and independent experts have created a blueprint to create a national strategy (Canadian Network of Women's Shelters & Transition Houses, n.d.).

It is recommended that everyone advocate for a national plan and a national media prevention strategy.

**Table 7.2 – Governmental Relationship Violence Resources in Canada**

| Agency | Resources | Summary |
|---|---|---|
| Funded by Public Health Agency of Canada, located at McMaster University) | National Collaborating Centre for Tools and Methods | Health Evidence™ – It has systematic reviews on various health topics including RV across the lifespan.<br><br>Evidence-Informed Public Health – It has the best available evidence-based on research, context and experience to inform practice and policy. |
| Funded by the Public Health Agency of Canada, located at the University of Northern BC | National Collaborating Centre for Indigenous Health | It has the best available evidence for Indigenous health. It has many resources in print and multimedia formats. |
| Funded by the Public Health Agency of Canada | National Collaborating Centre for Determinants of Health | It has resources on promising practices for creating equity in health. It also has public health training for equitable systems change |
| Government of Canada | For help dealing with family violence | This site has how to recognize abuse, get help for others or yourself, and how to plan for safety and find services in your area (Government of Canada, 2014a). |
| Government of Canada | Family Violence Initiative | Defines family violence and provides statistics, impact and tools to address RV. Thirteen agencies/departments within the federal government work together on this initiative. It is a website with links to other websites. (Government of Canada, 2014b). |
| Government of Canada | Resources for professionals | Has several brochures in different types of violence (Government of Canada, 2018a). |
| Government of Canada | Promoting safe relationships | Information on effective programs (Government of Canada, 2017a). |
| Government of Canada | Funding opportunities | Current funding opportunities on RV (Government of Canada, 2018b). |

| | | |
|---|---|---|
| Government of Canada | What provinces and territories are doing | Plans that each province has for addressing RV Government of Canada, 2017b). |

**Table 7.3 – Resources to Address Relationship Violence outside Canada**

| | | |
|---|---|---|
| World Health Organization | School-Based Violence Prevention Program: A practical handbook | This handbook provides a step by step approach on whole school-based programs and identifies ways to address implementation barriers. |
| World Health Organization | INSPIRE: Seven Strategies for Ending Violence Against Children | Developed by the World Health Organization (WHO) with multiple other agencies using the best available evidence to address violence for 0-17. It outlines 7 strategies to prevent violence against children. |
| World Health Organization | INSPIRE Handbook Action | Developed by WHO (2016) for implementing the seven strategies for ending violence against children based on the best available evidence. |
| Hazelden Betty Ford Foundation | Safe Dates | A free program that prevents dating violence. This program is available in many states California, Minnesota, Oregon, Illinois, New York, Florida, Massachusetts, Colorado and Washington. |
| National Institute of Justice | Shifting Boundaries | A program designed for 10 to 15 years old to reduce dating violence and harassment. It is free of charge and has at least one random controlled trial that shows effectiveness. |

| | | |
|---|---|---|
| National Institute of Justice | Bringing in the Bystander | Aims at changing attitudes and having individuals. It is similar to Community Champion. |
| Committee for Children | Second Step Social-Emotional Learning | Social-emotional learning program for preschool to middle school with evidence to help create healthy relationships and successful students. It has a cost. It also has bullying prevention programs. |
| Coaching Boys into Men | Coaching Boys into Men | A free program that uses coaches to influence the thoughts and actions of young boys. |
| Prevention Innovations Research Center | UsafeUS | An app that can be used by the university so the students can have resources on their phones. |

| | | |
|---|---|---|
| Prevention Institute | The Adverse Community Experiences Framework | It provides an understanding of how structural and community violence that impacts relationship violence can be addressed. The symptoms of community trauma are present in the social, physical and economic environment and need to be addressed. In the socio-cultural domain, it builds on community assets and needs to create connections between youth and adults. This builds resilience and prevents relationship violence. In the physical/environment domain, there is a need to create positive spaces and transportation for community members to interact. |

## Indigenous People

One vulnerable group to experience RV is Indigenous peoples. As well as a National Collaborating Centre for Indigenous health, there is the National Aboriginal Circle Against Family Violence (see below). Governments are starting to address this population and a number of resources have been funded. You can read more about Indigenous populations and RV in chapter 19.

The National Aboriginal Circle Against Family Violence (Canada) has created a number of resources, find the link and description from their website:

**""**

**ANANGOSH: Legal Information Manual for Shelter Workers**

This manual is designed to help Indigenous women and service providers address key aspects of violence, as well as understand Indigenous women's legal rights on matters related to leaving a violent relationship. It discusses legal tools for women's safety and provides information about relevant legal protections. The manual begins with an explanation of the rights-based framework to addressing violence against Indigenous women, and of the historical and social context that impacts Indigenous women in Canada.

Click here to download

""

**Resources for Shelter Workers Providing Services to First Nations Women**

This document is intended for the use of shelter workers who provide services to First Nations women in Canada. The document details legal services, provincial/territorial government services, INAC regional branches, provincial/territorial Human Rights commissions, and general resources.

Click here to download

NACAFV - Best Practices

**Ending Violence In Aboriginal Communities: Best Practices In Aboriginal Shelters and Communities**

A summary report based on consultations with twelve on-reserve women's' shelters from across the country. In addition to best practices, the report also considers barriers and challenges, shelter profiles, observations and conclusions.

Click here to download

NACAFV - Funding Policy

**Addressing Funding Policy Issues: INAC Funded Women's Shelters**

A study that explores how funding flows to on-reserve women's shelters, and the challenge that directors and staff face in accessing all of the funding that is designated for the shelter.

Click here to download

NACAFV - MRP **Responses from Aboriginal Women in Seven INAC-Funded Shelters Regarding Matrimonial Real Property (MRP)**

Findings and recommendations on the complex issue of the equitable division of Matrimonial Real Property (MRP) during a marital break-up, based on consultations with 42 participants (staff and clients) from 7 INAC funded women's shelters.

Click here to download

NACAFV - Policies and Procedures **Policies and Procedures – Guidelines for Shelters**

A reference guide to assist shelters to develop a Policies and Procedures Manual to facilitate the development, design, planning and delivery of services to women and their families. Includes examples and suggestions for operations policy, human resources, financial procedures, safety issues and other issues that might be faced in the work environment.

Click here to download

**NACAFV - Financial Skills 100** **Financial Skills and Literacy (Draft)**

A draft workbook designed to assist Aboriginal women in shelters to learn the tools they need to become financially self-sufficient. It approaches financial topics in a culturally appropriate manner, ranging from the very basics (e.g., opening a bank account, using a debit card) to budgeting and setting financial goals (*Note: Publication not available as a download. Please contact* NACAFV *to order a copy.*).

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# Chapter 8: Why Survivors Don't Report

BALBIR GURM AND JENNIFER MARCHBANK

*Key Messages*

- About 70% of domestic violence is never reported to the police. Even more alarming, only 5% of cases of sexual assault in BC are reported to the police.
- There are many reasons why survivors don't report, ranging from fear, to geographical location and access to services, to gender and age, to minority considerations, to name a few.
- This chapter provides information on an important aspect of relationship violence that is often not understood or misjudged by family and community, which is to identify some of the reasons why a survivor may not report the abuse/violence.
- The reasons why women or men stay in violent relationships are described, and the overlapping experiences are identified. These reasons underpin the need to make changes at individual, family, community and institutional levels in order to reduce and end violence in intimate relationships.
- There are many reasons for not reporting. It is time to switch the question from **why do victims not leave**

**to why do people abuse?** And **why does society continue to normalize and accept relationship violence?** Society still continues to blame the victim and question their behaviour.

Relationship violence is any form of physical, emotional, spiritual and financial abuse, negative social control or coercion that is suffered by anyone that has a bond or relationship with the offender. In the literature, we find words such as intimate partner violence (IPV), neglect, dating violence, family violence, battery, child neglect, child abuse, bullying, seniors or elder abuse, male violence, stalking, cyberbullying, strangulation, technology-facilitated coercive control, honour killing, female genital mutilation gang violence and workplace violence. In couples, violence can be perpetrated by women and men in opposite-sex relationships (Carney et al., 2007), within same-sex relationships (Rollè et al., 2018) and in relationships where the victim is LGBTQ2SAI+ (lesbian, gay, bisexual, transgender, queer, Two-Spirit, intersex and asexual plus (The Scottish Trans Alliance, 2010; Rollè et al., 2018). Relationship violence is a result of multiple impacts such as taken for granted inequalities, policies and practices that accept sexism, racism, ageism, xenophobia and homophobia. It can span the entire age spectrum. It may start in-utero and end with death. It is a global epidemic, but those impacted do not report the crime.

## Why do survivors not report?

There are many policies and legislation addressing RV, yet individuals are frequently hesitant to report it and to seek help.

Often society asks why partners do not leave abusive relationships, instead of asking why does the perpetrator abuse or why does society accepts relationship violence? Two major theories of help-seeking—survivor theory and process model—explain how survivors, for instance, cope when experiencing RV.

The **survivor theory** describes the ways in which survivors actively cope with RV. These include repeated attempts to access informal and formal resources like talking to a close friend or looking for a supportive agency (Gondolf & Fisher, 1988).

The **process model** describes the efforts of survivors to try to reduce or end the violence. It includes recognizing the problem and trying to find solutions to it. Once the problem is recognized, survivors often try strategies that they believe will help to end the violence (Campbell et al., 1998).

Although these theories show patterns and strategies used by survivors, it is not enough to expect that RV can be diminished or even eradicated without considering why people become offenders, and how and why society reinforces and accepts RV (see chapter 6). According to the British Columbia Legal Society, survivors' (women) help-seeking behaviours in heterosexual relationships involve concerns that include:

- Believe or hope that the abuse will end
- The "make-up" period after violence reassures them or strengthens their emotional bond with their partner
- Victims depend on their partner—to pay the bills, take care of them, or for other help
- Fear that their partner will become even more violent if they leave
- Fear for the safety of their children and other loved ones
- Fear that their children will be taken into government care
- Fear of losing their home

- Fear for the safety of their pets or farm animals
- Fear that no one will believe that the abuse happened
- They are isolated from their family and friends, and part of the abuse may have been to ensure their isolation
- They do not feel they have the support they need
- Fear of being deported or of losing their immigration status
- They do not know about their rights or the help that is available
- Fear of the legal system
- They feel pressure from their family or friends to stay
- They feel pressure or blame from their community
- They live in a rural area with few services and supports available
- They live in a small town where everyone knows everyone's business (Feindel & Roulette, 2010, p. 14)
- They do not want to bring shame to their families, they want to save face (Holmes & Hunt, 2017)

West Coast Leaf (2018) report We Are Here: Women's Experiences of the Barriers to Reporting Sexual Assault shows that only 5% of cases of sexual assault in BC are reported to the police by those who identify as women and that a lack of training of those in the justice system was a significant barrier to reporting. Prochuck (2018) acknowledges that "sexual assault is a form of gender-based violence that disproportionately harms not only women, but also Two-Spirit people, gender non-conforming people, trans people of all genders (not only women), intersex people, and people with non-binary gender identities" (p. 7).

The reasons for not reporting sexual assault are below (Prochuck, 2018).

- Consider the crime as minor and not worth reporting (71%)

- The incident was a private or personal matter and was handled informally (67%)
- Did not want the hassle of dealing with the police (45%)
- There was a lack of evidence (43%)
- Believe that the offender wouldn't be convicted or adequately punished (40%)
- Believe that the offender did not intend to cause harm (39%)
- Fear the court process or didn't want the hassle of going to court (34%)
- Did not want to get the offender in trouble (30%)
- Did not want others to know about the assault (30%)
- Believe that police wouldn't have been effective (26%)
- Fear retaliation by the offender (22%)
- Believed police wouldn't have located the offender (21%)
- Past experiences with police had been unsatisfactory (13%)
- Believe that police would be biased (13%)
- Felt that reporting would bring shame and dishonour to the family (12%)

There is an overlap between the reasons why women and men stay in abusive relationships. Below is a list of reasons why men stay :

- Fear that they would not be believed (Hines & Douglas, 2014; Demsey, 2013)
- Not knowing of any services that could help (Hines & Douglas, 2014; Demsey, 2013)
- Lack of accessible services to support abused men (Demsey, 2013)
- Embarrassment and fear of being disbelieved Demsey, 2013)
- Shame because the "public story" of domestic abuse

that only males perpetrate abuse that violate(s) the rules of hegemonic masculinity (Connell, 2005) It may be similar to LGBQT+ individuals
- Do not recognize it as abuse and normalize the behaviour (Demsey, 2013)

Below are the reasons why men stay from a booklet created by the Government of Alberta (n.d.). Whether or not there are children involved, a man may stay in an abusive situation because:

- He feels afraid or guilty
- He feels he is financially insecure
- He feels a sense of obligation to his female partner
- He wants to honour his religious convictions or cultural expectations
- His partner reminds him of religious convictions or cultural expectations
- He still has hope for the relationship
- He feels ashamed to admit he is being abused

A man with children may stay in the relationship because

- He doesn't want to lose access to his children
- He doesn't want to leave the children with his abusive partner
- He may not trust the courts to handle child custody fairly
- He doesn't want to be the one that "breaks up" the family

To learn more about the experience of men that are abused see chapter 18.

Burnes et al. (2019) estimated that only 15.4% of older adults report to police. Some of the reasons are:

- Fear of revictimization- the most prevalent reason

- Embarrassment
- Fear
- Denial
- Isolation
- Lack of resources
- Lack of knowledge about reporting procedures (Burnes et al., 2019)

To learn more about the older adult's experience of abuse, go to chapter 17.

Indigenous people do not report for many of the same reasons as others but also because of generational trauma and toxic stress. Some reasons why they do not access services are:

- Low awareness of them
- Their distance from the home community
- The lack of transportation
- Poor relationships with the police
- Lack of faith in the effectiveness of the resources
- Lack of privacy in communities and the consequent shame about accessing resources
- Complex relationships among the victim, the abuser, their families and other community members
- The desire to keep the family intact at all costs (because of fear of the unknown and of losing face, as well as the possibility of losing one's children, home and assets) (Public Health Agency of Canada, n.d.)

Learn more about the historical trauma of Indigenous populations and RV in chapter 19.

There are no statistics on why LGBTQ2SIA+ do not report but these are some of the reasons they do not access services:

- Not aware of services
- Judgement by service providers

- Non-inclusive language
- Fear of being outed
- Unsafe practices by agencies (Center for Research and Education on Violence Against Women and Children, 2015)

See chapter 20 for a fuller discussion of LGBTQ2SIA+ persons and RV.

Similarly, other minorities that also do not report in high numbers are refugees and immigrants. They have similar reasons to others, but some specific reasons are:

- Fear of deportation
- Lack of trust in the police
- Language challenges
- Not aware of services
- Not aware that it is a crime
- Accept it as normal

To learn more about the immigrant and refugee population, go to chapter 21.

There are many reasons for not reporting. It is time to switch the question from **why do victims not leave to why do people abuse?** And **why does society continue to normalize and accept relationship violence?** Society still continues to blame the victim and question their behaviour.

Vulnerable groups like children and older adults experience further challenges because they are often dependent on a family adult who might be perpetrating violence. Visible minority groups like Indigenous peoples, LGBTQ2SIA+ and those with disabilities face extra challenges seeking help, for violence and discrimination are widely accepted and propagated by individuals in society (Lee & Ostergard Jr, 2017). In addition, those already marginalized may have less access to computers, phones and even to being out of the home alone to seek out services and supports. This isolation

was exacerbated during the COVID-19 with the closure of schools, libraries, coffee shops and salons.

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# Chapter 9: Legislation and Policy

BALBIR GURM

*Key Messages*

- Internationally, the United Nations' Declaration on the Elimination of Violence Against Women serves as a guiding framework for countries that ratified this treaty.
- In Canada, the Department of Justice (2019) outlines the criminal code offences in Family Law related to relationship violence.
- Six provinces and three territories have passed their own legislation on family violence.
- In British Columbia, the Family Law Act (2011) covers all forms of abuse against a family member and protection orders.
    - Additionally, the Child, Family and Community Service Act (BC Government, 2017) requires child abuse—including a reason to believe a child is exposed to domestic violence – to be reported.
- The Violence Against Women in Relationships Policy (Government of British Columbia, 2010) is

another key source document that promotes an integrated response to this issue.

- Check out the Canadian Resource Centre for Victims of Crime (n.d.) for more information.

Relationship violence is any form of physical, emotional, spiritual and financial abuse, negative social control or coercion that is suffered by anyone that has a bond or relationship with the offender. In the literature, we find words such as intimate partner violence (IPV), neglect, dating violence, family violence, battery, child neglect, child abuse, bullying, seniors or elder abuse, male violence, stalking, cyberbullying, strangulation, technology-facilitated coercive control, honour killing, female genital mutilation gang violence and workplace violence. In couples, violence can be perpetrated by women and men in opposite-sex relationships (Carney et al., 2007), within same-sex relationships (Rollè et al., 2018) and in relationships where the victim is LGBTQ2SAI+ (lesbian, gay, bisexual, transgender, queer, Two-Spirit, intersex and asexual plus (The Scottish Trans Alliance, 2010; Rollè et al., 2018). Relationship violence is a result of multiple impacts such as taken for granted inequalities, policies and practices that accept sexism, racism, ageism, xenophobia and homophobia. It can span the entire age spectrum. It may start in-utero and end with death.

First and foremost, RV is a violation of the Human Rights Act. It is a criminal and ethical offence. In this chapter, we bring together links to statues and resources. There are national policies and international conventions, as well as legislation to charge perpetrators of relationship violence. You will find information regarding children and youth and adults. This section tries to bring together the legislation that impacts British Columbians.

## Policies and Resources

There are a number of resources for working with families. There are also principles that need to be followed laid out in The BC Handbook for Action on Child Abuse and Neglect for Service Providers (2017, p. 14-15). Some of them are described below.

- The safety and well-being of children are paramount considerations
- Children are entitled to be protected from abuse, neglect, harm or the threat of harm
- A family is a preferred environment for the care and upbringing of children, and the responsibility for the protection of children rests primarily with the parents
- If, with available support services, a family can provide a safe and nurturing environment for child support services should be provided
- The child's views should be taken into account when decisions relating to a child are made
- Kinship ties and a child's attachment to the extended family should be preserved, if possible
- The cultural identity of Indigenous children should be preserved
- Decisions relating to children should be made and implemented in a timely manner
    - Families and children should be informed of the services available to them and be encouraged to participate in decisions affecting them
    - Indigenous people should be involved in the planning and delivery of services to Aboriginal families and their children
    - Services should be planned and delivered in ways that are sensitive to the needs and the cultural, racial and religious heritage of those receiving the services

- Services should be integrated, wherever possible and appropriate, with services provided by government ministries, community agencies and Community Living British Columbia
- The community should be involved, wherever possible and appropriate, in the planning and delivery of services, including preventive and support services to families and children

Also, there is in Canada, the Canadian Resource Centre for Victims of Crime (n.d.) that has a number of publications for victims such as explaining restraining orders which is a helpful support to victims. To support the understanding of violence among children, Child Abuse, How to help Victims (2017) shows the history of Canadian laws on child abuse. In British Columbia, there are many policies like the Violence Against Women in Relationships Policy [VAWIR] (2010) introduced in 1993. The primary purpose of the VAWIR policy is to ensure an effective, integrated and coordinated justice and child welfare response to domestic violence. The goal is to support and protect those individuals at risk and facilitate offender management and accountability.

The Intimate Partner Violence Policy for Crown Counsel was updated in 2019. It discusses the processes for Crown Counsel from definitions of domestic violence, bail conditions and preparation for hearings.

Although many organizations have policies, and we have legislation, the policies are not enacted, they are in writing only. Sometimes, survivors are not believed; other times, they are intimidated, and at times, organizational management investigates its own employees and is biased by all things in society. It is such a complex issue, and the evidence required to prosecute needs to be meticulously gathered.

The Honourable retired Canadian Supreme Court Justice Donna Martinson and Professor Emerita and founder of the FREDA Institute Margaret Jackson wrote a report on the family law in

relationship violence cases that involves women and children. They highlight that judges also have their own biases and need to be aware of them in making decisions. Also, Martinson and Jackson (2019) state that women serving organizations need to be involved in the education of judges to strengthen their understanding of the complexities of relationship violence and how it shows up in the courthouse.

Furthermore, they both state decisions need to be made based on equity rights and go through how to order and make sense of parenting assessments, discuss that a child needs to be heard and explain how section 21 reports have not improved for there are no guidelines on what must be included in these reports and no stated qualifications for assessors. As well, assessors do not work from a trauma-informed culturally competent perspective. They argue that psychological tests are relied upon that have no predictive evidence. Also, many women do not report abuse in divorce cases because they fear they will be seen as ineffective parents. Martinson and Jackson go through all the conventions from the United Nations (UN) that impact family law as well as case law that impacts BC decisions (Martinson & Jackson, 2019). For details, read the full report.

## Legal Services

West Coast Leaf (2020) launched A toolkit for navigating section 276 and 278 Criminal Code matters as complainant counsel in criminal proceedings. Elba Bendo, Director of Law Reform at West Coast Leaf explains that best practice is to have specialized courts.

https://admin.video.ubc.ca/p/150/sp/15000/embedIframeJs/uiconf_id/23448622/partner_id/150?iframeembed=true&playerId=kaltura_player&entry_id=0_02c0rh1k&flashvars[streamerType]=auto&flashvars[localizationCode]=en_CA&flashvars[leadWithHTML5]=true&flashvars[sideBarContain

er.plugin]=true&flashvars[sideBarContainer.position]=left&flashvars[sideBarContainer.clickToClose]=true&flashvars[chapters.plugin]=true&flashvars[chapters.layout]=vertical&flashvars[chapters.thumbnailRotator]=false&flashvars[streamSelector.plugin]=true&flashvars[EmbedPlayer.SpinnerTarget]=videoHolder&flashvars[dualScreen.plugin]=true&flashvars[hotspots.plugin]=1&flashvars[Kaltura.addCrossOriginToIframe]=true&&wid=0_fvg8kcqu

The Legal Services Society has a number of easy to read publications for the public in plain language. Click here to access the list of publications. Survivors tell us that they are revictimized by the legal system. It is difficult to prosecute perpetrators. Survivors are only called as witnesses in these cases even though they are the targets of the assaults. Survivors need to repeat their stories a number of times, and they feel like they are on trial, and their integrity is being questioned. Jeeti Pooni, who was sexually assaulted as a young child who did not disclose until she was an adult with a couple of daughters of her own, discusses how she was disappointed with the court's disposition (ruling). Click here to read or listen to a CBC interview with Jeeti Pooni as she discusses her story

EVABC, a provincial funded organization also has developed Independent Legal Advice For Sexual Assault Survivors Training Pilot Project. Click here to access it.

## Criminal Code Offences

There are multiple criminal codes that the law relies upon, but the first and foremost for relationship violence is the Human Rights Act. Also, the Canada Department of Justice (2019) outlines the criminal code offences in Family Law that cover crimes related to physical and sexual abuse, psychological, emotional abuse, neglect and financial abuse, as well as administration of justice. See below:

Offences related to the use of physical and sexual violence such as:

- Assault causing bodily harm, with a weapon and aggravated assault (ss. 265–268)
- Kidnapping and forcible confinement (s. 279)
- Trafficking in persons (ss. 279.01)
- Abduction of a young person (ss. 280–283)
- Homicide, murder, attempted murder, infanticide and manslaughter (ss. 229–231 and 235)
- Sexual assault causing bodily harm, with a weapon and aggravated sexual assault (ss. 271–273)
- Sexual offences against children and youth (ss. 151, 152, 153, 155 and 170–172)
- Child pornography (s. 163.1)

Offences related to the administration of justice such as:

- Disobeying order of the court (s. 127)
- Failure to comply with the condition of undertaking (s.145(3))
- Failure to comply with probation order (s. 733.1)
- Breach of recognizance (peace bond) (s. 811)

Offences related to some forms of psychological or emotional abuse within the family that involve using words or actions to control, isolate, intimidate or dehumanize someone such as:

- Criminal harassment, sometimes called "stalking" (s. 264)
- Uttering threats (s. 264.1)
- Making indecent and harassing phone calls (s. 372)
- Trespassing at night (s. 177)
- Mischief (s. 430)

Offences related to neglect within the family such as:

- Failure to provide necessaries of life (s. 215)
- Abandoning child (ss. 218)
- Criminal negligence, including negligence causing bodily harm and death (ss. 219–221)

Offences related to financial abuse within the family such as:

- Theft (ss. 322, 328–330, 334)
- Theft by a person holding power of attorney (s. 331)
- Misappropriation of money held under direction (s. 332)
- Theft of, forgery of a credit card (s. 342)
- Extortion (s. 346)
- Forgery (s. 366)
- Fraud (s.380(1))

Protecting Canada's Seniors Act (2012) states the vulnerability of age and the financial situation needs to be considered in sentencing.

Six provinces and three territories have passed their own legislation on family violence. In BC, there is the Family Law Act (2011) that covers all forms of abuse against a family member and protection orders. The act covers child parenting arrangements, guardianship, family law dispute resolution and family justice counsellors. The Child, Family and Community Service Act (2017) requires that anyone who has reason to believe that a **child** (or youth) has been or is likely to be abused or **neglected** and that the parent is unwilling or unable to protect the **child** (or youth) must report the suspected **abuse** or **neglect** to a **child welfare** worker.

For more information see: https://www2.gov.bc.ca/gov/content/safety/public-safety/protecting-children/reporting-child-abuse

BC passed Bill 23: Sexual Violence and Misconduct Policy requiring all post-secondary institutions to have a policy on sexual misconduct and develop the complaint process and evaluate it on a three-year cycle.

## International Conventions

Canada is a signatory to multiple United Nations (UN) conventions on human rights and relationship violence. In 1993, the United Nations Assembly—of which Canada is a member state—first passed the Declaration on the Elimination of Violence Against Women (UN, 2009a).

Canada is a member of the Organization of American States that adopted the Inter-American Convention on the Prevention, Punishment, and Eradication of Violence Against Women (Department of International Law, 1994), which is considered the first treaty to outline women's rights against violence. The agreement states that women should be "free from every form of violence, including physical, sexual and psychological violence perpetrated by family members or intimate partners, members of the community or the state" (Organization of the Americas, 2013).

Also, the UN Assembly (2014) passed a resolution (18/147) Elimination of domestic violence against women (UN, 2015). It expanded the definition of domestic violence to include those related by blood and intimacy, and it included economic deprivation and isolation in its definition. The UN Assembly (2018) passed 73/148 Intensification of efforts to prevent and eliminate all forms of violence against women and girls: sexual harassment and resolutions like 64/137 (2010), 63/155 (2009), 62/133 (2008) and 61/143 (2006). A series of resolutions on the "Elimination of all forms of violence, including crimes against women" (59/167 (2005), 57/181 (2002), and 55/68 (2000); and "in-depth study of all forms of violence against women resolutions" (60/136 (2006) and 58/185 (2004). (UN 2019, 2010a, 2009b, 2008, 2006a, 2005, 2006b, 2004).

As well, there are a series of resolutions The UN Human Rights Council (HRC) has passed and several resolutions are on eliminating discrimination and violence against women, 14/12 (UN, 2010), 15/23 (UN, 2010b), 12/17 (UN, 2009c), 11/2 (UN, 2009d), 7/24 (UN 2008b),

and many others. The United Nations resolutions and reports on RV against women can be found at UN Women website.

There are several resolutions on the Rights of the Child (UN, 2017) and the social policy paper working paper no. 16 on Rights of the Older Person (UN, 2012). In 2011a, an open-ended working group on the rights of the older person established to continue to evaluate the rights of the older person framework and identify and address gaps. Reports and resolutions on the older person can be found at the UN department of economics and social affairs (UN, 2011b). In 2019, the International Labour Council passed a convention on Violence and Harassment, and an accompanying non-binding recommendation that provides guidance on the convention's obligations. Canada has not ratified the treaty that would require it to create national laws, prevention measures, information campaigns and workplace violence prevention policies.

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# Chapter 10: Navigating the System: Getting Help

BALBIR GURM

*Key Messages*

- RV is grossly underreported to police. In fact, in Canada only approximately 17% of cases are reported.
- The greatest form of "non-emergency" assistance to RV is disclosures to family or friends. Frequently, a friend or family member or even the survivor may not identify the situation as a case of relationship violence (intimate partner violence, elder abuse, child abuse and neglect, etc.). Therefore, it is imperative that everyone become a community champion and know how to identify and support someone who is experiencing RV. A range of resources, below, can help you become familiar with key resources and what to do if you're in a position of receiving a disclosure.
- For immediate assistance, call 911. If a survivor is in need of medical attention and does not want to involve the police, they can access the Surrey Mobile Assault Response Team (SMART) in the Fraser Health region (Surrey Women's Centre, 2019) to get assistance getting to the hospital. The SMART

program partners with VictimLinkBC, and it can be accessed 24 hours per day, 7 days per week.

- RV is a complex issue, and different professions hold different pieces to the same puzzle – emphasizing the critical need that organizations work in harmony to support those impacted by RV, so that progression through "the system" does not further traumatize those involved. Learn more about how these professionals work to address RV below.

Relationship violence is any form of physical, emotional, spiritual and financial abuse, negative social control or coercion that is suffered by anyone that has a bond or relationship with the offender. In the literature, we find words such as intimate partner violence (IPV), neglect, dating violence, family violence, battery, child neglect, child abuse, bullying, seniors or elder abuse, male violence, stalking, cyberbullying, strangulation, technology-facilitated coercive control, honour killing, female genital mutilation gang violence and workplace violence. In couples, violence can be perpetrated by women and men in opposite-sex relationships (Carney et al., 2007), within same-sex relationships (Rollè et al., 2018) and in relationships where the victim is LGBTQ2SIA+ (lesbian, gay, bisexual, transgender, queer, Two-Spirit, intersex and asexual plus (The Scottish Trans Alliance, 2010; Rollè et al., 2018). Relationship violence is a result of multiple impacts such as taken for granted inequalities, policies and practices that accept sexism, racism, ageism, xenophobia and homophobia. It can span the entire age spectrum. It may start in-utero and end with death.

# Getting Help

## Non-emergency Assistance

It is known that most relationship violence is not reported to the police. Estimates indicate that in Canada, only 17% of RV is reported and most often (these statistics vary depending on the source) if a person tells they tell a friend or family member. Frequently, a friend, family member or even the survivor may not identify the situation as a case of relationship violence (intimate partner violence, elder abuse, child abuse and neglect, etc.). Therefore, it is imperative that everyone become a community champion. We encourage you to download the toolkit and learn how to recognize relationship violence or abuse and respond to the survivor, providing them with resources and safety when needed. You may also visit the Government of Canada website (2019) or the Centers for Disease Control and Prevention (CDC, 2018) website to read publications related to this topic.

To learn about types of abuse, consequences and actions, please click here (CDC, 2018). This video is about domestic violence, but it is applicable to relationship violence in general. Be informed, relationship violence impacts many people and you can help. It is crucial that you are able to support a friend or family member and get them to safety. If you are not aware of the services in your area, you can go to VictimLinkBC (2019) website or email VictimLinkBC@bc211.ca and locate services within British Columbia. You can also call VictimLink at 1-800-563-0808 24 hours a day, 7 days a week. These resources offer free information in over 100 languages. They can help you access victim service workers who can advocate and give you support to access a safe house, as well as a number of other resources.

Outside of BC, but within Canada, you can access the Government

of Canada (2019) website and locate resources in your province. When survivors are assaulted, they have a choice to make. They need to think if they will stay in a violent situation, call the non-emergency line or call the emergency line. While supporting the survivor, if the survivor chooses to stay and/or decide to call the non-emergency line (1-800-563-0808 in British Columbia), it is important to support their decision unless there is imminent harm or emergency care is required. Many survivors state they feel re-assaulted within the system, so please make sure you allow the survivor to make the decision and ensure that you remind them that relationship violence is not their fault. There are a number of agencies and services that can provide support. Click here for the types of support available (Government of Canada, 2019). While accessing support services, the following workers may be involved in providing help: victim support worker, doctor, nurse or counsellor, depending on the choices the survivor makes. The roles of workers in the system are explained further down.

Adult survivors can flee to shelter and or obtain counselling and other services even if they do not call the police. For a directory of services specific to relationship violence, click here (NEVR, 2019). For shelters/transition homes in BC, click here (BC Housing, n.d.).

Perpetrators, on the other hand, have very few counselling/programming choices unless they are prosecuted and found guilty. One program that male perpetrators can self refer to is the Options Community Services called Caring Dads. Program manager, Harpal Johl states: "This service works well for clients. In my many years of running the relationship violence program, I did not see as much buy-in from male offenders as I do with this program. I think it may be because we focus on the impact on children in program delivery". There are few BC services for male survivors of relationship abuse and only one specific society for male survivors of sexual abuse, BC Society for Male Survivors of Sexual Abuse (2020). Click here to access their website. There is another website out of California, the USA that has an excellent guide for male survivors, click here (Help Guide, n.d.). Male survivors can access

the services originally set up for female survivors of relationship violence such as those at Surrey Women's Centre (2019).

For those who do not leave the abusive relationship, it is still very important that they create a safety plan. This can be done with a friend/family member or with a  services support worker. Review the elements of a safety plan in the Community Champion toolkit (NEVR, 2019) or read  Creating a Safety Plan booklet (Government of British Columbia, 2015). To listen to a video on safety planning, click here (Learning to End Abuse, 2017a).

## Emergency Assistance

For immediate assistance, call 911. If a survivor is in need of medical attention and does not want to involve the police, they can access the Surrey Mobile Assault Response Team (SMART) in the Fraser Health region (Surrey Women's Centre, 2019) to get assistance getting to the hospital. The SMART program partners with VictimLinkBC, and it can be accessed 24 hours per day, 7 days per week. A service support worker can be reached by calling 604-583-1295. The SMART van comes to the site and provides accompaniment to the hospital after a stated sexual assault. The support worker can help the survivor access services and provide support. If the survivor wishes, the support worker will accompany law enforcement as well. Forensic nurses can collect evidence in the emergency department, in case the survivor wants to report to the police at a later time and date.

**Smart Van**

Emergency Outreach Van | Surrey Women's Centre

"Nine-one-one (911) what is your emergency" can be heard in Canada. It is the number to call for immediate assistance. The first point of contact is the emergency services dispatcher. Below is a description of a 911 call to provide information on the process if you choose to call 911.

## 911 Case Study

Please be aware that the following case study includes details of a violent act and reader discretion is advised.

The 911 dispatcher asked the caller to describe the situation. It was a child stating: – My daddy is trying to stab my mommy. There was a history of calls for domestic violence from this number in the past. The operator obtained the address from the child. Having determined it was an assault in progress, the 911 operator dispatched the police to the home. When police responded to this 911 call regarding a serious assault, they were told the dispute was between a male and a female. The male had a knife, and they were on the street. Upon arrival, the police found several neighbours on the street watching the dispute. They located a woman lying on the ground, and she was bleeding profusely from a wound to her abdomen. Standing over top of the injured woman was a male person, and he was in possession of a machete type knife. The knife was covered in blood, and there was a pool of blood on the ground where the woman was lying. The male was screaming at the woman as she lay partially conscious. Also, standing near the couple was a 12-year-old girl, and she was crying and very distraught. The male and female were married a few months prior to this date. The husband was very irritated, and he was yelling and screaming at his wife as she was lying on the ground. When the male person saw the police officers (males and females) arriving on the scene, he ran at a female police officer, knife in hand and attacked her. The male was subdued, taken to the ground, handcuffed, placed in the rear of a police vehicle and closely guarded. He was eventually removed from the scene. The woman was in serious condition, and she was transported to the hospital via ambulance. The daughter accompanied her mother inside the ambulance. Several of the neighbours remained in the area, and many of them were in shock, traumatized by the gravity of this incident. Police Victim Services staff and volunteers were requested to respond and to assist at the

scene. Several witnesses were transported from the scene to the police department for further interviews, and their statements were taken. The paramedics arrived on the scene, assessed the survivors and bandaged the knife wound. Upon arrival at the hospital, the woman was assessed by a registered nurse (RN) and the Emergency Physician (EP) They both suspected there may have been a sexual assault as well as the physical injuries and a forensic nurse was called. While the victim was undergoing assessment and preparation for surgery, the forensic nurse documented physical findings indicating defensive bruises and cuts on the patient's arms and hands. Since police were involved, the victim's clothing was collected and with the victim's permission provided to police. Care was taken to preserve as much forensic evidence as possible. Once the patient had undergone her life saving surgery for her abdominal wound and was fully conscious, the forensic nurse returned. With the patient's informed consent and her affirmation that she had indeed been forced to have intercourse with the accused prior to the physical assault, the forensic nurse completed a medical/ forensic examination, obtained internal forensic samples and provided resources for follow up for the patient.

Support services staff arrived at the hospital and they attended to the couple's young daughter. She, too, was severely traumatized and required treatment at the hospital. The young girl was also the subject of an extensive interview. She was aware that her father had been arrested and taken to jail and that her mother was in very serious condition in the operating room. At this point, she was very much on her own. She did not have any family or friends in Canada to care for her.

The husband was arrested and transported by police to jail. He was charged, cautioned and was afforded the opportunity to call a lawyer. He refused the lawyer and he refused to speak with the police. He was very irate and belligerent. He was lodged in a custody cell and remanded in custody.

The police conducted their investigations at the scene. The investigation involved a forensic examination of the street scene

and the family residence. The residence was locked down by the police and further examination would be conducted pending the condition of the victim.

Since the daughter did not have any immediate family or caregivers, several neighbours offered to look after the young girl until such time as her mother was released from the hospital. Unfortunately, the victim's injuries were very serious and she remained in the hospital for several months. She was paralyzed from the waist down and would never walk again. She received damage to her spine and she required several operations to repair the damage to her abdomen. She received several months of treatment and physiotherapy.

Due to the fact that the victim was to remain in the hospital for several months, it became extremely difficult for the neighbours to continue to care for the daughter. The Ministry of Children and Families took custody of the daughter and she was placed into a foster home until such time as her mother would be able to care for her. See the process involved on the Ministry website (Government of British Columbia, n.d.).

The husband remained in custody pending a trial. The police investigations continued, and the victim was subject to several interviews with the police victim services and the crown prosecutor's office. Each of these agencies has a specific function to perform regarding the prosecution of the husband.

Here is a training video from the United States on domestic violence. It discusses a little bit about relationship violence, the process for evidence collection and interviewing that police officers follow (The IACP, 2017).

Different workers/professionals are involved in addressing relationship violence. It is really important that all service providers work together. Listen to a video on the importance of collaboration. Each person has a different role in the system, and everyone needs to work together (Learning to End Abuse, 2017b).

The Government of British Columbia website (n.d.) shows the role of the victim support worker is to:

- Helping victims talk to the police
- Providing information about the criminal justice system, including help with peace bonds and protection orders
- Providing court support, including going to court with victims
- Helping complete a Crime Victim Assistance Program application to apply for benefits
- Helping to understand and prepare a Victim Impact Statement and an emergency safety plan
- Talking about the experience and helping people deal with emotions arising from being a victim of crime
- Notifying victims about the status of offenders in custody at provincial institutions
- Call victim link at 1-800-563-0808 anytime for support

## Service Providers and their Roles

1. 911 dispatcher's role is to quickly assess the situation and dispatch emergency services (police/fire/ambulance). They try to keep you on the line if possible and get detailed information such as phone number, address, the situation and environment, such as finding out where the perpetrator is and if they are armed.

2. Police member's role is to deal with the emergency and provide safety to all involved. They are trained to assess the situation immediately and call other services as needed. They also are trained to conduct investigations by taking a close look at the environment and interviewing you and anyone that may have seen/heard something. The police write a report to Crown counsel who decides if there is enough evidence to accuse the offender of a criminal offence, lay charges. Here is a good video that shows how police do their work.
3. Service or Transition Support Worker can be found in community agencies and also with domestic violence units in the police departments. Their role is to help the person emotionally and help them navigate the system from the time they come in contact with the survivor through a trial if needed. They also may be the person who communicates with the survivor and informs them of the movements of the offender, whether they are in custody or released. They are an advocate and a resource navigator for the survivor. For a service (victim) support worker handbook, click here. They help survivors to transition to a violence-free life. They may help access services such as legal aid, counselling, parenting classes, education, income support, child care, training, housing or employment.
4. MCFD Child Protection Worker protects the child from harm. Their job is to talk to the family members and assess the home and family to decide if the child is safe. They may provide support to families, supervise the child in the home or remove the child and place he/she with foster parents or others. To find a child protection office in BC click here.
5. The Forensic Nurse (FN) is a Registered Nurse or Nurse Practitioner who has specialized education and skills to address the medical and forensic needs of survivors of abuse. Their role is to conduct a physical assessment, identify pertinent findings, document these findings, collect and preserve forensic samples according to forensic evidence

protocols, maintain a chain of custody and provide nursing interventions. Documentation includes specialized forms and body maps with a medical-legal report generated. The average time for the interview and examination process varies between 2.5 to 5 hours depending on the circumstances of the incident. Some examinations may be shorter, some may be longer. The FN always ensures the patient is safe and cared for during this time frame. The R.N./N.P also provides medications for prevention/prophylaxis of pregnancy, HIV and sexually transmitted diseases. They can also follow up with survivors on a limited basis as well as referring the survivor to the FHA Embrace Clinic for short term discharge care. The FN consults with the legal system if criminal charges are filed and may be called as a witness in Criminal Court to testify regarding the medical forensic examination conducted. To learn about how a medical forensic exam is conducted, click here. (This is a United States video so may differ in different jurisdictions). If you need to be assessed by a forensic nurse, they ask you not to drink or eat anything, bath/shower or change clothes, wash your genitals, pee or poop, brush or floss your teeth, comb or brush your hair or chew gum to preserve the evidence. There are forensic nurses in several hospitals and clinics in BC. To locate a forensic nurse examiner, click on the health authority: Provincial Health, Coastal Health, Island Health, Interior Health and Fraser Health. If you are not sure of which health authority you reside, in click here.

6. Crown Counsel is a lawyer. It is their role to decide if there is enough evidence to lay charges. They do not need your consent. They usually base their decision on whether a judge is likely to find the accused (offender) guilty and if it is in the best interest of the public. Crown counsel interviews the survivor to obtain details to go to court and present the case before the judge. They also provide an explanation to the survivor about their decision to not lay charges. To learn more click here. For more details see the crown counsel policy manual.

7. Judge is an individual with a background in law who is appointed by the government to hear cases and make a decision. This person listens to both the survivor and the accused and determines if the person is guilty or not and if any punishment (called a sentence) should be administered. To know more about going to court, click here.
8. The survivor is usually traumatized and is assigned to a service support worker who is able to accompany the victim to court. Also, the survivor is eligible for counselling services for herself and her children.

## Housing and Other Services

Survivors who have gone to court are eligible for counselling services for themselves and their children. The survivor may also require housing. To access a directory of housing operated by non-profit societies, click here. There are different levels of housing and the service support worker can help with accessing housing.

- First stage shelter/emergency shelter/healing lodge: this is an emergency shelter for those fleeing relationship violence. Survivors can stay in these shelters for several days, weeks or even months depending on the shelter.
- Second stage shelter: can be accessed after the first stage and the amount of time you can stay varies from months to years depending on the shelter's policy.
- Third stage housing: is from months to years and it is for those who have recovered from the acute trauma of relationship violence and are ready to become more independent. It usually does not have services within the complex, and it is more affordable than general housing.

Shelters also have services but these can vary. Services may include

individual and group counselling, children's programs, parenting classes, mental health and addiction services, nutritional classes and community kitchens, Indigenous programming, legal and housing services, support for immigrant and refugee women, men's programs (for both those who have abused and those who have experienced abuse), and assistance with applications to educational and apprenticeship programs.

Moving expenses or care for their pet(s) is something that survivors may need assistance with. There is a company called 'Shelter Movers' with dedicated volunteers that can help move your possessions with locations in Nova Scotia, Toronto, Ottawa and Vancouver. Click here to access their website. On this homepage, you can watch Sophie Gregoire Trudeau (who has partnered with Shelter Movers) complete a move, a testimonial and a panel discussion on how RV has been impacted by COVID-19.

Support workers can help you find shelter for your pet and BC SPCA will also accept a pet for emergency care from those fleeing RV.

## The Legal Stuff

The story above is based on true incidents but it does not reflect any one's particular story or a specific call made for emergency assistance. Relationship violence is under-reported to the police. See chapter 8 on Why do people not report.

Once cases are reported and the police provide the investigative report, a prosecutor reviews the information and decides whether to proceed with charges or not. The role of the survivor is one of providing testimony or victim impact statements. It is up to the Crown Counsel to press charges and prosecute.

Generally, the accused hires a lawyer and tries to minimize the offence. Once the judge has heard from both sides, they make a decision and find the accused guilty or not guilty. If the accused

is not guilty, they are free to leave. If the accused is found guilty, the judge can order jail or community time or a combination. Jail time is considered a custodial sentence, details of the different forms of custodial sentences can be found here. Details regarding community sentences can be found in this link. You can read about other conditions such as no contact here.

## Surviving the Legal System

Survivors tell us that they are revictimized by our systems. That is why it is important for those talking with the survivor to build trust, acknowledge the impact of the violence in this U.S.A based report: (Governor's Commission on Domestic Violence and Sexual Assault, 2018, p. 21), and allow a service support worker to be present during all interviews. Haskell & Randall (2019) wrote a report for Justice Canada on the Impact of Trauma on Sexual Assault Victims. They document the impacts on survivors including neurological impacts, difficulty with memory and recall and the need for all professionals to switch to trauma-informed best practices in the criminal justice system (Haskell & Randall, 2019). Also, West Coast Leaf launched the toolkit on criminal proceedings for counsel because many survivors felt traumatized and victimized by the courts. This toolkit provides some ways to mitigate the impact on survivors. Click here to access toolkit on section 272 and 278 Criminal Code.

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Some survivors feel defeated by the system while others go on with their lives. One example of lifelong courage is a woman who was sexually assaulted in childhood, along with her sisters but did not report it until she was an adult with two young daughters of her own. Her story was heard in a British Columbia court, and she went on to be the subject of a documentary. Her name is Jeeti Pooni, she is one of the brave ones, who has shared her story so that others will come forward and heal.

She told Balbir Gurm that the outcome did not matter, what mattered was that she could tell her truth. She did a similar interview with CBC. Listen to Jeeti Pooni talk (chapter 9) about her motivation to come forward many years later and watch the trailer to the documentary in which she is the main subject Because we are girls (2019).

The above information is for adults who suffer RV. If you suspect a child is in danger, you need to call 1-800-663-9122 immediately. If you are a child and need to talk with someone, call 310-1234 any time, day or night. Also for older adults, access SAIL, call 1-866-437-1940 from 8 AM – 8 PM 7 days a week excluding holidays or visit the Seniors First BC website.

## Alternative Dispute Resolution

The Justice Council of Canada (n.d.) states that most cases do not go to court. Restorative justice (RJ) is an umbrella term for all processes outside the court system that bring survivors, offenders and perhaps their communities together to talk about the crime (National Resource Center on Domestic Violence). Types of RJ include mediation between the offender and survivor, family conferencing and reconciliation circles that involve the community. The goal is to repair harm, make amends, and create trust by both the survivor and offender by talking about the crime from their perspectives. It allows each person to understand the perspective of the other. In some processes, the community is also included. Some members of the Network to Eliminate Violence in Relationships (NEVR) state that restorative justice can work to hold the offender accountable and bring closure for the survivor. Other members state that it should not be used because the process reinforces a power dynamic that resulted in relationship violence in the first place. Similar concerns are expressed in the literature (Ptacek & Frederick, 2009). Although a quick search of restorative justice

brings up many articles, very few evaluation studies are published. One recent study by Mills et al. (2019) found that when restorative justice circles are used with traditional relationship violence programs, a significant reduction in new cases occurs, so these researchers recommend that RJ be offered as an option to address RV. The Public Prosecution of Canada handbook that outlines when crown counsel may consider alternative dispute resolution is found here. A study of restorative justice processes in some Indigenous communities done for the Department of Justice Canada indicates that most survivors and offenders were pleased with the process and outcomes (Government of Canada).

To learn more about access to justice for victims of crime, please see the training document for university students Module 2: Access to Justice for Victims from the United Nations Office on Drugs and Crime (UNODC) that NEVR member Yvon Dandurand, Faculty, University of the Fraser Valley, co-authored. Coming soon is Module 14: Independence of the Judiciary and the Role of Prosecutors.

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# Chapter 11: Understanding the Healthcare System Response: Forensic Nursing as a Change Agent

SHEILA EARLY

*Key Messages*

- It is well recognized that RV is a healthcare issue.
- This chapter provides the historical perspective of Forensic Nursing and its role in changing the healthcare response to RV over the last five decades. These roles navigate the complexities associated with intersections between the health care and justice systems while attending to the assessment and treatment of trauma, and/or death of victims and perpetrators of violence, criminal activity and traumatic accidents.
- The role development of the Forensic Nurse Examiners highlights how a change in healthcare response to the individual who has been subjected to sexual violence, has led to changed responses in RV including child maltreatment, elder maltreatment, intimate partner violence, interpersonal violence,

human trafficking, care of perpetrators of violence and trauma.

- The future shows promise for even more changes in the healthcare response to RV with increased emphasis on the value of forensic nursing science and forensic science in educating on best practices for the forensic patient populations they care for daily.

Relationship violence is any form of physical, emotional, spiritual and financial abuse, negative social control or coercion that is suffered by anyone that has a bond or relationship with the offender. In the literature, we find words such as intimate partner violence (IPV), neglect, dating violence, family violence, battery, child neglect, child abuse, bullying, seniors or elder abuse, male violence, stalking, cyberbullying, strangulation, technology-facilitated coercive control, honour killing, female genital mutilation gang violence and workplace violence. In couples, violence can be perpetrated by women and men in opposite-sex relationships (Carney et al., 2007), within same-sex relationships (Rollè et al., 2018) and in relationships where the victim is LGBTQ2SIA+ (lesbian, gay, bisexual, transgender, queer, Two-Spirit, intersex and asexual plus (The Scottish Trans Alliance, 2010; Rollè et al., 2018). Relationship violence is a result of multiple impacts such as taken for granted inequalities, policies and practices that accept sexism, racism, ageism, xenophobia and homophobia. It can span the entire age spectrum. It may start in-utero and end with death. This chapter discusses the role of the Forensic Nurse Examiner in RV.

## What is Forensic Nursing?

In Canada, Forensic Nursing (FN) is an area of nursing that the majority of health care providers and the general public are not familiar with. The provision of health care to those who have undergone violence and trauma as well as being victims of crimes with legal implications has not been at the forefront of nursing as we know it in Canada. Ironically, the first aspects of Forensic Nursing started in Canada in 1975 when Dr. John Butt, a forensic pathologist in Calgary, Alberta hired registered nurses to work as death investigators in the Medical Examiner's Office (American Nurses Association and International Association of Forensic Nurses [ANA & IAFN]; Pakosh, 2016). Dr. Butt concluded in a five-year study that "the registered nurse provided the qualities and professionalism essential to a scientific, social and cultural investigation of death" (Pakosh 2016, p. 528).

So, what exactly is Forensic Nursing? There are many definitions that have evolved since the 1990's when the area of nursing expanded into mainstream nursing. In 1991, Virginia Lynch, a forensic nursing pioneer, stated forensic nursing is

> […]the application of the forensic aspects of healthcare that are combined with the bio/psycho/social/spiritual education of the registered nurse in the scientific investigation and the treatment of trauma, and/or death of victims and perpetrators of violence, criminal activity and traumatic accidents. The forensic nurse provides direct services to individual clients, consultation services to nursing, medical and law-related agencies, as well as providing expert court testimony in areas dealing with questioned death investigation processes, adequacy of services, delivery and specialized diagnosis of specific conditions related to nursing (Lynch 1991).

The International Association of Forensic Nurses (IAFN), formed in 1992, currently uses the following definition of Forensic Nursing: "the practice of nursing globally when health and legal systems intersect" (IAFN, 2009)

Similarly, the definition accepted by the Canadian Forensic Nurses Association (CFNA) refers to,

> [...] the application of the forensic aspects of health care combined with the biopsychosocial education of the registered nurse in the scientific investigation and treatment of trauma, and or death of victims and perpetrators of violence, criminal activity, and traumatic accidents within the clinical or community institution (CFNA, 2020).

## How Forensic Nursing Changed Canadian Healthcare

Forensic Nursing has changed how healthcare responds to specific patient populations, particularly in the settings relating to relationship violence, child maltreatment, elder care, intentional and unintentional trauma investigation, death investigation, corrections and, of course, public health settings. Forensic nursing, using forensic nursing science, forensic science, and overlaying justice systems has added a long-overlooked dimension to health care. Patients/clients not only deserve the best healthcare response to their individual circumstances but also the best forensic nursing care available to them. The Justice System depends on healthcare providers to contribute their healthcare expertise to the case at hand, whether it is within the criminal or civil systems. Often, this expertise left gaps that forensic nursing is filling and will continue to fill over the next decades. The goal is to provide the patient/client with the best outcomes possible for each individual.

## Forensic Nursing History in Canada

In order to understand Forensic Nursing's impact on the healthcare systems in changing the response to relationship violence and other areas of violence and trauma in Canada, one has to look briefly at the history of this area as it has evolved since 1975. It was a slow start until the early 1990's as most of the progress was based in the United States of America (USA) in the area of sexual violence. In Canada, a few nurses worked as death investigators, a large number of nurses worked in Corrections like prisons or specialized forensic psychiatric units and emergency department physicians and nurses managed acute episodes of relationship violence (IPV, child maltreatment, elder maltreatment), as well as intentional and unintentional trauma. Forensic and legal components to care for the individual were not considered the purview of the health system and only medical/nursing care was the priority.

In 1992, in two different Canadian locations, the long-standing issue of care of the adolescent/adult patient who presented with a post-sexual event to acute care became a target for change. In Winnipeg, Manitoba and Surrey, British Columbia, two pilot projects were championed by a Nurse Educator, Sheila Early (Surrey) and Beth Ariss, an Emergency Nurse (Winnipeg). The funding for the Surrey pilot was obtained by Sandi Schenstead, Nurse Manager of the Emergency Department (ED) at Surrey Memorial Hospital. The impetus was to change the current care of these individuals within the context of the ED. For decades, these patients were routinely subjected to delays and limited interventions of care for a variety of reasons:

- Triaged as non-urgent (often because there were no immediate physical injuries)
- Provision of care was by a physician and physicians were not always available 24/7 in EDs
- Nurses provided nursing care only and could not

collect samples
- Law enforcement interviews with patients prior to bringing the patient for medical care
- Transportation was not always available for the patient
- Education was limited in medical and nursing curricula regarding sexual assault in general and forensic components to care in particular

The two pilot projects were formed to develop a new caregiver role for nursing. Sexual Assault Nurse Examiners (SANE) were registered nurses who were specifically educated to care for the medical, legal and forensic aspects for individuals presenting the post-sexual event. These nurses underwent an extensive education and practicum program in order to qualify for this new role in Canadian nursing. The role was based on existing programs in the USA, which had sprung up in Minneapolis, Minnesota, Amarillo, Texas and Memphis, Tennessee, in the mid-1980s to 1990s. The two pioneer programs commenced in late 1993 and early 1994. They were the forerunners for approximately 60+ established programs that exist in eight of the ten Canadian provinces today. Ontario, New Brunswick and Nova Scotia have established Provincial Nurse Examiner networks with Ontario's 36 Centres spanning the province. To read more about the Ontario Network of Sexual Assault & Domestic Violence Treatment Centres, click here.

## Understanding Forensic Nursing and its Impact on Relationship Violence (and other forms of violence and trauma)

In chapter 16 of the 'The Lawyer's Guide to the Forensic Sciences" (Pakosh, 2016), Early states that "the forensic nurse (FN) must be prepared to handle a variety of situations and patients, as the

expertise of the FN may be helpful in the investigation of a range of offences including sexual abuse, intimate partner violence and human trafficking" (p. 530). The role of the FN in acute care expanded gradually with the advent of the SANE within EDs. Slowly, the realization came about that the specialized skills possessed by these nurses could be useful in many other areas within the ED. Obviously, any form of RV including intimate partner violence, child maltreatment, elder maltreatment, intentional and unintentional incidents of violence and trauma were among the "forensic patient population" (Henderson et al., 2012) that could benefit from the FN's skills. Unfortunately, the FNs mandate initially only included competent adolescents/adults who presented post a stated non-consensual sexual event. So the RV/IPV/DV patient was not offered the services of the FN unless there was a sexual event as well. Gradually, the examination and documentation skills of the FN were recognized as useful in RV cases. Changes in other areas of RV have progressed over the last two decades. The table below shows what the care for victims of violence was before the mid-1990s and is currently.

**Table 11.1 Changes in Healthcare Response to Relationship Violence: Forensic Nursing acting as a Change Agent (1992-present)** Adapted from Early (April 17, 2015). *Forensic Nursing: Game Changer in Healthcare* (presentation). American Association of Legal Nurse Consultants National Conference. Indianapolis, Indiana.

| Historically | Evolved to the Present |
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| Medical and nursing education curricula did not include in-depth knowledge on the care for patients who presented post-sexual violence, domestic violence, child abuse, elder abuse (RV). | Violence across lifespan education is available at post-secondary educational facilities. British Columbia Institute of Technology (BCIT) offers a Graduate Certificate in Forensic Health Sciences and undergraduate courses are available in other educational institutions in Canada. |
| Patients presenting post a non-consensual sexual event waited in acute care settings for varying lengths of time, often hours. They were cared for by professionals who had little or no experience in assessment of sexual violence, recognition of significant injuries, forensic sample collections or documentation of findings. | Specialized healthcare response teams in centers respond within 0 -60 minutes to provide best practice medical and forensic care based on the individual's needs. Sexual Assault Nurse Examiner/ Forensic Nurse Examiners Programs are present in 8/10 provinces in Canada and approximately 800 programs in the USA by 2016 (Office for Victims of Crime [OVC], n.d.). Community agencies collaborate with acute care programs to provide resources before, during and after medical interventions to provide additional services to survivors who have a variety of needs beyond acute interventions. The Victoria Sexual Assault Center in Victoria, B.C. is the only community-based examination center in Canada opening in 2016 with FN's on call to the site.Avalon Sexual Assault Centre in Halifax, N.S. began operational control as Canada's only community-based service employing FNs to work in partnership with three local hospitals EDs providing direct patient care. A previous SANE pilot project had failed even though it had run from 1997 to 2000. |

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| IPV/DV/RV patients presenting to an ED for care were often not recognized as having intentional injuries vs. non-intentional injuries. The patient's history did not always fit with the physical findings in many cases. Patients were treated for physical findings with minimal documentation. Many were seen in EDs frequently for 'accidental injuries". | Specialized screening tools for IPV/DV/RV identification are available to identify high-risk patients. Many such tools are utilized in EDs across Canada. At one point universal screening of all patients presenting to EDs took place. As education increased on the identification of RV patients, the tools have been in less use. Healthcare costs of IPV/DV have been identified in numerous studies as documented in chapter 5 increasing the desire to identify and treat the causes of RV on a public health level.<br>See NEVR's mission. |
| Child maltreatment/abuse often undetected and treated as unintentional injuries as an awareness of the differences between intentional and unintentional injuries was not always included in educational curricula. The availability of social workers in the ED was limited to larger centers and follow up not always available. | Along with mandatory reporting of child maltreatment/abuse (see Chapter 9 for pertinent legislation) came more education on intentional injuries and social workers became part of the ED team. Community follow up was linked to acute care visits. Specialized child abuse teams both acute and non-acute developed. FNs were educated in pediatric acute sexual abuse care and added this mandate to the existing Adolescent/Adult teams in many provinces in the mid-2000s. Post-secondary pediatric sexual abuse education became available for both medical and nursing professionals online at BCIT (2013). |

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| In care deaths (acute and non-acute) were not always preserved intact as HCP (healthcare professional) awareness of legal implications was lacking. Deaths such as suicide/homicide/foul play may have been attributed to natural causes.<br>Medical Examiners were required to have a medical background; however, Coroners were not always required to have medical knowledge. In rural areas, Coroners might be non-professionals for example. | Death scenes are preserved intact by HCP who are educated in the importance of not altering a scene until legally allowed to do so.<br>In provinces with Coroner's system, RNs now bring nursing science expertise to the Coroner role. For several years, the Chief Coroner of Saskatchewan was a Registered Psychiatric Nurse. In Ontario's Office of the Chief Coroner, a Nurse Practitioner (NP), a former forensic nurse examiner serves as Provincial Nurse Manager, Chair of the Domestic Violence Death Review Committee and has R.N.s as Coroner investigators. |
| Health care professional's awareness of laws governing their professions and practice has been evolving past 50 years. | Many laws and statutes must be adhered to by HCPs. Provincial laws have changed over the decades and now include, but are not limited to: Information and Privacy acts, Infants Act, Health Professions Act, Criminal Code of Canada, For a more detailed description of such laws see Chapter 4. For the FN, the Criminal Code of Canada is an integral part of their education. |
| Educational aspects of forensic nursing not included in basic, post-secondary nursing and continuing education after the emergence of the subspecialty in the 1990s. | Currently, several post-secondary educational institutions offer post-secondary education including certificates and degrees. Continuing education in forensic nursing and medicine and forensic science are also offered in a variety of formats in North America and globally. To access the list of offerings, click here. |

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| Prior to 1994 in Canada, an RN testifying in the Criminal Justice Sexual Assault charge case was not recognized as an Expert witness. The RN provided fact testimony without the opinion testimony an Expert is able to provide. | Since 1994, the FN Examiners have been frequently deemed an Expert witness in many provinces in Canada "In Surrey, British Columbia. the forensic nurse examiner testifying as an expert in sexual violence routinely provides opinion evidence in criminal cases involving children, adolescents and adults" (Pakosh 2016). The move to forensic nurse-based care for sexual violence has been validated as a viable and important tool for Crown in the justice systems of Canada. |
| Documentation of findings in RV by HCPs caring for patients was not consistently complete, accurate and objective in medical/ nursing charting and reports. | "Written documentation in the ED or acute care record also needs to be viewed as valuable evidence and must be free of bias and subjectivity" ( Constantino et al., 2013, p.320) With increased education on documentation which meets the needs for both healthcare and medico-legal documentation the care provided to the RV patient becomes a principle tool of that care. Defining medical terms consistently and using them correctly (for example difference between a cut and a laceration) and recording "all observations, interactions, and outcomes between the FN and the patient" (Pakosh 2016, p.541) has become best practice. Documentation may take many forms including the use of standardized forms, video, photography and body maps. A Canadian Forensic Nurse. Cathy Carter-Snell developed a documentation tool called "BALDSTEP" to aid documentation of bruises, abrasions, lacerations, deformities, swelling, tenderness, erythema, and patterned injury (Pakosh 2016). |

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| Elder maltreatment/abuse in healthcare settings might not be recognized for similar reasons as RV in general. Lack of education, lack of knowledge on what constitutes maltreatment, even the definitions themselves were not clearly defined. Lynch stated in 2011 "elder maltreatment and neglect is dangerously underdiagnosed and underreported" (Lynch 2011 p. 355) | Lynch also stated that "it is the forensic nurse's professional responsibility to identify and appropriately intervene in elder maltreatment cases" (Lynch 2011, p. 365). Consequently, ED and acute care units became more responsive to the elder patient presenting with overt and covert symptoms of neglect and/or abuse including sexual abuse. Awareness of the multiple forms of elder maltreatment in healthcare education and the general public has resulted in the identification and assessment of cases that previously may have been missed. |

The previous table highlights significant changes in how the healthcare response to RV and other forms of violence and trauma has changed over the last three decades. There are certainly more changes that have not been documented in this chapter as they relate to conceptual change other than RV. They include the premise that perpetrators of violence and/or crimes have the same healthcare and medico-legal rights as victims and require the same objectivity and neutrality in their care. The healthcare professional is not a determiner of guilt or innocence.

## Healthcare Change for Victims of Sexual Assault

More importantly, how has the healthcare response changed the care of the individual who has been the victim of a non-consensual sexual event? (Sexual assault is a crime under the Criminal Code of Canada but not a medical diagnosis see chapter 9 for Sections of Criminal Code relating to sexual assault). Read about service providers and their roles in chapter 10 to see that there are community and healthcare based responses that did not exist in the historical past.

- Patients are provided with the information and resources to make informed decisions on what services and care are available to them (please note this is for competent adolescents and adults, competent being the keyword).
- The decision as to whether or not they report the incident to law enforcement is still currently only theirs to make. In the USA, there is mandatory reporting of sexual violence in California for example.
- Healthcare of the individual is not based on whether law enforcement is involved or not.
- Patients usually have the choice of having forensic samples collected and stored for varying periods of time. For example, in B.C. samples collected may be stored for up to one year by specialized forensic nursing units.
- The health and well being of the individual always comes as the first priority. For example, if collecting a forensic sample interferes with life-threatening procedures, that collection is deferred. However, documentation of all findings and observations continues to be valuable even when there is not a collection of forensic samples.
- Patients have supports available to them prior to accessing healthcare, during the process and after by any number of community agencies that have developed since the 1970s. It is not uncommon for patients to hug their FN caregiver at the end of an extensive medical-forensic examination.[1]
- If legal proceedings become part of the individual's process, the FN is available to provide testimony as either a fact or expert witness as part of their ongoing role. With an extensive education in court and legal proceedings, the FN is well equipped to provide the court information to guide in the determination of a

legal outcome.

- Holistic care is best practice for all victims and perpetrators of any form of RV. "Early screening, identification and treatment of intimate partner violence patients can help break often serious and deadly cycles of violence" (Lynch 2011, p. 370).

Studies and published articles over the last two decades validate that healthcare response to RV needed to change its response to the individual patient's medical and forensic needs. Here are just a few pertinent studies:

**Shared decision making** – as a better approach to the care HCPs (Healthcare Professionals) provide to patients/clients. This refers to providing the individual with information and resources in order that they make the best-informed decision appropriate for that individual at that particular time. According to Mohammed & Montori (2015), this approach is not taught in medical schools. Studies do show patients want more information than HCPs may have provided in the past. Today, the internet seems to be the "second opinion" with sometimes drastic negative effects. So, the FN is in a position to provide a patient with appropriate information and resources and take the time to assist rather than direct a patient to their decision. The FN is dedicated to that particular patient so clinical time is not the drawback it is within a busy and sometimes overwhelming ED. To learn more, watch the video, click here (Mohammed & Montori, 2015).

**Canadian Emergency Department Survey** – published in 2008 by McClennan, Worster and McMillan, the survey wanted to determine how many Canadian EDs used universal screening tools and intervention policies and procedures over a 10 year period. The results were compared to a 1994 study to see if research and education regarding IPV were instrumental in integrating changes in the healthcare response to IPV. The survey concluded that "despite increased research into IPV issues, there was no significant change between 1994 and 2004 in the existence of IPV policies or

universal screening in Canadian EDs" ( McClennan et al., 2008, p. 325).

**Forensic Education in the ED** – Henderson et al. (2012) studied ED physicians' and nurses' forensic knowledge, their practice experiences and their forensic learning needs. They compared the results finding no significant difference in education, knowledge and confidence in caring for the forensic patient between the two professions. However, only just over half of both physicians and nurses felt confident to care for and manage a forensic patient indicating forensic knowledge was not only needed in the EDs but desired. Further, the study reached conclusions including the recognition that "proficient, safe, quality care for the forensic patient must be operationalized in the ED setting" (Henderson et al., 2012, p. 176).

**Canadian Client Satisfaction Survey** – on Nurse-led SV/DV Services. Du Mont et al. (2014) surveyed 30 of the 35 SA/DV Centres in Ontario regarding client satisfaction. The large scale survey involved over 1000 participants with the following results: 98.6% stated they received the care they needed, 98.8% stated their overall care was excellent or good, and 95.4% stated the care was provided in a sensitive manner. The negative findings were long wait times, negative ED staff attitude, privacy and confidentiality issues and difficulty in accessing services. So, there is still improvement to be made in the healthcare response to RV.

Here is a three-part documentary video that is an excellent resource from the Enfermeiros Forenses (2015) part I, part II and part III.

## Future Healthcare Response Changes

Historically, there have been significant positive and much-needed changes to how healthcare responds to RV and all forms of violence and trauma. Forensic healthcare is now entering areas that have

been identified as health-related and could benefit from the specialized skills of the FN and others who have had specialized forensic nursing science, forensic science and forensic medicine education.

- Human trafficking is becoming part of the healthcare mandate for forensic nurses. B.C. led the way in producing an education module in 2015 for all healthcare providers in the identification of the human trafficked person. To read the module, please, click here (Fraser Health, 2018).
- Strangulation in RV has not been recognized as the life-threatening event it can be. Forensic Emergency Medicine has developed a protocol for the medical and forensic care of the patient who has or may have been strangled in any violent event. To learn more about strangulation, click here (Training Institute on Strangulation Prevention, n.d.).
- Forensic science and forensic nursing science research is conducting studies to determine the presence of bruising underneath the skin not visible to the naked eye. Anecdotally, an alternate light source seemed to indicate unseen bruising; however, research is being conducted to validate findings. Read the studies here (Scafide et al., 2020).

*Based on the personal experience of Sheila Early, a Forensic Nurse for 14 years.

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# Chapter 12: Campaigns on Relationship Violence

BALBIR GURM AND JENNIFER MARCHBANK

*Key Messages*

- The best way to address RV is to prevent it in the first place. Although a number of programs have been identified, none to date have been evaluated.
- This chapter provides information on the different campaigns that have been organized internationally but focusses mainly on those organized locally or in Canada. These campaigns are to raise awareness about violence against women. Campaigns are focused on educating the public on the rate of rape/assault on women, missing or murdered Indigenous women, how to be more than a bystander and how men can get involved. These campaigns provide an opportunity to understand the issues and engage the public in action and dialogue.
- The existence of campaigns such as these is laudable, but often there are no resources to properly assess their efficacy. Many bystander intervention programs assess attitudes and knowledge immediately after the campaign, but few evaluate long-term impacts of perpetration or victimization.

For programs to be effective, they need to be sustained over the long-term.

The NEVR campaign @NEVRcampaign on Twitter was started by a group of nursing students from KPU at the request of NEVR members. They wanted to use social media to address the issue of relationship violence. The NEVR campaign collaborates with community stakeholders and partners in order to advocate, educate and work to eradicate violence in relationships. There are websites, Facebook and Twitter. The campaign is managed by nursing students as part of their nursing courses on community change. While the Facebook page displays announcements and photos and it is regularly updated by a NEVR member, Twitter has been mainly used during conferences to tweet about the conference highlights. Individuals can find a great range of resources and promotions on the NEVR website, which receives the support of Kwantlen Polytechnic University. This campaign could be utilized more in the local area.

NEVR integrates politicians, survivors and local service providers into its activities to raise awareness and ask for a change in our community. NEVR also participates in the National Day of Remembrance and Action on Violence Against Women (December 6th) which is recognized as the Canadian One Billion Rising Campaign and also in the national OBR in a day in February. The Kwantlen Faculty Association has held a yearly event since the Montreal massacre and a yearly Dec 6 event at Kwantlen Polytechnic University and the Public Service Alliance of Canada (PSAC) holds an event for Dec 6 every year in the

community and United Food and Commercial Workers International Union Local 247 has an annual Shoe Memorial in front of the Vancouver Art Gallery to remember the women that are killed and raise awareness of violence against women and Dr. Balbir Gurm was one of the speakers in 2019. NEVR has partnered with PSAC since 2017, and Dr. Balbir has spoken yearly on various topics at the event related to RV, including the need for everyone to work together to address the issue. PSAC also started the Red Dress Campaign (Public Service Alliance of Canada, 2014) to demand justice for missing and murdered Indigenous girls and women. More campaigns are listed below.

**SaySomething Campaign**

The SaySomething campaign was started by a past BC provincial government at the request of various organizations, including NEVR. It was a bystander campaign with resources on domestic and sexual violence. There is a website in English/Cantonese/Punjabi that has statistics and short videos that individuals can post on social media to increase awareness. It has a resources section with tabs to click: **I need help, I need resources, I want to help**. It also has a link to victimlinkbc (Government of British Columbia, n.d.), a 24-hour helpline.

**One Billion Rising – OBR Campaign**

One Billion Rising (OBR) campaign was started in 2012 with the main focus of addressing the great number of women who experience rape or sexual assault. Around the globe, statistics indicate that one in three women will be raped or assaulted during their life-course. At the beginning of this campaign, it was estimated

that the number of victims was around one billion women and girls due to this number, the campaign was named One Billing Rising to show the impact of rape and assault on women/girls across the globe. It was a call to action. People around the world are asked to walk into the streets on February 14, bring signs, give speeches, etc. in order to raise awareness about violence and try to change the culture of society.

Each year, a specific theme is identified. In the Vancouver Lower Mainland area, we have a campaign for missing and murdered Indigenous women that takes place on February 14 in Vancouver, and so NEVR participates in the OBR campaign, but this is scheduled for another day that is convenient to the committee.

**White Ribbon Campaign**

The White Ribbon Campaign was started in 1991 by Jack Layton (former federal New Democratic Party Leader), Michael Kaufman and Ron Sluserin in Toronto, Canada. This international movement was created after the Montreal Massacre. The White Ribbon targets men asking them to wear a white ribbon and take a pledge to speak up against gendered violence and not to use violence. The White Ribbon campaign also raises money but does not apply for grants that women's organizations need for funding. There is a website for the White Ribbon campaign with resources updated in 2019 that can be downloaded for free. It was the first bystander campaign in Canada. The website has definitions and signs of abuse, resources for perpetrators, support services, what you can do to help and how to promote positive masculinity and encourage other males to join the movement. Although it is not prominent in BC, there is the White Ribbon Campaign in Australia that has built on Canada's campaign and included schools in their outreach. In BC, we have a similar campaign aimed to support schools and universities that was started much later aimed at Indigenous men, the Moosehide campaign.

**Moosehide Campaign**

The Moosehide campaign was started by Paul Lacerte and his daughter Raven, to have men and boys stand up against the high

rate of abuse in Indigenous communities and call men to positive action. Men and boys are asked to wear a piece of moosehide as a brooch so that others in the community would recognize they were standing up against violence or ask them why they are wearing a moosehide. It is meant to be a conversation starter. The campaign has grown to a call for action for all genders and various resources and educational materials for K-12 students and teachers. Originally started for and with men, it now includes all gender and sexual diverse people.

**Be More Than a Bystander Campaign**

The Be More than a Bystander campaign was started in Vancouver BC by Ending Violence Association of BC – EVA BC and partners with the local professional football team – the BC Lions. EVA BC is our provincial umbrella organization for domestic violence service providers. Grants from Status of Women Canada, the BC Ministry of Children and Family Development, and Encana Corporation have funded a series of videos featuring BC Lions team members teaching viewers how to speak up and act against violence. As well, the Provincial Ministry of Public Safety and Solicitor General, in the last several years, added funding to support this work. This campaign has expanded across Canada using other professional football teams. EVA's website has many resources that can be downloaded and used.

**Pink Shirt Day Campaign – International**

Pink Shirt Day originated in Nova Scotia, Canada, and it became an international campaign in 2012 after being endorsed by the United Nations. This movement started after a teenage boy was bullied for wearing a pink shirt and was subjected to homophobic threats of violence. Two senior boys organized other students to wear pink to challenge bullying people for stepping outside of normative gender and sexuality behaviours. Diane Naugler (2010) provides a history of the beginnings of this campaign and discusses the forces that shape male on male bullying in adolescence. She concludes that "…the media coverage and popularization of the pink anti-bullying campaign in Nova Scotia exhibit the convention of our

societal denial of the routinely aggressive, violent, and traumatizing gendered policing of young boys" (p. 360) and calls upon us to stop accepting gender policing and boy on boy bullying as normal and unremarkable.

This campaign is dedicated to working in schools with teachers, students and parents. The campaign's signature is a pink shirt that is worn throughout the specific day and its intent is to increase awareness about bullying and engage people in anti-bullying conversations to prevent bullying among kids and adolescents. As such, the campaign has lost much of its focus on policing gender.

**MARD (Men Against Rape & Discrimination) Campaign**

Farhan Akhtar, a Bollywood award-winning film director, producer, actor and singer initiated MARD – Men Against Rape and Discrimination – a 2013 social campaign, after lawyer Pallavi Purkayastha who worked with him was sexually assaulted and then murdered by her watchman in her home. In 2014, Akhtar became the first man to be appointed Regional UN Women Ambassador for South Asia and an advocate for UN Women's HeForShe campaign.

**Effectiveness of Campaigns**

The existence of campaigns such as these is laudable, but often there are no resources to properly assess their efficacy. Many bystander intervention programs assess attitudes and knowledge immediately after the campaign, but few evaluate long-term impacts of perpetration or victimization. For programs to be effective, they need to be sustained over the long-term. University programs for social change that are semester-long have shown long-term effectiveness. Thus, these campaigns need to be consistent and sustained over many years. The NEVR campaign relies on students, so it is not as sustainable as many other campaigns.

Canadian campaigns (mainly) are highlighted. Most of these campaigns deal with heterosexual intimate partner violence. The main messages from these campaigns need to be expanded to create a national campaign that is inclusive of all adults and children.

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# Chapter 13: Assessing Risk

BALBIR GURM AND GLAUCIA SALGADO

*Key Messages*

- The use of Risk Assessment Tools can aid professionals in their response to enhance the safety of victims and their children.
- Risk assessment is important for case planning. If not used carefully, it can be discriminatory and cause harm to individuals, families and communities.
- A number of risk assessment tools are used in Canada and around the world. Assessors need to keep in mind the objective, group, culture and intersectionality when selecting tools.
- Research suggests there are some factors that increase the risk to re-offend. These include mental illness, history of complaints with the victim, violation of no-contact order, and continued contact between perpetrator and victim.

Relationship violence is any form of physical, emotional, spiritual and financial abuse, negative social control or coercion that is suffered by anyone that has a bond or relationship with the offender. In the literature, we find words such as intimate partner violence (IPV), neglect, dating violence, family violence, battery, child neglect, child abuse, bullying, seniors or elder abuse, male violence, stalking, cyberbullying, strangulation, technology-facilitated coercive control, honour killing, female genital mutilation

gang violence and workplace violence. In couples, violence can be perpetrated by women and men in opposite-sex relationships (Carney et al., 2007), within same-sex relationships (Rollè et al., 2018) and in relationships where the victim is LGBTQ2SIA+ (lesbian, gay, bisexual, transgender, queer, Two-Spirit, intersex and asexual plus (The Scottish Trans Alliance, 2010; Rollè et al., 2018). Relationship violence is a result of multiple impacts such as taken for granted inequalities, policies and practices that accept sexism, racism, ageism, xenophobia and homophobia. It can span the entire age spectrum. It may start in-utero and end with death.

## Risk Assessment

To address RV, it is important to be able to determine individual risk. There are a number of risk assessment tools for different populations. A common criticism is that assessment tools often take a Eurocentric approach and may not be able to fully appreciate or assess complex risk factors in cross-cultural contexts. If not used carefully, they can be discriminatory and cause harm to individuals, families and communities. It is important to apply these assessments taking into account guiding principles that are often outlined in legislation and policy. Risk assessment is important in order to do case planning.

In this chapter, we try to bring together knowledge about risk assessment and provide empirical evidence. Click here to understand why it is important to assess risk of RV. A summary of vulnerable populations, risk assessment, risk management and safety planning can be found in Table 13.1 (Jeffery et al., 2018). Also, a number of risk assessment tools are used in Canada and around the world. Click here to see the inventory of assessment tools used in Canada. Click here to read a good summary of risk assessment models. Murphy & McDonnell (2006) review how to assess and respond to the risk of RV. Locally, the Burnaby RCMP requested

a group of researchers to identify characteristics that lead to re-offending. They found increased risk due to mental illness (8 times), history of complaints with the victim (2.5 times), violation of no-contact order (15 times), and continued contact with the offender (3 times) (McCormick et al., 2011).

**Table 13.1 Summary of Vulnerabilities and Findings Regarding Risk Assessment, Risk Management, and Safety Planning Across the Four Vulnerable Populations** (Jeffrey, N., Fairbairn, J., Campbell, M., Dawson, M., Jaffe, P. & Straatman, A-L. (2018). Canadian Domestic Homicide Prevention Initiative with Vulnerable Populations (CDHPIVP) *Literature Review on Risk Assessment, Risk Management and Safety Planning*. Canadian Domestic Homicide Prevention Initiative.

| Population | Risk Management | Safety Planning |
|---|---|---|
| Indigenous | • Should be culturally informed and consider sociocultural/ historical aspects of risk<br>• Should incorporate traditional practices and ceremonies if applicable<br>• Should include Indigenous staff throughout risk assessment process including program planning and delivery<br>• Should focus on healing for the whole family<br>• Should include community education that discusses the issue of domestic violence, challenges stigma and denial, and identifies strategies for intervention | • Should be culturally informed and consider sociocultural/historical aspects of risk<br>• Should emphasize women's strength and capacities<br>• Should involve Elders and other community members/leaders |

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|---|---|---|
| Rural, Remote, & Northern (RRN) | • Should be culturally-informed and consider sociocultural/ historical aspects of risk<br>• Potential for the use of the following strategies: firearm removal and restricted access policies; "safe at home" program models; and more meaningful justice system consequences<br>• Current lenient treatment by criminal justice actors<br>• Barriers obtaining and enforcing protection orders<br>• Importance of service/sector coordination and collaboration | • Should be culturally-informed regarding the community and consider sociocultural/historical aspects of risk<br>• Importance of: considering RRN barriers to leaving perpetrator and focusing on minimizing harm; identifying formal and informal supports; being creative when formal services are unavailable; including arrangements for pets and farm animals; addressing confidentiality concerns<br>• Importance of healthcare settings in safety planning<br>• Importance of service/ sector coordination and collaboration<br>• Potential usefulness of web-and computer-based tools |

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| Immigrant & Refugee (IR) | • Should be culturally-informed and consider sociocultural/ historical aspects of risk<br>• Should consider sociocultural, ethnocultural, and historical aspects of risk<br>• Should strengthen informal supports; educate on gender, domestic violence, and Canadian laws; help increase English language proficiency, and address post-migration stressors<br>• Should integrate/ collaborate with immigrant settlement, employment, or religious programs<br>• Importance of service/sector coordination and collaboration | • Should be culturally-informed and consider sociocultural/ historical aspects of risk<br>• Should consider sociocultural, ethnocultural, and historical aspects of risk<br>• Importance of considering IR barriers to leaving abuser and focusing on minimizing harm; identifying formal and informal supports; utilizing non-traditional supports and points of intervention (e.g., settlement sector and multicultural serving agencies); educating about domestic violence and women's rights; and fostering cultural resiliency<br>• Should help address economic and structural issues<br>• Should emphasize and foster community support<br>• Importance of service/ sector coordination and collaboration |

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| Children Experiencing Domestic Violence | • Should focus on early intervention and on separating parents<br>• Should consider the best interests/safety of the children<br>• Potential importance of child protection agencies in intervening with parent abuser<br>• Potential of focusing on perpetrators' roles as parents<br>• Importance of service/sector coordination and collaboration | • Should consider and involve children and their voice using developmentally appropriate strategies<br>• Importance of considering barriers to leaving perpetrator when children are involved and focusing on pragmatic safety solutions and minimizing harm<br>• Should differentiate domestic violence cases from other forms of child maltreatment and address concurrent child maltreatment<br>• Importance of service/sector coordination and collaboration; information sharing; and risk assessments for family court |

| Population | Vulnerabilities | Risk Assessment |
|---|---|---|
| Indigenous | • Historical and current injustices (e.g., Indian Act, residential school system, sixties scoop, and colonization)<br>• Loss of culture, traditional lifestyle (intergenerational effects of residential school system)<br>• Geographic, social, cultural, and economic isolation<br>• Lower education attainment<br>• Substance abuse and mental health issues (related to historical injustices)<br>• Economic and structural issues (e.g., poverty, high cost of living, and overcrowding)<br>• Limited availability of non-Indigenous and/or Indigenous-specific services<br>• Lack of culturally-trained/sensitive service providers | • Need to develop Indigenous-specific risk assessment tools/guidelines<br>• Should be culturally informed and consider sociocultural/historical aspects of risk specific to the community<br>• Should incorporate questions about rurality, isolation, availability of firearms, code of silence in the community, unemployment, quality of education, availability of services, housing conditions, gender inequality, and community protocols and policies to address domestic violence situations |

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| Rural, Remote, & Northern (RRN) | • Physical and social isolation<br>• Economic and structural issues (e.g., higher cost of living, limited employment opportunities)<br>• Adherence to traditional and patriarchal cultural values<br>• Limited availability or accessibility of services<br>• Lack of resources and proper training for services, screening, and management<br>• Lack of privacy, anonymity, and confidentiality<br>• Strong firearm traditions | • Should be culturally-informed and consider sociocultural/ historical aspects of risk<br>• Importance of healthcare settings in assessing risk<br>• Importance of service/ sector coordination and collaboration<br>• Potential usefulness of web-and computer-based tools<br>• No RRN-specific tools identified in the literature |

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| Immigrant & Refugee (IR) | • Physical, social, cultural, or economic isolation<br>• Migration and acculturation stressors<br>• Economic and structural issues (e.g., poverty or un/underemployment)<br>• Adherence to traditional and patriarchal cultural values and gender roles<br>• Language and cultural barriers<br>• Precarious or non-legal status and other legal barriers<br>• Socio-cultural influences (e.g., family honour and unity)<br>• Power imbalance in relationships (e.g., threat of deportation in sponsorship arrangements)<br>• Lack of knowledge of Canadian systems/laws/culture<br>• Discrimination | • Should be culturally-informed and consider sociocultural/historical aspects of risk<br>• Should consider sociocultural, ethnocultural, and historical aspects of risk<br>• Should be multi-dimensional (e.g., considers financial, social, and legal risk factors)<br>• Importance of service/sector coordination and collaboration |

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| Children Experiencing Domestic Violence | • Children's dependency on the perpetrator<br>• Children's inability or reluctance to report<br>• Lack of proper training for service providers/risk assessors; confusion over policies and legislation<br>• Child and parent/victim's concern that the child could be taken away<br>• Parental separation as an important risk factor for lethality<br>• Custody and access dispute<br>• Conflating high conflict divorce with DV<br>• Inadequate response of police and recognition by family court of DV as a factor in protecting children | • Recognition that child's risk parallels mother/victim's risk<br>• Importance of building trust with mother/victim to gather risk information<br>• Potential importance of child protection agencies, healthcare settings, and police in assessing risk<br>• Importance of service/sector coordination and collaboration, including the justice system and family court<br>• Training required to engage with and monitor perpetrators and hold them accountable |

## Spousal Violence

Click here to find the inventory of spousal violence assessment tools in different jurisdictions in Canada (Department of Justice Canada, 2013). To read a report created for Justice Canada on tools, click here (Millar et al., 2013). These tools are used to identify offender risk. Roehl et al. (2005) assessed the validity of the following evaluation tools: the Danger Assessment (DA), DV-MOSAIC, Domestic Violence Screening Instrument (DVSI), Kingston Screening Instrument for Domestic Violence (K-SID) and (two questions inquiring about the) victim's perception. They found the

DA performs the best followed by the victim's perceptions. You may read the full report here.

In the UK, the MARAC Model is used. It is a risk assessment conference with multi-agencies. To learn more click here.

From the literature, we identify those with empirical evidence that follow an established violence risk strategy (Douglas et al., 2014). These tools must have a correlation between the identification of risk factors in determining recommendations and strategies to manage these risks. There is little agreement in the literature on how and by whom risk assessment tools should be implemented. You can find below the validity and reliability of eight assessment tools that were evaluated in 2012 and one in 2019. These are summaries from the Partner Abuse State of Knowledge Project (Hamel, 2012) and one from Australia (FVRAT).

**Table 13.2 – Measurement Tools to Assess Relationship Violence**

| MEASUREMENT TOOLS | Score | Summary | For more information |
|---|---|---|---|
| Ontario Domestic Assault Risk Assessment (ODARA) | 0.64 – 0.77 | Predicting recidivism was good to excellent. | ODARA screening tool form (Hilton et al., 2010). |
| Domestic Violence Risk Appraisal Guide (DVRAG) | AUC = 0.70 ($p < .001$) | The inter-rater reliability for both instruments was excellent. However, only one study reported the cited AUC value. | Please, contact Nzoe Hilton<br><br>zhilton@mhcp.on.ca |
| The Domestic Violence Screening Inventory (DVSI) and Domestic Violence Screening Inventory-Revised (DVSI-R) | AUC range 0.61 – 0.71 | Good predictors of new family violence incidents and IPV recurrence | Please, contact Joseph DiTunno at Joseph.DiTunno@jud.ct.govA write up on DVSI-R |
| Violence Risk Appraisal Guide (VRAG) and Sex Offender Risk Appraisal Guide (SORAG) | AUC 0.66 – 0.71 and 0.67 – 0.75 | Were examined in three studies, neither of which are IPV specific. | Violence Risk Appraisal Guide (Quinsey et al., 2006) |
| The Level of Service Inventory-Revised (LSI-R) and Level of Service Inventory – Ontario. Revision (LSI-OR) | AUC 0.50 and 0.73 (in both) | Discussed in four articles, both of which were predicting IPV recidivism. | Girard & Wormith (2004)<br><br>The level of Service Inventory (Andrews & Bonta, 2011) |
| Spousal Assault Risk Assessment guide (SARA) | AUC 0.52 – 0.65 | The interrater reliability (IRR) for the SARA was excellent for total scores, good for the summary risk ratings, and poor for the critical items. | (Kropp & Gibas, 2010)<br><br>SARA research summary |

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| Brief Spousal Assault Form for the Evaluation of Risk (B-SAFER) | | No article examined the B-SAFER predictive validity, but one did report the IRR based on 12 cases with a mean interclass coefficient (ICC) of 0.57. | Brief Spousal Assault Form for the Evaluation Risk<br><br>(Kropp & Hart, 2005)<br>B-Safer document on the development and pilot from Justice Canada |

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| The Danger Assessment (DA) | | It has the largest body of literature behind it, but there are limitations in the research that inhibit a precise determination of the psychometric properties of the measure thus far. Victim appraisals of the risk of future IPV show some evidence of predictive accuracy; however, further research is needed to determine the best means with which to collect the victim's reports and determining the conditions (e.g., stalking) and characteristics of victims that should be considered (e.g., PTSD, substance use). | The Danger Assessment tool<br><br>(Campbell, 2009). |

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| A research scale for the assessment of psychopathy in criminal populations (HARE) | Reliability > 0.85 | This is an assessment tool that serves to help to identify an individual's characteristics of psychopathy. It is suggested not to be used as a single tool of assessment. | (Hare, 1980)<br><br>HARE checklist |
| A refined version of the Family Violence Risk Assessment Tool (FVRAT) | Four-fifths of high-risk and low-risk DV cases were correctly classified (83%) | It helps identify repeat risk. | Download the full report on the tool from this site |

There does not seem to be a single superior tool, and there is modest predictive accuracy for most tools. The authors conclude more research is needed. Assessors need to keep in mind the objective, group, culture and intersectionality when selecting tools. Hanson et al. (2007) conducted a meta-analysis on risk assessment for Public Safety Canada and found that the victim's assessment of risk is similar to predictive tools and that no tool is clearly more accurate than another. Read the full report here. Northcott (n.d.) conducted a review of domestic violence tools for Justice Canada. She looked at the purpose of tools, types of tools and ways tools can use in decision-making. Her report can be accessed here.

As well, there are checklists for those in the domestic violence system. These checklists help community response teams to improve their efforts. The Battered Women Justice Project has collated checklists click here.

## Older Adults

A number of tools, including the literature review by Storey (2020), identified risk factors that make older adults more vulnerable and the offender more likely to continue to abuse. Also, he conducted a thorough literature review and created the Elder Abuse Risk Level Index (EARLI), so that those working with older adults could identify risk and intervene. Storey states that earlier risk assessment tools are not based on empirical research. At the time of publication, the EARLI had not been tested. In addition, he recommends that practitioners use the risk and vulnerability factors below to conduct a full assessment (Storey, 2020).

**Table 13.3 – Summary criteria for elder abuse risk and vulnerability factors (Storey, 2020, p. 4)**

| Factors | Perpetrator risk factor criteria | Victim vulnerability factor criteria |
|---|---|---|
| 1. Problems with physical health | a) Illness such as chronic illness, physical disability, poor health and recent declines in health.<br><br>b) Functional impairment related to Activities and Instrumental Activities of Daily Living, such as grooming and meal preparation, respectively. | Same criteria as perpetrators, with the added concern that victims will not be able to contact help when needed. |
| 2. Problems with mental health | a) Problems with mental and personality functioning, that can result in substantial problems with cognition, mood, and behaviour.<br><br>b) Major mental disorder, personality disorder and cognitive impairment. | Same criteria as perpetrators. |
| **3.** Problems with substance use | a) Serious problems with health, occupational, financial, social, or legal functioning resulting from the use of illegal substances or the misuse of legal substances (e.g., alcohol, prescribed medications). | The same criteria as perpetrators, with the additional criteria that use, may impair the victim's ability to protect themselves. |

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| **4.** Dependency | a) Perpetrator's dependency on the victim or other individuals. | Victim's dependency on the perpetrator | |
| | b) Dependency is most often related to housing and finances but can also be emotional and functional in nature. | Dependency can be functional, financial, social or emotional in nature | |
| **5.** Problems with stress and coping | a) Serious problems with stress related to an inability to cope with life problems. | Serious problems with stress related to an inability to cope with life problems. | |
| | b) Problems may be a reaction to unusually stressful life events, inadequate coping with normal or day-to-day life stresses, or inadequate coping with caregiving responsibilities. | Problems may be a reaction to unusually stressful life events, abuse, or the consequences of and reactions to impairments caused by functional, cognitive, or emotional problems.<br><br>Includes engaging in self-neglect. | |

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|---|---|---|
| **6.** Problems with attitudes | a) Serious problems with attitudes related to caregiving, older persons, and the rights of others.<br><br>b) Includes unrealistic expectations of the victim and antisocial attitudes. | Serious problems with minimization of and inconsistent attitudes toward the perpetrator, their behaviour, and the risks they pose. |
| **7.** Victimization | a) Previous abuse experienced or witnessed during childhood or adolescence. | Previous abuse experienced or witnessed during the lifetime, other than the current episode of elder abuse by the perpetrator. |
| **8.** Problems with relationships | a) Serious problems establishing or maintaining positive, prosocial intimate (romantic) and non-intimate relationships<br><br>b) Includes conflictual relationships, feelings of social isolation and a lack of social support. | Serious problems with relationships, including those with the perpetrator and other social relationships.<br><br>Includes conflictual relationships, social isolation and a lack of social support. |

## Children

Identifying the risk of relationship violence for children is complex. Social workers are tasked on behalf of governments and child

welfare agencies to assess risk among children in their families. As with adults, children are at greater risk at the time of parental separation. Social workers must interview family members and weigh the vulnerability factors against the protective factors using their personal experience and knowledge to determine if the child is safe in a home. Department of Justice (2016) in Canada has identified 2 scales (Ages and Stages Social-Emotional (AS-SEQ) Questionnaire and Children Exposed to Domestic Violence Scale) for children and both of these have been shown to be effective in a 2018 systematic review of Socio-Emotional Screening for Young Children in Welfare by McCrae & Brown (2018). A table with all the instruments reviewed can be found in the link McCrae and Brown Social-Emotional Screening Tools. Department of Justice Canada (2013) identifies a third tool to use with children, the Danger Assessment mentioned earlier because children are often in danger because of spousal violence.

Ravi and Tonui (2020) did a systematic review to assess the reliability and validity of the Child Exposure to Domestic Violence (CEDV) Scale. Their final sample included 13 studies. They found good reliability across populations (0.79-0.97) and some evidence of concurrent validity (it compares well with a measure that is effective) but no evidence of factor validity (that it actually measures what is intended to measure). They state the scale should be used by social workers to identify relevant actions, but it should continue to be researched.

McTavish et al. (2020) reviewed instruments used to identify maltreatment They narrowed the review to 19 articles representing 18 studies. The studies included various assessment strategies including three instruments: 1) the SPUTOVAMO checklist, 2) the Escape instrument, and 3) a 6-item screening questionnaire for child sex trafficking. They found that the tools were ineffective because they either identified false negatives or false positives (McTavish et al., 2020). They were not a good measurement.

In the United States, the National Child Traumatic Stress Network-NCTSN (n.d.) was established in 1980 with a mission

**to raise the standard of care and improve access to services for traumatized children, their families and communities throughout the United States**. The NCTSN has a list of 72 different inventories and scales. It is a list of evaluation data. Unfortunately, they do not list the two scales from the Justice Canada site. Only some of the inventories are free to access. The site itself is a good resource.

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# Chapter 14: Creating Healthy Relationships How to Change to Reduce and Eliminate Relationship Violence

BALBIR GURM AND GLAUCIA SALGADO

*Key Messages*

- Based on different theories, there may be different actions that can be taken to reduce the acceptance of relationship violence. Some actions we recommend are:
    - Make a personal commitment to change. Take the pledge at all our rallies and events.
    - Highlight personal stories of abuse and impacts on families.
    - Promote local helplines and have support for those who want to stop abusing.
    - Provide feedback to those that create an environment of safety and equity.
    - Establish a national prevention campaign that shows the impact of violence, and normalizes healthy relationships.
    - Normalize equitable decision-making among

couples.

- Encourage media to describe the impacts of relationship violence.
- Share the stories of survivors in our communities.

Relationship violence is any form of physical, emotional, spiritual and financial abuse, negative social control or coercion that is suffered by anyone that has a bond or relationship with the offender. In the literature, we find words such as intimate partner violence (IPV), neglect, dating violence, family violence, battery, child neglect, child abuse, bullying, seniors or elder abuse, male violence, stalking, cyberbullying, strangulation, technology-facilitated coercive control, honour killing, female genital mutilation gang violence and workplace violence. In couples, violence can be perpetrated by women and men in opposite-sex relationships (Carney et al., 2007), within same-sex relationships (Rollè et al., 2018) and in relationships where the victim is LGBTQ2SIA+ (lesbian, gay, bisexual, transgender, queer, Two-Spirit, intersex and asexual plus (The Scottish Trans Alliance, 2010; Rollà et al., 2018). Relationship violence is a result of multiple impacts such as taken for granted inequalities, policies and practices that accept sexism, racism, ageism, xenophobia and homophobia. It can span the entire age spectrum. It may start in-utero and end with death.

## Behavioural Change Models

Relationship violence is a pandemic affecting every country in the world and it needs to be addressed. How can we change individuals/societies and communities? There are a number of

behavioural change models that can be used, and a summary can be found below (Dyson & Flood, n.d.).

- The Elaboration Likelihood Model (ELM) argues that lasting attitude and behaviour change occurs when participants are motivated to hear a message, able to understand it and perceive the message as relevant to them. For example, if I believe what you are saying is relevant to me, I will listen carefully.

- The Social-Ecological Model suggests that the problem of violence against women is essentially one of culture and environment, rather than one of the psychological or biological deficits in individuals. For example, violence against women continues not because of genetic or mental health issues, but because society accepts it.

- The Social Norms Approach suggests that the majority culture, or normative environment, may support an individual's beliefs and behaviours and seeks to achieve change through social marketing. This approach aims to shift men's perception of social norms by revealing the extent to which other men also disagree with violence or are uncomfortable with common norms of masculinity. For example, if other men or people think what you are doing is wrong, you are less likely to do it. In some cultures, the phrase "what will people say" is used to keep survivors from reporting to keep the relationship abuse a private matter.

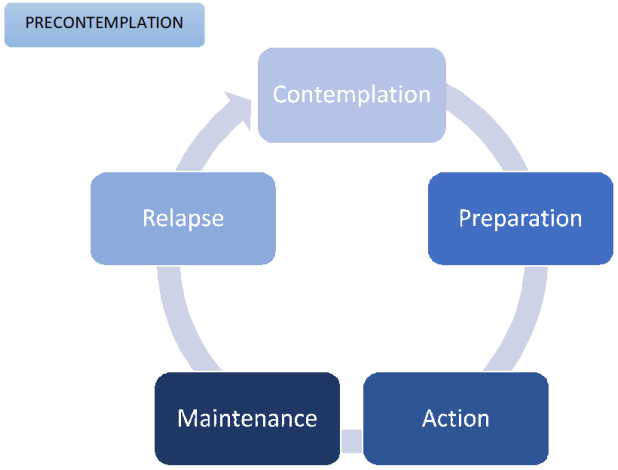
- The Community of Responsibility Model is based on the premise that everyone in a community has a role to play in ending violence against women(Dyson &

Flood, n.d. p 16-17). For example, it is not an issue just for men, women, or children but for every single one of us even if we are not involved in the abuse cycle.

- The Appreciative Inquiry model is based on the premise that we need to focus on the positive and amplify it. For more details click here.

We believe change needs to be addressed using multiple approaches. There are many other theories that can be utilized to implement personal/family and community change. The **Transtheoretical Model of planned change** was developed by James Prochaska and colleagues (Prochaska et al., 1992) from health psychology. It contains more than 20 years of research documenting its success. It is highlighted below. This model has 6 steps that repeat making it a cyclical model.

**Figure 14.1 – Process of Change**




Prochaska et al., 1992

1. Precontemplation (Not yet acknowledging that there is a

problem behaviour that needs to be changed)
2. Contemplation (Acknowledging that there is a problem but not yet ready or sure of wanting to make a change)
3. Preparation/Determination (Getting ready to change)
4. Action/Willpower (Changing behaviour)
5. Maintenance (Maintaining the behaviour change) and
6. Relapse (Returning to older behaviours and abandoning the new changes) (Prochaska et al., 1992)

From years of research, it is now believed that there are 10 processes that help individuals move through change. Gurm (n.d.) adapted these processes that were originally created for anti-smoking to anti-violence programs organized. These processes are listed under the heading of experiential or behavioural (see below). They were retrieved from The Stages of Change pdf where more details can be found.

**Processes of Change: Experiential**

1. Consciousness Raising [Increasing awareness]

I recall the information I had received on the prevalence of the issue and some signs and symptoms of abuse.

2. Dramatic Relief [Emotional arousal]

I react emotionally to the personal stories of abuse.

3. Environmental Reevaluation [Social reappraisal]

I consider the view that abuse in its different forms is toxic, it is a serious health issue across the lifespan.

4. Social Liberation [Environmental opportunities]

I find society changing in ways that make it easier for survivors to come forward. The #metoo has helped.

5. Self Reevaluation [Self reappraisal]

**Figure 14.2 – Process of Change Experimental (adapted)**


**II. Processes of Change: Behavioural for male offenders in heterosexual relationships**

6. Stimulus Control [Re-engineering]

I remove things from my home and computer that reminds me of toxic masculinity and I do not watch movies nor listen to music that normalizes controlling others' behaviour; I have material on healthy relationships in my home.

7. Helping Relationship [Supporting]

I have someone who listens when I need to talk about my abusive behaviour.

8. Counter Conditioning [Substituting]

I find that taking deep breaths and a short walk helps me to control my abusive behaviour. When I find myself getting angry (emotionally in the gut) I stop the reaction by recognizing and taking deep breaths.

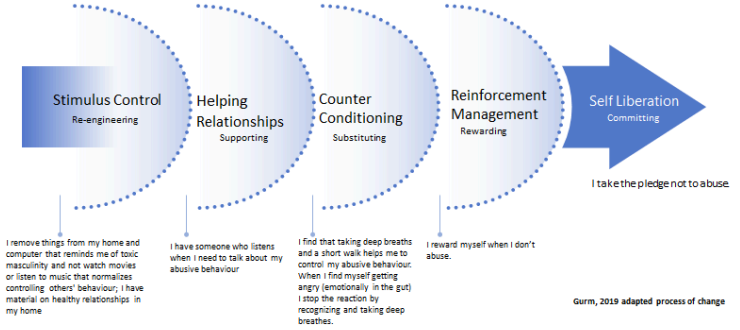
9. Reinforcement Management [Rewarding]

I reward myself when I don't abuse.

10. Self Liberation [Committing]

I take the pledge not to abuse.

**Figure 14.3 – Process of Change Behavioural (adapted)**




These steps are mediated by the characteristics of those involved. Each one of us can do this on a personal level.

## Appreciative Inquiry

NEVR uses the appreciative inquiry (AI) approach to address relationship violence. Click here for a quick overview of AI. The AI model originally had 4 steps and was developed for organizations but now has been expanded to 5 steps, and it can be applied to individuals, organizations and communities. Click here to read about the 5D model.

1. Define – we have explained the issue of RV in multiple chapters

2) Discover – we centre human rights legislation and socio-environmental framework

3) Dream – we identify the goal, what we envision

- Governments work with media to create positive messages about healthy communication so they are abundant.
- Everyone is treated with dignity and respect and not traumatized.

4) Design – we suggest actions

- Make resources open access and plan to train each person to be a community champion (this is what we are doing)
- Create a central repository for all resources similar to the COVID-19 response
- Governments and non-profit organizations work together to ensure adequate services to deal with relationship violence exist (design)
- Governments at all levels to work together to create national campaigns on relationship violence to run over a generation (25-30 years) (design)
- Communities are made aware of relationship violence resources (design)

5) Destiny – when we reach our goal, we want to embed the processes

- Keep statistics on RV and share and build on successes

## Bystander Training

Bystander training is extremely important, yet there is no standard teaching approach. From the teaching literature, we need to create a signature pedagogy for these programs, for the way we teach is as important as what content we teach. Signature pedagogy's key principles are:

1. Break complex skills into small components in teaching and learning – this can be done by scaffolding and having group members practice components of the skill and then put the complex skill together.
2. Be intentional with sequencing – plan and design with the end in mind.
3. Team teach – have individuals from different disciplines teach

the content to show perspectives – for example, with peer teaching, you could have three people with a diversity of gender identity, race, socioeconomic status teach together.
4. Active learning and real-world problem solving – provide real-life situations that may be gathered from the group being taught or developed together with service agencies. This will allow participants to mimic the situations that they may see.
5. Context – the social, biological and emotional environment is important. Need to ensure cultural safety and intersectionality and provide food at workshops.
6. Learning environment – need to ensure that the rationale of all elements of the above (1-5) are explained. Learners need to understand why design and delivery are so important. (Adapted from Gurung et al., 2009 by author, Balbir Gurm for this chapter).

## Human Rights Education

Human rights is a theme for RV as it is a human rights violation; it is a social justice concern. The United Nations Global Programme for the Implementation of the Doha Declaration (United Nations Office on Drugs and Crime – UNODC) created education materials on social justice. NEVR member, Yvon Dandurand, was part of the United Nations Team involved in the development of these modules that were created using the best available evidence and expert knowledge. The modules provide lectures, slides, and in-class exercises for university faculty to use free of charge to combat injustices, access the modules here.

Human Rights Education (HRE) is a lifelong process for all. It is an important contributor to the prevention of RV and early intervention. This is particularly true for children and youth, where they learn peaceful problem-solving, relationship skills and boundaries, during their formative development periods. Access to

HRE provides an opportunity to develop skills and attitudes that support healthy relationships or to unlearn negative behaviours/attitudes from their own experiences and exposures to RV. The International Centre for Human Rights Education provides toolkits on human rights and focuses on gender-equality. Their Play it Fair toolkit teaches children and positive youth values, such as non-discrimination, respect for diversity, gender equality, inclusion and solidarity are shared and contribute to a sense of common humanity (Equitas, n.d.). All their toolkits can be found here. Discrimination and relationship violence are widespread, deep-rooted, and prevalent in all parts of the world. Equitas helps to strengthen collaboration between women's organizations and human rights organizations and to encourage decision-makers to respect their obligations related to gender equality. All these toolkits need to be adapted to include minority lenses including gender and sexual diversity and race.

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# Chapter 15: Relationship violence against women commonly called IPV or domestic violence

BALBIR GURM AND GLAUCIA SALGADO

*Key Messages*

- There are many theories that have been presented over the years to explain relationship violence, including psychological, psychopathological, sociological, structural, and others. We accept the socio-environmental model, as it draws on them all.
- The "cycle of abuse" and "power and control" wheel are among the most common frameworks to understand the interplay of violence in relationships.
- Other researchers have gone so far as to classify the types of abuse that are most common as intimate terrorism, violent resistance, mutual violent resistance and situational couple violence.
- There is a debate regarding the gendered nature of violence, with the feminist school of thought arguing that it is predominantly men who perpetrate violence. However, recent discussions highlight gender

symmetry – see chapter 5.

- While Canadian statistics support the idea of gender symmetry on the lower end of the violence continuum, they also show that women are more likely to experience violence more severely and frequently than men. Challenges in reporting make it difficult to understand this phenomenon with accuracy.
- NEVR's position is not to argue about who is the most victimized, but to work across agencies to reduce relationship violence across the lifespan. The work of NEVR continues to promote collaborative practices and integration with local and provincial government partners.

Relationship violence is any form of physical, emotional, spiritual and financial abuse, negative social control or coercion that is suffered by anyone that has a bond or relationship with the offender. In the literature, we find words such as intimate partner violence (IPV), neglect, dating violence, family violence, battery, child neglect, child abuse, bullying, seniors or elder abuse, male violence, stalking, cyberbullying, strangulation, technology-facilitated coercive control, honour killing, female genital mutilation gang violence and workplace violence. In couples, violence can be perpetrated by women and men in opposite-sex relationships (Carney et al., 2007), within same-sex relationships (Rollè et al., 2018) and in relationships where the victim is LGBTQ2SIA+ (lesbian, gay, bisexual, transgender, queer, Two-Spirit, intersex and asexual plus) (The Scottish Trans Alliance, 2010; Rollè et al., 2018). Relationship violence is a result of multiple impacts such as taken for granted inequalities, policies and practices that accept sexism,

racism, ageism, xenophobia and homophobia. It can span the entire age spectrum. It may start in-utero and end with death.

## RV Against Women

In this chapter, we focus on RV against women. Here is a video on the definition of RV, commonly referred to as intimate partner violence or domestic violence when it is against adults (Centers for Disease Control and Prevention [CDC], 2018). Click here to listen to a survivor talk about her experience (Learning to End Abuse, 2017).

Relationship violence against women is a complex and multi-dimensional issue. Besides affecting women and societies worldwide, it is considered a significant public health problem with short and long-term consequences (World Health Organization [WHO], 2017). Social structural issues related to acceptance and legitimization of violence against women are critical factors related to the pervasiveness of this crime (Gonzáles, 2017; Herrero et al., 2017). Abuse against women encompasses a range of violent behaviours that are multifaceted in its forms and aetiologia. From issues correlated to geographical and cultural norms to the manifestation of unequal power in many societies, generally, such actions refer to physical and psychological violence, and sexual abuse (United Nations [UN], 1993; WHO, 2017). The literature tends to use the terms abuse, violence and maltreatment interchangeably when referring to any subtype of abuse against women. Similarly, most literature refers to these terminologies when addressing violence in heterosexual relationships. All forms of abuse against women have significant negative results on the overall health and the life of women. Largely, the most prevalent form of violence against women is sexual abuse, and it is often differentiated from physical abuse. One measure of violence used by many governments, the Conflict Tactic Scale, does not consider sexual abuse as an act of violence – see chapter 5. Besides physical,

psychological and sexual abuse, the literature refers to stalking behaviour, economic and power inequalities as critical forms of violence against women (Breiding, 2014; Carter, 2015; Postmus et al., 2016).

It is estimated that 1 in 3 women worldwide has experienced some form of violence (WHO, 2017). In Canada, the rates are similar (28%) and greater among Aboriginal, immigrant women and those with disabilities (see chapter 5). For the most part, statistics are primarily based on physical and sexual violence, partly because RV is underreported (see chapter 5) and partly because prosecutions mainly occur for these two forms of violence. Globally, 38% of murders against women are committed by their male partners and women are twice as likely as men to experience sexual assault, being beaten, choked or threatened with a gun or a knife (WHO, 2017). Also, women who identify themselves as lesbian or bisexual are at increased risk compared to heterosexual women, 11% versus 3%, respectively (Ibrahim, 2019), see chapter 20.

See percentage information of cases below:

- Women and girls between the ages of 15 to 24 years old represent 67% of all cases
- 79% of police-reported relationship violence is against women and girls (Burczycka & Conroy, 2018)
- The homicide rate is four times greater among women versus men (David, 2017).
- Pregnant women have an increased risk of relationship violence (Baird, 2015; Garcia-Moreno et al., 2006)
- Indigenous women are more vulnerable to experience physical abuse (60%) than non-aboriginal women, 60% versus 41%, respectively (Boyce, 2016)

There is overlap in risk factors, signs, symptoms and treatment options for all those impacted by RV regardless of age, sexual orientation, race, economic status, etc (see chapter 5).

Out of all forms of RV, violence against women and girls has been studied the most in Canada and around the world. Most of the literature has normalized heterosexual relationships and identified the male as the offender, indicating that this issue is being addressed, at least in many studies, as a gender-based approach. However, as shown in chapter 18, RV can be perpetrated by both men and women.

RV can also occur in non-heterosexual relationships (LGBTQ2SIA+). LGBTQ2SIA+ is the most recent term being used in Canada and in the North American context. It is defined as follows: L=Lesbian, G=Gay, B=Bisexual, T=Transgender, Q=Queer or Questioning, 2S = Two-Sprit, I=Intersex and A=Asexual. RV occurs within a social context that has hegemonic practices that may be passed on for generations. It can span the entire age spectrum. This chapter focuses on RV against those who identify as female or women. There is a separate chapter for children and girls are included there. Also, a chapter each for older adults, LGBTQ2SIA+, immigrant and refugee communities and Indigenous populations.

## Stalking

Besides the most discussed types of relationship violence (i.e., physical, psychological and sexual abuse), the literature refers to stalking behaviour, economic and power inequalities as critical forms of violence against women (Breiding, 2014; Postmus et al., 2016, Carter, 2015). Stalking—also called criminal harassment—refers to unwanted surveillance. These behaviours occur as repeated episodes of being called, watched, followed, receiving unwanted gifts and threatening messages. To learn more and hear a personal account, click here (Outside of the Shadows, 2017). Although stalking has been categorized as a distinct form of abuse, it tends to occur concomitantly with physical. However, stalking, considered a crime in Canada and the US, is not perceived

as a criminal offence in many countries due to the lack of proper legislation to address these behaviours (Department of Justice Canada, 2003; WHO, 2017). Despite Canada having established stalking as a crime – declaring even the month of January as the Stalking Awareness Month – there are critical gaps in criminal justice even in countries such as Canada that recognize stalking as a crime (Statistics Canada, 2018; WHO, 2017). Canadian statistics reveal that women who report stalking to the police "did not see tangible justice systems outcome to ensure protection from the stalker" (Statistics Canada, 2018, p. 24). In the US, criminal justice requires that at least two or more different events of stalking have occurred to establish criminal stalking behaviour (Office for Victims of Crime [OVC], 2018). However, there are extreme cases, in which one occurrence is enough to trigger harmful results (National Center for Victims of Crime [NCVC], 2011).

## Economic Abuse and Power

When verifying data on economic abuse and power, an analysis of 4 articles suggests that power inequalities and economic abuse are intrinsically connected. Historically, men are more likely to hold high social positions, and economic and political influence, which in turn generates a relationship between power and oppression. For those "in charge", this interplay means having control over resources and choices while labelling women as inferior and subordinate. As a result, this situation limits access to education and work opportunities that consequently hinder women's chances of self-efficacy and enjoying control over their own lives (Anderson et al., 2010; Barner et al., 2014; Sanders, 2015; Shtybel & Artemenko, 2016). Congruently, studies explaining the high incidence of violence against women indicate the critical role of the patriarchal system affecting behaviours and promoting a society that consents to unequal relations of power and privileges (Carter, 2015).

Furthermore, social norms, values and roles are critical to explaining violence against women (Hunnicutt, 2009; Yllo & Straus, 2017).

## Health Impacts

As incidents, prevalence rates and types of abuse against women become more apparent, its health consequences are also better understood. Flury and Nyberg (2010) suggest that women who have experienced violence are more likely to show poor mental and physical health and vulnerability to diseases. Health challenges that result from RV impact the heart, digestive, reproductive, muscle and bones and nervous systems that may lead to chronic physical and psychological conditions, post-traumatic stress disorder, depression and anxiety (CDC, 2003). Besides these overall health outcomes, women face a lack of opportunities to improve their social condition leading to the perpetuation of low socio-economic status and victimization (Dillon et al., 2013).

## Attitude

Although there are several studies on violence against women, systematic reviews indicate that intimate partner violence towards women is still poorly understood. After analyzes of 62 articles published between 2000 and 2018, a study by Gracia and colleagues (2020) indicates that intimate partner violence towards women correlated with three main areas – attitudes, socio-demographic attributes, and psychological variables. Although all these three areas were critical, studies included in the review indicated that attitudes had the strongest correlation with IPV towards women. Among attitudes described in the studies were legitimation and

acceptability of violence, attitudes related to intervention and perception of violence severity. Even though attitudes had the strongest correlation, only a small percentage of studies (9.7%) evaluated change in attitudes after an intervention program (Gracia et al., 2020). This suggests that there may be a need to focus on these types of behaviours and how to change them.

## Understandings

Most of the literature on RV against women is based on feminist theories and approaches. Also, early theories that explained relationship violence against women were generally based on heterosexual relationships and psychological frameworks. In the mid-1900s, wife-beating was considered a symptom of a dysfunctional relationship by a disturbed spouse. These theories focused on personality disorders and dysfunction secondary to social factors. However, these views used to explain relationship violence were challenged because they did not hold the dominant male accountable, blamed the victim and positioned RV as simply a family matter.

A student of famous psychologist Sigmund Freud, Helene Deutsch, in her article The Significance of Masochism in the Mental Life of Women, Part I: 'Feminine' Masochism and its Relation to Frigidit (1929) stated that women enjoyed masochistic sex putting the blame on the female victims for sexual violence. The feminist movement of the 1970s (most writings came from those known as Radical feminists) challenged these positions as did family theorists.

While Walker (1979) explained RV with the term "battered women syndrome", suggesting that some women have low self-esteem, feelings of guilt, and traditional views about marriage and gender that lead to learned helplessness. Women may develop a state of consciousness in which they believe that no matter what they do,

they cannot change their situations. As well, in cultures, at present or historically, women were and still are taught to obey men.

> From father's house to a husband's house to a grave that still might not be her own, a woman acquiesces to male authority in order to gain some protection from male violence. She confirms, in order to be as safe as she can be. (Dworkin, 1983, p. 14)

This socialization continues from generation to generation through societal and government processes (Foucault, 1977). Social structural issues linked to acceptance and legitimization of violence against women are critical factors related to the pervasiveness of this crime (Gonzáles, 2017; Herrero et al., 2017).

Relationship violence can happen to women of any age, class or race. Walker (1979) was one of the first to debunk that only certain types of women suffered relationship violence. This led us to the Duluth Model and the Power and Control Wheel and the Cycle of Abuse used by many transition homes and service agencies today. In the cycle of abuse, abusers **act out** and hit their victims, then they try to **rationalize and justify** their actions and the survivor may blame themselves for the abuse. Once the survivor accepts the story of the abuser the **pretend normal** cycle starts, where the couple proceeds as if everything is fine. It is calm and peaceful until the tension starts to **build-up** overstresses or conflicts and the abuser starts to feel helpless and may start calling the survivor names. Then the stress and powerlessness are so great, it leads to an acute episode of severe violence (**act out**). The cycle may last hours or weeks, but it tends to get shorter over time and acute violence becomes more frequent.

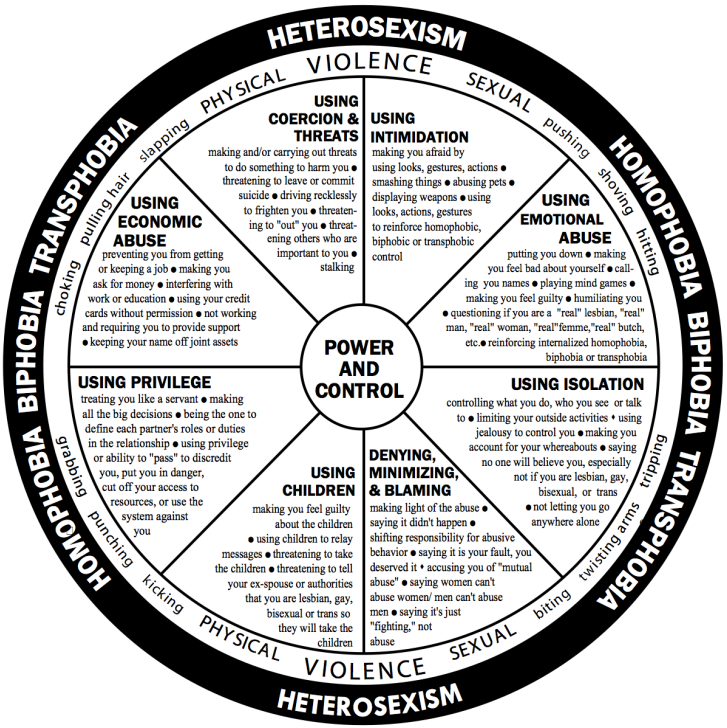
**Figure 15.1 – Cycle of Abuse**

chart representing the cycle of violenceGovernment of Manitoba (n.d.)

# Power and Control

Gendered violence is the dominant model that is used in Canada, and it posited that men use a variety of control tactics on their partners and that intimate partner violence should mainly be concerned about males perpetrating violence towards females (Dobash & Dobash, 2004). The Power and Control Wheel (below) shows a variety of tactics that are used by partners. The Duluth Model is based on the fact that there are power relationships, and these power relationships are used to control behaviour (Pence, 2017). The Duluth Model of Intervention can be found here.

**Figure 15.2 – Power and Control (National Center on Domestic and Sexual Violence, n.d.)**



The power and control wheel explains the tactics that abusers may use to keep power and control in a relationship. Listen to YouTube videos on the Power and Control wheel. For the overview, video click here. From this site you can also access a YouTube video on each of the tactics on the wheel, using coercion and threats, using intimidation, using emotional abuse, using isolation, denying, minimizing & blaming, using children, using privilege and using economic abuse.

The Duluth Model requires agencies to work together under 4 principles:

1. Change will be required at the basic infrastructure levels of the multiple agencies involved in case processing. Workers must be coordinated in ways that enhance their capacity to protect victims and must comply fully with inter-agency agreements. Participating agencies must work cooperatively on examining, adjusting and standardizing practices by making changes in eight core methods of coordinating workers' actions on a case. This involves:

    a. Identifying each agency's mission, purpose and specific function or task at each point of intervention in these cases.

    b. Crafting policies guiding each point of intervention.

    c. Providing administrative tools that guide individual practitioners in carrying out their duties. (e.g. 911 computer screens, specially crafted police report formats, D.V. appropriate pre-sentence investigation formats; education and counselling curricula designed for abusers).

    d. Creating a system that links practitioners to each other so that each practitioner is positioned to act in ways that assist subsequent interveners in their interventions.

    e. Adopting inter-agency systems of accountability, including; an inter-agency tracking and information

sharing system; periodic evaluations of aspects of the model; bi-monthly inter-agency meetings to identify, analyze and resolve systemic problems in the handling of cases; accountability clauses in written policies.

f. Establishing a cooperative plan to seek appropriate resources.

g. Reaching agreements on operative assumptions, theories and concepts to be embedded in written policies and administrative practices.

h. Developing and delivering training across agencies on policies procedures and concepts.

2. The overall strategy must be victim-safety centred. There is an important role for independent victim advocacy services and rehabilitation programming for offenders. Small independent monitoring and coordinating organizations should be set up to coordinate workgroups, operate the tracking system, and help coordinate periodic evaluations and research projects. Victim advocacy organizations should be central in all aspects of designing intervention strategies.

3. Agencies must participate as collaborating partners. Each agency agrees to identify, analyze, and find solutions to any ways in which their practices might compromise the collective intervention goals. Small ad hoc problem-solving groups, training committees, evaluation projects, and regular meetings are used to coordinate interventions. These working groups are typically facilitated by DAIP staff but, when appropriate, maybe lead by another participating agency.

4. Abusers must be consistently held accountable for their use of violence. Effective intervention requires a clear and consistent response by police and the courts to initial and repeated acts of abuse. These include:

a. Mandatory arrest for primary aggressors;

b. Emergency housing, education groups and

advocacy for victims;

c. Evidenced-based prosecution of cases;

d. Jail sentences in which offenders receive increasingly harsh penalties for repeated acts of aggression;

e. The use of court-ordered educational groups for men who batter; and,

f. The use of a coordinating organization (DAIP) to track offenders, ensure that recurrent offenders or those in non-compliance do not fall through the cracks and that victim-safety is central to the response (Pence, n.d.).

Johnson (2011) questioned that males are always the ones that exert power and control or that violence is equal between different sexes. Using the Duluth model and the power and control wheel, they created 4 categories below. These categories move RV from thinking that males perpetrate violence against females to an understanding that RV is a result of the environment created by the interactions and history of the partners involved in the relationship.

1. Intimate terrorism – The partner uses violence for general control. Involves the combination of physical and/or sexual violence with a variety of non-violent control tactics, such as economic abuse, emotional abuse, the use of children, threats and intimidation, the invocation of male privilege, constant monitoring, blaming the victim, threats to report to immigration authorities, or threats to "out"(to make public an aspect of identity or experience, such as sexuality) a person to work or family. There is a connection between offenders that have suffered violence as children and their chances of perpetrating violence; however, the vast majority of people abused as children do not grow up to become abusers.
2. Violent resistance – The perpetrator uses violence for general control and the partner responds with their own

violence. Some women respond to violence with their own violence. Others do not think they have any hope of winning and may kill their partners.

3. Situational couple violence – The perpetrator is violent (the partner may be too) but neither uses general control over the other. It is a situation or incident that happens that brings the violence to happen a minor incident 40% of the time that leads to arguments, aggression and then violence. It is believed to be about the same between men and women.
4. Mutual violent resistance – Both members of the couple are both violent and controlling (Johnson, 2010).

## Policies and Processes

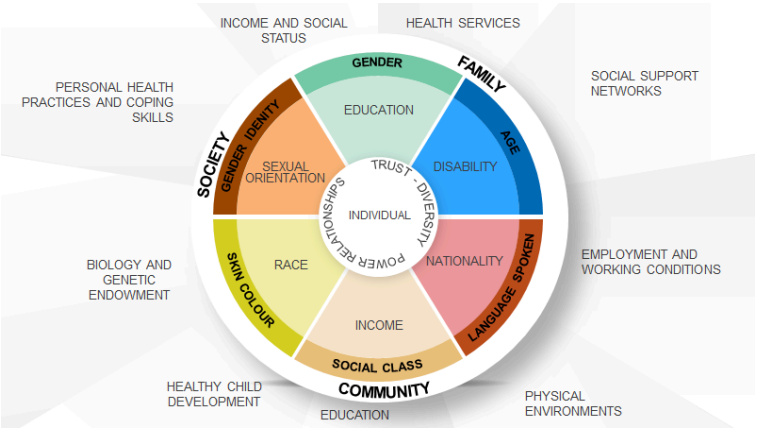
Most of the research and scholarship in Western countries is based on the feminist perspective or gender-based violence perspective that is situated in a patriarchal society assuming that violence is perpetrated by males against females. This scholarship has been effective, for it has brought gender issues to the attention of governments and been successful at decreasing the gender gap by advocating for policies and practices. For instance, Canada has mandatory arrest and prosecution policies, but this solution remains divisive. Those who support the prosecution policies against violence state that it protects the women and it holds the offender accountable. However, those who disagree with these policies state that they do not deter relationship violence and may, in fact, increase it, because it teaches offenders how to not get caught. But has it worked? In the early days of this law, most families did not want convictions but wanted help to stop violence (Houston, 2014). This is similar to today. For instance, when RV is discussed on South Asian radio stations in BC, women call in and state: "I just want the police to come and stop the violence but I do not want my

partner to be charged and sent to jail." This sentiment is similar to what the police tell us. They may be called in several times to the same household, but each time the woman states she does not want charges, only for the violence to stop.

Besides court processes, there are alternative dispute resolution processes (see chapter 8). The most common are mediation and healing/peace/reconciliation circles and sentencing circles. These processes involve the partners dialoguing with each other (mediation) and also dialoguing with the community (circles). A combination of processes may be used. The goal of court processes is to provide offender accountability and safety for the survivor. The primary goal of mediation and circles is to facilitate healing. This may be an approach that could be expanded.

This gender-based prevalent perspective does not account for the rates of violence we see against men and violence we see across gender variant groups (see chapter 5). The gender-based perspective accounts for patriarchal societies that are at the extreme end such as some developing nations but do not necessarily explain the relationship violence along the patriarchy spectrum on non-heterosexual relationships. Therefore, we suggest the model below better reflects current understandings. The NEVR RV Model is an integration of the Socio-environment Model, and, Multiple Ways of Knowing, Intersectionality and Cultural Safety Frameworks. The NEVR RV model accepts that power in relationships is a combination of overlapping processes, socio-environmental interactions that are influenced by multiple roles of people. When working with individuals it is important to recognize one's position of privilege and create cultural safety for the client. A culturally safe environment is trusting and equal where the client feels that they can be themselves without repercussions and only a client can decide if they are culturally safe. For a fuller discussion, see chapter 6.

**Figure 15.3 – NEVR RV Model**




Each person working in the RV sector needs to reflect on their own assumptions and power within the system in order to begin to create a culturally safe environment (First Nations Health Authority [FNHA], n.d.). This model accounts for the relationship violence experienced by gender and sexually diverse groups across the lifespan. It questions that males are always the ones with power and can be used to explain the statistics which show similar rates of abuse for males and females (see chapter 5).

## Risk Factors for Violence Against Women

Bantams et al. (2018) reported on the risk factors of violence in relationships with female survivors.

**Individual Risk Factors**

- Low self-esteem
- Low income
- Low academic achievement/low verbal IQ
- Young age
- Aggressive or delinquent behaviour as a youth
- Heavy alcohol and drug use
- Depression and suicide attempts

- Anger and hostility
- Lack of non-violent social problem-solving skills
- Antisocial personality traits and conduct problems
- Poor behavioural control/impulsiveness
- Borderline personality traits
- Prior history of being physically abusive
- Having few friends and being isolated from other people
- Unemployment
- Emotional dependence and insecurity
- Belief in strict gender roles (e.g., male dominance and aggression in relationships)
- Desire for power and control in relationships
- Hostility towards women
- Attitudes accepting or justifying IPV
- Being a victim of physical or psychological abuse (consistently one of the strongest predictors of perpetration)
- Witnessing IPV between parents as a child
- History of experiencing poor parenting as a child
- History of experiencing physical discipline as a child
- Unplanned pregnancy (CDC, 2019)

**Risk factors for men who abuse women and girls from WHO (2017) and Neilson (2013).**

- Low education
- History of child abuse
- Witnessed abuse of mother
- Alcoholism
- Unequal gender norms
- Acceptance of violence
- Male privilege
- See women as subordinate
- Situations of conflict, post-conflict and displacement

(WHO, 2017)

According to the First Nations Health Authority (2020), during pandemics such as the COVID-19 when citizens are asked to stay home, RV is a serious threat to many women and girls. Risk factors that are exacerbated are:

- Stress
- Loss and separation of friends, family, coworkers
- Loss of livelihood/financial hardship
- Loss of homes and resources
- Personal loss
- Uncertainty and anxiety
- Change in housing arrangements
- Breakdown of norms, including loss of routines
- Loss of control

To learn more about social determinants, visit the National Collaborating Centre on Social Determinants of Health. You will find a library of resources on topics such as intersectoral collaboration, anti-racism and health equity.

## COVID-19

A number of resources related to RV and COVID-19 can be found here (Learning Network, 2020).

Pimental reported that women's shelters are seeing an increase in calls during the COVID-19 pandemic and that women and children have been turned away (National News, 2020). There has been a 300% increase to the 24-hour support line for relationship violence (Eagland, 2020) in the Vancouver, BC area. Toronto City News reported that 10% of women are very concerned about violence in the home during the COVID-19 pandemic (City News, 2020).

Eight of twenty-two police agencies in the United States have seen an increase in RV calls (NBC News, 2020). Actions taken depend on available resources, politics and legislation at any given time. There are a number of resources in BC from counselling, shelters, legal services, job programs and parenting programs. A full list can be found on the BC211 website. For the Surrey area, a specific resource of services is the Pink Book (Network to Eliminate Violence in Relationship [NEVR], 2019). You can also access a national report on shelters and transitions houses for abused women and children here (Women's Shelter Canada, 2015).

The legislation and policies that impact RV are discussed in chapter 9. Resources vary from community to community, with fewer resources being available in the north. There is also the big "P" politics. Politics may interfere with the allocation of resources and actions.

## Action

The Network to Eliminate Violence in Relationships (NEVR), along with other stakeholders continues to lobby British Columbia's government to treat relationship violence like other global epidemics. The Provincial Office of Domestic Violence (PODV) was created in 2011, and NEVR worked closely with the provincial office and was able to provide regular input. PODV worked closely with the Office of the Representative for Children and Youth. With a change in government in 2017, PODV was phased out, and a Parliamentary Secretary of Gender Equality position was created under the Minister of Finance (Government of BC) and coordination responsibility moved to the Ministry of Public Safety and Solicitor General's Community Safety and Crime Prevention Branch, which has responsibility for victim services and violence against women counselling and outreach programs

PODV operated from a gendered lens and that still is the

approach. All ministries are to operate through a gendered lens or GBA+. Relationship violence cuts across multiple ministries, and we all need to work together across all ministries to address this pandemic.

In the past, to highlight the fact that ministries need to work together on RV, a Ministers' Forum was organized by NEVR and PODV. Seven BC Ministers attended community consultation to hear from community leaders why it is imperative to work together to address RV.

**Figure 15.5 – Ministers' Forum**

The Ministers heard from community leaders and vowed to work across ministries. NEVR continues to discuss this issue with local politicians and lobby for a national relationship violence plan and campaign. The Network of NGOs, Trade Unions and Independent Experts created a Blueprint for a National Action plan (Canadian Network of Women's Shelter & Transition House, 2015). The Canadian federal government (2017) created a Ministry for Status of Women and passed an act to create the Department for Women and Gender Equity Act (2018), and introduced a gender-based analysis plan. This department has worked towards creating a gender-based analysis course and implemented bills to increase representation on boards, management and introduced workplace legislation (Status of Women Canada, 2018). In 2019, The Status of Women Canada passed a framework to create gender equality (Status of Women Canada, 2020). The federal government since 1988 has tried to integrate child abuse and neglect, elder abuse and domestic or intimate partner violence under family violence by collaborating with 12 departments and agencies. You can access the Family Violence Initiative website here and read the materials. In reality, we all need to work off one framework in Canada. Alberta

created a framework to end family violence that is a good example of a framework that can be adapted by all jurisdictions (Government of Alberta, n.d.).

This work in RV still continues in silos. Different ministries and the provinces do not work together, and our literature continues to separate research and toolkits by age and gender. We need academics, service providers, community members (offenders/survivors, family/friends of survivors) and governments to work together and reduce duplication of effort because we need to be efficient and effective and not defend our turfs. We need to use a model that promotes social justice and accounts for relationship violence across genders and sexualities, across age, across dis/abilities etc. As well, we need to value all types of knowledge, both academic and practice. For a full description of types of knowledge and knowing, see Gurm (2013).

Universities can help educate citizens on relationship violence by creating courses based on research and projects completed by the United Nations. The United Nations Global Programme for the Implementation of the Doha Declaration (United Nations Office on Drugs and Crime, [UNODC], 2019) created education materials on social justice. NEVR member Yvon Dandurand was part of the United Nations Team that created these modules. Several apply to relationship violence. They are created using the best available evidence and expert knowledge. The modules provide lectures, slides, in-class exercises for university faculty to use free of charge to combat injustices. Under the UNODC (2019) Module 10 Violence against women and girls was created. As well, there are training modules for university students. It is good training but it still refers to RV as a gendered crime even though this theory does not explain RV by non-males. The training is available here.

Women can access services to help them address their situation without involving the police, but once the police are involved, then crown counsel may choose to prosecute the partner (see chapter 10). Many services are aimed at making the women independent and providing her with safe space (housing) and then helping her

to integrate into society. Women do not take the decision to leave lightly, and there are many reasons why they do not leave (see chapter 8). Also, when they choose to leave, it is the most dangerous time for women because it places them at greater risk of being abused. Some women choose to stay in relationships even though they may be suffering. In this case, they can be made aware of and encouraged to attend counselling, parenting or employment programs to improve their situations. Access BC resources at BC211.

Relationship violence can be classified as a pandemic because it is prevalent in the whole world. Instead of debating if the problem is greater for women or any other group, we need to remain curious and question how society is organized, the norms, resources, policies and institutional practices and how they may be contributing to relationship violence. All stakeholders need to consider using the NEVR RV model above and the NEVR Action model (Chapter 6) and work together to ensure that our interactions, actions and programs and policies are safe and equitable for everyone. We need to address historical oppression and aim to eliminate relationship violence in all its forms.

## Initiatives

Shift, The Project to End Domestic Violence is an excellent resource for the prevention of intimate partner violence. We suggest you start with this site. It is a collaboration of government, academics, and multiple agencies focused on stopping violence before it starts. This is an excellent site for anyone looking for information from a multi-agency think tank. It brings together resources on helping address intimate partner violence.

The Canadian initiative to try to understand what are effective programs is the National Collaborating Centre for Methods and Tools for public health. As well, it has a checklist for how to decide

if you should continue with your current program, how to set up an evaluation for your program and how to use evidence in practice.

The Centre for Research & Education on Violence against Women & Children is an excellent resource for knowledge and training. One of the things you can learn more about on the website is risk assessment and management. They have regular online training and work on various projects.

The Canadian Domestic Homicide Prevention Initiative is a knowledge hub. It brings together risk assessment, management, and safety planning strategies. It has a clickable map that highlights work being done in different jurisdictions. Click here for the BC initiatives. Also, for an excellent literature review on preventing domestic homicides, click here.

In a review, the best report was found in the grey literature. A comprehensive report written for Women and Gender Equality Canada is the most comprehensive review of programs that we have found. Crooks et al. (2020) wrote Primary Prevention of Violence Against Women and Girls Current Knowledge about Program Effectiveness. This report includes primary prevention programs with evaluation data for schools, bystander intervention programs, programs for specific groups: men and boys, high-risk youth, women with disabilities and indigenous women. It also covers advocacy, change and collaborations. It is a comprehensive report and we suggest, to get a good understanding of how to address intimate partner violence, you read it first.

Several initiatives addressing violence against women were found in the academic literature. Initiatives range from preventive programs offered in schools to advocacy and shelter programs and interventions to improve men's and women's relationships. However, many of them have not been evaluated, so there is uncertainty about outcomes. Some studies suggest that evaluating such initiatives is essential, for some programs might be more likely to cause harm than benefits (Ellsberg et al., 2014). In a meta-analysis that evaluated interventions, Rivas et al. (2016) found some evidence that intensive advocacy for women who experience IPV may

improve victims' lives for up to two years after intervention. It is not clear if short-term and brief advocacy interventions may create benefits for those who experience IPV. Among women who most benefit from advocacy, interventions are refugees, pregnant women and those who live in shelters. Although these results indicate mental health benefits, it is not clear if such interventions can reduce abuse.

Tankard, Paluck and Prentice (2019) studied if economic empowerment would lead to social empowerment. They compared the benefits of savings account plus health services vs health services alone in Columbia and found that although depression decreased, IVP victimization did not. In another study, the MAISHA project in which small financial loans are administered to improve women's economic situation conducted a controlled trial. The intervention group met for 10 sessions to discuss loan repayment and participated in activities to empower women and prevent IPV and the control group only met to discuss loan repayment. There were 485 women in the intervention group and 434 in the control group. At (2 years) follow-up, the risk for sexual and intimate partner violence was 25% less in the intervention group. The risk of intimate partner violence alone was 32% less in the intervention group compared to the control group and this was statistically significant (p=.043). For sexual violence, it was not statistically significant (p=.316). For emotional abuse, the evidence was adequate that the intervention worked (p=.910) (Kapiga et al., p. e1431). Overall, the program was effective in decreasing the risk of intimate partner violence.

## Projects, Services and Resources to Prevent IPV

There are also prevention programs listed in the chapter for older adults, children, Indigenous population, LGBTQ2SIA+ and men.

**Table 15.1 – List of Programs in Canada**

| Agency | Programs | Summary |
|---|---|---|
| **Surrey Women's Centre** | Surrey Women's Centre | They provide 24 hours services to assist women who may suffer RV. They have emergency, legal, medical and social services for anyone that wishes to access. Originally started for women, they now see men and gender-variant clients. |
| **Ending Violence Association of BC** | Ending Violence Association of BC | EVABC has a number of initiatives for BC including prevention programs and training for service providers. It is the provincial organization that has as one of its mandates to try to bring information to service providers. |
| **Battered Women's Support Services** | Battered Women's Support Services | BWSS is an initiative created in Canada that offers support to women who have experienced any form of abuse. Besides providing legal resources and advocacy services, the action includes community education and training, support over the phone through a crisis line, online information about economic strategies to deal with challenging financial situations, and a variety of supportive material like strategic safety plan, and transition housing information. |

| | | |
|---|---|---|
| **The Moose Hide Campaign** | The Moose Hide Campaign | The Moose Hide Campaign is an initiative created in BC, Canada, to increase awareness about violence against women. Besides hosting annual meetings and events, they have a presence in many Canadian Universities through specific projects with information about women's violence and how to prevent it. |
| **Out of Violence** | Out of Violence | The Out of Violence program is an initiative promoted through the Canadian Women organization—a Canadian foundation—that offers support to women who have experienced different forms of violence like sexual harassment and assault. |
| **The Intimate Partner Violence Prevention Program (IPV)** | The Intimate Partner Violence Prevention Program (IPV) | The Intimate Partner Violence prevention program is an initiative created through the Canadian Centre for Gender and Sexual Diversity to support LGBTQ2S victims of intimate partner violence. |
| **Elizabeth Fry Society of Greater Vancouver** | Elizabeth Fry | Elizabeth Fry offers support with shelter, family services, counselling, employment and educational support for women who are at risk of violence. |

**Table 15.2 – List of Programs outside Canada**

| Agency | Program | Summary |
|---|---|---|
| **MAISHA Project** | MAISHA Project | The Maisha is an initiative created in 2014 that aims to understand the impact of providing small financial loans and the impact of gender training in reducing intimate partner violence in Tanzania. Small loans are provided to women through microfinance and gender training (IMAGE) comprises of a set of 10-sessions training every two weeks. |
| **preventIPV** | preventIPV | It is a website in the US that brings together all national and international resources. It has thousands of resources and links to other resources on such topics as policy, training, programs, etc. |
| **National Domestic Violence Hotline** | National Domestic Violence Hotline | The NDVH offers a hotline service available in all states of the US, 24-hours a day via phone call, text and online chat, free awareness and educational material on subtypes of violence against women and relationship skills and boundaries, resources like agencies and services available in different states of US. |

| | | |
|---|---|---|
| **NPY Women's Council** | NPY Women's Council | The NPY Women's is an organization established in Australia. Created in 1980, they are focused on providing services to support Anangu women and children in 26 Aboriginal communities in the Central Australia region. |
| **The Spotlight Initiative** | The Spotlight Initiative | The Spotlight initiative was initiated in 2017 with the collaboration between the European Union and the United Nations. Through working with regional agencies and governmental authorities in 28 countries, this initiative provides strategies and support programs that address patriarchy, social norms, discrimination against women, legislation and policy gaps. |
| **Stepping-Stones** | Stepping-Stones | Stepping-Stones was created in response to the needs of a religious group that found themselves having critical concerns about intimate partner violence in the community. The program involves community-based participatory learning on intimate partner violence and HIV. This intervention is delivered over 50-hours into groups of women separated from men. |

| | | |
|---|---|---|
| **The Safe Homes and Respect for Everyone Project (SHARE)** | **The Safe Homes and Respect for Everyone Project (SHARE)** | SHARE is a program created to address intimate partner violence and HIV related infections in Uganda. This intervention includes services like advocacy, community activism, special events, and learning material available to the community. |

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# Chapter 16: Knowledge about Relationship Violence Against Children

BALBIR GURM AND GLAUCIA SALGADO

*Key Messages*

- Relationship violence against children is known as child abuse and neglect. It includes children who witness abuse and any act or omission by the parent or guardian, resulting in (or likely to result in) harm to the child or youth.
- 1 in 3 children younger than 15 years old has experienced some form of abuse in Canada.
- Several studies and reviews indicate correlations between RV among children and impacts on children's brain development and bio-psycho-social development from the time of conception throughout their life span.
- Systematic reviews have identified resilience factors in preventing or reducing adverse effects. These resilience factors are secure relationship and emotion regulation, social support, warm and affectionate relationships and cognitive skills and academic achievement.
- Effective prevention programs include parenting

programs that strengthen the family unit and minimize harm to the child through education to the parent(s)/caregiver(s) through the introduction of alternative punishment strategies and parental self-management strategies.

Relationship violence is any form of physical, emotional, spiritual and financial abuse, negative social control or coercion that is suffered by anyone that has a bond or relationship with the offender. In the literature, we find words such as intimate partner violence (IPV), neglect, dating violence, family violence, battery, child neglect, child abuse, bullying, seniors or elder abuse, male violence, stalking, cyberbullying, strangulation, technology-facilitated coercive control, honour killing, female genital mutilation gang violence and workplace violence. In couples, violence can be perpetrated by women and men in opposite-sex relationships (Carney et al., 2007), within same-sex relationships (Rollè et al., 2018) and in relationships where the victim is LGBTQ2SIA+ (lesbian, gay, bisexual, transgender, queer, Two-Spirit, intersex and asexual plus) (The Scottish Trans Alliance, 2010; Rollè et al., 2018). Relationship violence is a result of multiple impacts such as taken for granted inequalities, policies and practices that accept sexism, racism, ageism, xenophobia and homophobia. It can span the entire age spectrum. It may start in-utero and end with death.

## Relationship Violence Against Children

This chapter provides information on the impact of violence on children and their development. Relationship violence against

children is known as child abuse and neglect. RV can have lifelong consequences to the child in terms of their development potential. Information on these adverse childhood effects is provided. Furthermore, resources that can be helpful are described, and these are largely parenting programs that are available. The goal of these parenting programs is to strengthen the family unit and minimize harm to the child through education to the parent(s) and other caregivers.

## Definition and Prevalence

Relationship violence against children is known as child abuse and neglect. Child abuse is considered a severe issue that affects children worldwide. Although rates are not always reported, countries like Canada shows that 1 in 3 children younger than 15 years old had experienced some form of abuse (Statistics Canada, 2015). In Canada, for generations, we had the Indian Residential Schools, which forcibly removed Indigenous children from their families. In these residential schools is where many children suffered abuse and neglect. They were not allowed to speak their language or learn about their culture. The children were also isolated from their loved ones and taught the values of the dominant culture. The last residential school did not close until 1996 and Indigenous communities still suffer from the original and intergenerational trauma caused by this system.

In the US the Children's Bureau (2020) provides the following statistics for 2018:

- Child abuse and neglect: 678,000 children are impacted
- Victim rate is 9.2 victims per 1,000 children
- 26.7 per 1,000 for children up to age one
- 9.6 per 1,000 for girls
- 8.7 per 1,000 for boys

- 15.2 per 1,000 for Indigenous (American Indian & Alaskan Native) children
- 14.0 per 1,000 for African American children

Globally, 25% of adults state they have been abused as children (World Health Organization [WHO], 2016). The WHO goes on to state that internationally, 1 in 5 women and 1 in 13 men acknowledge they were abused as children.

Relationship violence against children is any behaviour or the failure to provide basic needs to someone under 18 years old. It involves an act or omission by the parent or guardian, resulting in (or likely to result in) harm to the child or youth. The forms of child abuse from BC Handbook for Action on Child Abuse and Neglect (Ministry of Children and Family Development, 2017) include:

- Neglect failure to provide food, shelter, primary health care, supervision or protection from risks, to the extent that the child's or youth's physical health, development or safety is, or is likely to be, harmed (p. 25)
- Physical abuse is a deliberate physical assault or action by a person that results in or is likely to result in physical harm to a child or youth. It includes the use of unreasonable force to discipline a child or adolescent or prevent a child or youth from harming him/herself or others. The injuries sustained by the child or teenager may vary in severity and range from bruising, burns, welts or bite marks to significant fractures of the bones or skull to, in the most extreme situations, death (p. 24)
- Emotional (or psychological) abuse can include a pattern of scapegoating, rejection, verbal attacks on the child, threats, stalking, insults, or humiliation
- Sexual abuse is when a child or youth is used (or likely to be used) for the sexual gratification of another person. It includes touching or invitation to contact for sexual purposes, intercourse (vaginal, oral or anal), menacing or threatening

sexual acts, obscene gestures, obscene communications or stalking, sexual references to the child's or youth's body or behaviour, requests that the child or youth expose their body for sexual purposes, deliberate exposure of the child or adolescent to sexual activity or material, and sexual aspects of organized or ritual abuse (p.24)

- Sexual exploitation is a form of sexual abuse that occurs when a child or youth engages in sexual activity, usually through manipulation or coercion, in exchange for money, drugs, food, shelter or other considerations. Sexual activity includes: performing sexual acts, sexually explicit activity for entertainment, involvement with escort or massage parlour services and appearing in pornographic images (p. 24-25)

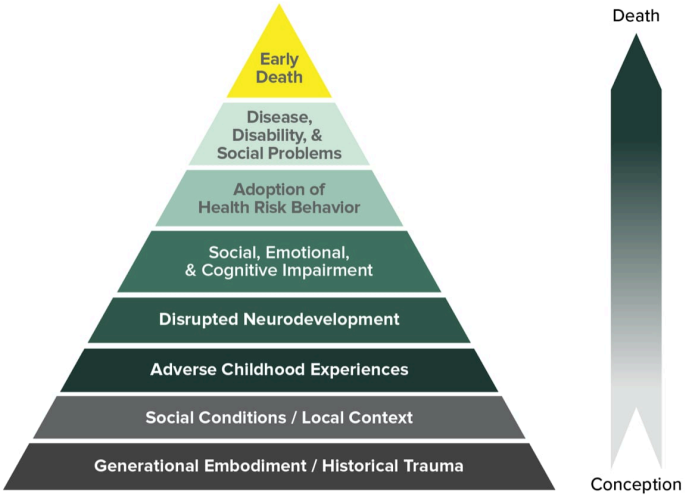
NEVR's definition of relationship violence also includes relationships with gangs because they inflict violence on those who are involved with them. Colleagues at the University of the Fraser Valley have written about relationship violence in gang groups of Abbotsford. They discuss how gangs are now more networked and job-specific, and they are only loyal to the money. This relationship violence has led to the deaths of gang members and results in the use of many public resources. The full report is available at Developing strategies on violence prevention and community safety in Abbotsford (South Asian Institute, 2019).

## Impact of RV against Children

Since the 1990s, significant research has been conducted to show the longitudinal impact of abuse and violence on children's development. Several studies and systematic reviews provide evidence on the correlations between RV among children (including children who witness abuse) and the impact on children's brain development and bio-psycho-social development (Mueller &

Tronick, 2019; Nocentini et al., 2019; Petersen et al., 2014; Racine et al., 2018; Teicher et al., 2006). Click here to watch a video on the impact of RV on children. The adverse childhood experiences study findings below demonstrate the relationship between childhood adverse events such as experiences of relationship violence against children and health and well-being consequences throughout life. See details from Kaiser Permanent Adverse Childhood Experiences (ACE) study (Centers for Disease Control and Prevention [CDC], 2020). Figure 16.1 explains how generational trauma is transmitted at conception and impacts health and social behaviours through the life span and leads to an early death.

**Figure 16.1 – Adverse Childhood Experiences** (CDC-Kaiser Ace Study, 2020)




Mechanism by which Adverse Childhood Experiences Influence Health and Well-being Throughout the Lifespan

The CDC-Kaiser Permanent Adverse Childhood Experiences (ACE) study collected information from 17,000 individuals in California, US. Questionnaires and surveys are available online, and data continues to be collected by healthcare practitioners. The ACE study included three categories of violence: abuse, neglect and family challenges. The research shows that there is an impact on the child from the time of conception. Also, the longer the time

of exposure, the more significant the biopsychosocial implications for the child that can even lead to death. There are sensitive and critical periods of a child's brain development from birth to age 8 (Figure 16.2). During these years, the brain is most vulnerable and influenced by experiences at home, school and community and has the greatest and long-term impact on how the child's brain and behaviour are developed (Petersen et al., 2014). Figure 16.2 shows the typical brain development of children ages 0-8, and it is essential to understand that exposure to, and experiences of RV, will have a lifelong impact on children, particularly those under the age of 8 because their brain is forming neuron connections and capacities that are critical for life. The ACE study underscores this developmental issue. Find a summary of the ACE study here. Figure 16.2 shows the typical development for children 0-8 which may be impacted due to trauma from relationship violence.

**Figure 16.2 – Typical Developmental Domains for Children Ages 0-8**

Image result for sensitive periods in early brain development"

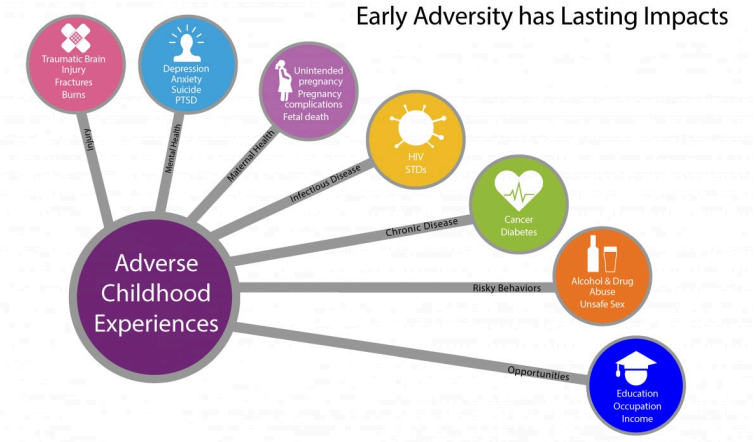
Findings consistent with the ACE study were found in a systematic review. Mueller & Tronick (2019) suggest that early exposure to relationship violence impacts the brain and behaviour in several ways:

- Exposure during pregnancy may lead to:
  - Antepartum hemorrhage
  - Intrauterine growth
  - Preterm delivery
  - Fetal death
  - Increased cortisol (stress hormone) resulting in high stress and decreased focus for infant
- Exposure during infancy to early childhood (first five years) may lead to:
  - Eating problems, sleep disturbances and mood issues, poor overall health, higher irritability, increased

screaming and crying
- Increased hyperarousal and fear, aggression and interference with development and sometimes loss of already learnt skills such as toileting in severe RV
- Long-term consequences are liked to PTSD, social and general anxiety, social withdrawal and depression
- Decreased IQ and cognitive function

The above is consistent with findings that verbal abuse (yelling, swearing, blaming, insulting) and witnessing family violence can cause higher levels of depression, anger, hostility and dissociation than familial sexual abuse without verbal abuse and domestic violence (Teicher et al., 2006). Parental arguing can lead to hyper-arousal in the infant, causing sleep disturbances and the inability of self-regulation that lead to the development of aggressive or submissive behaviours. In addition, Nocentini et al. (2019), in a meta-analysis, found that conflict, violence, child maltreatment, and authoritarian parenting are associated with an increased risk of bullying and cyberbullying. Check some of the lasting health issues from relationship violence from the ACE Study below. Early adversity may lead to injury (traumatic brain injury, fractures and burns), mental health challenges (depression, anxiety, suicide, PTSD), maternal health challenges (unintended pregnancies, pregnancy complications, fetal death), infectious disease (HIV, STDS), chronic disease (cancer, diabetes), risky behaviours (alcohol & drug abuse, unsafe sex) and decreased opportunities (education, occupation and income).

**Figure 16.3 – Impact of Early Adversity**




(CDC, 2020)

## Resilience Factors

Systematic reviews have been conducted to understand what can help children not develop adverse effects. The resilience factors identified are:

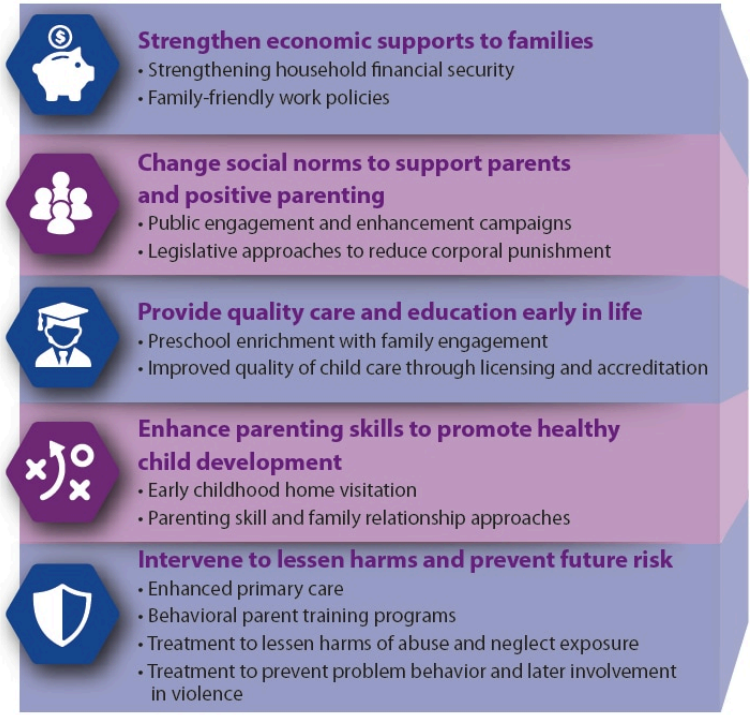
- Secure relationship and emotion regulation (Mueller & Tronick, 2019; Gartland et al., 2019)
- Social support (Racine et al., 2018; Nocentini et al., 2019)
- Warm and affectionate relationship (Nocentini et al., 2019)
- Cognitive skills and academic achievement (Gartland et al., 2019)

## Prevention

Primary prevention at a broad policy level is required because the resources required to deal with relationship violence are in the

billions. Recommendations of a report prepared by the Centers for Disease Control and Prevention (2016, p.10) discusses a public health approach to relationship violence. You can find the chart from the report in figure 16.4. It states five goals and some strategies to prevent violence in families. Primary prevention should be aimed to: 1. Strengthen economic supports to families through improving household financial security and family-friendly workplace policies. 2. Change social norms to support parents and positive parenting through public campaigns and legislation that reduces corporal punishment. 3. Provide quality care and early education through preschools and family engagement, and improved quality of childcare through licensing and accreditation. 4. Enhance parenting skills to promote healthy child development through early childhood education and parenting skills and family approaches. 5. Intervene to prevent future risk through enhanced primary care, behavioural parent training programs, treatment to decrease the harm of abuse and neglect exposure, and treatment to prevent problem behaviour and later involvement in violence (CDC, 2020).

**Figure 16.4 – Primary Prevention (CDC, 2020)**




The CDC (2019) published a paper on prevention based on the best available evidence for governments and policymakers that expands on the five ideas above.

## Actions

These policies need to be translated into actions. In order to develop effective interventions, it may be prudent to understand the perspective of survivors of childhood abuse. Arai et al. (2019) synthesized 33 qualitative reports and "...recommend that professionals be mindful of diversity in children's experiences of DVA (domestic violence and abuse) and tailor their treatment approach accordingly. Listening carefully to children's own

accounts may be more effective than the assumption that children are affected by DVA in the same way" (p. 10). This is extremely important because many studies report results in averages that may not apply to any single person. Children and young people should be allowed to describe their experience and may require the assistance of professionals to explore these experiences. This process is necessary in order for professionals to respond appropriately. There may be a tool that can be used to help assess children. Ravi and Toni (2019) conducted a systematic review to identify the usefulness of the Child Exposure to Domestic Violence Scale (CEDV). They found the scale had internal consistency and validity (measured what it is designed to measure) even when used across different cultures. They state this tool may be used by social workers.

Although the impacts of relationship violence on a large scale are fairly well understood, there is less research on effective programs. A few systematic reviews are below.

Leijten et al. (2019) conducted a systematic review using qualitative comparative analysis. They found the two components of effective programs were alternative punishment strategies and parental self-management strategies. The Child Welfare Information Gateway in the United States (2019), in their brief issue state relevant and effective programs, should include the components below. Read the full brief.

- Providing parents with an opportunity to network with, and receive support from, parents who are in or who have been in similar circumstances
- Efforts to engage fathers
- Treating parents as equal partners when determining which services would be most beneficial for them and their children
- Tailoring programs to the specific needs of families
- Addressing trauma to ensure that it does not interfere with parenting and healthy development

- Ensuring families with multiple needs receive coordinated services
- Offering programs that are culturally relevant to meet the needs among the diverse population

In addition requirements of programs include:

- Positive parent-child interaction and communication skills
- Importance of parental consistency
- Time for parents to practise new skills during coached training sessions
- The use of a time-out when emotions or behaviours escalate
- Requiring providers to have a minimum of a postsecondary/bachelor's degree and often a graduate degree
- Duration of training or treatment ranges from 5 to 20 weeks
- Services are typically offered in both the home and in the community
- Feedback is provided during parenting sessions (Barth & Liggett-Creel, 2014)

The report reviews the literature and has a directory of websites (p. 7) where you can find the evidence for programs. Using all available data, the CDC created positive parenting tips from 0-17 organized by age (CDC, 2020):

Infants (0-1)
Toddlers (1-2)
Toddlers (2-3)
Preschoolers (3-5)
Middle Childhood (6-8)
Middle Childhood (9-11)
Young Teens (12-14)

Teenagers (15-17)

One effective service located in Surrey BC is Sophie's Place Child & Youth Advocacy Centre. It has integrated services that address the needs of children 0-18 years of age who have been sexually, physically or mentally abused. The centre has the ability to video record testimony to decrease the number of times the story has to be repeated.

## Effective Research-based Programs

The following are effective research-based programs. Many are offered free of cost. Visit their websites for more information.

**Table 16.1 – List of Programs in Canada**

| Agency | Program | Summary |
|---|---|---|
| Healthy Families BC | BC Healthy Connections Project | The BC Healthy Connections Project ensures that all pregnant and parenting women receive the care that they and their families need (Healthy Families British Columbia, 2015). |
| Child and Youth Advocacy Centres (CYAC) | CYAS | CYACs provide coordination (and sometimes co-location) of police, child protection workers and victim services, to minimize system-induced trauma by providing a single, child-friendly setting for victims, witnesses and their non-offending family members. They support children to navigate complex investigation processes, while reducing the number of meetings/ interviews and coordinating effective referrals to services such as health and mental health. There a are a number of them across BC. Find one near you |

| | | |
|---|---|---|
| Violence is Preventable (VIP) | VIP | Violence Is Preventable (VIP) is a free, confidential, school-based violence prevention program for students in grades K-12 that reflects the competencies outlined by Ministry of Education. VIP presentations are delivered by Prevention, Education, Advocacy, Counselling and Empowerment (PEACE) Program counsellors. VIP increases awareness of the effects that domestic violence has on students while connecting those experiencing violence to PEACE program counselling. List of Programs. |
| McMaster University | Nurse-Family Program | Home visits provided by nurses and training staff to provide support to mothers (McMaster University, 2015). |
| NSPCC and Fraser Health Authority | Caring Dads | It targets fathers to enhance the safety and well-being of their children (NSPCC, 2017). |
| Strengthening Families Initiative | Strengthening Families Program | It intends to facilitate a closer connection with families allowing parents to get help more easily with staff members (Center for the Study of Social Policy, 2013). |

| | | |
|---|---|---|
| PREVNet | PREVNet | It is a national organization, PREVNet that brings together researchers and community organizations from across Canada to address bullying. It is a healthy relationship hub. PREVNet has many resources including toolkits for bullying prevention in schools. It is an excellent site. |
| Stroh Health and BC | Respectful Futures | It is a resource for 12 to 18 year olds that can be delivered in schools and in communities throughout BC in order to prevent relationship violence. Its focus would be to promote social inclusion and to help to create and reinforce a better understanding of healthy and respectful relationships. |
| Group of Organizations | Early Childhood Exposure to Domestic Violence: You can help | It brings resources on the definition of domestic and how it impacts children. This resource also shows signs used to identify violence and strategies to help victims. |
| KPU and Surrey Schools | Peer Mentor Manual for Middle and High School. | Offers peer training manual on healthy relationships for grades 5 and up NEVR, n.d.). |

**Table 16.2 – Programs outside Canada**

| **Agency** | **Program** | Summary |
|---|---|---|
| Triple P International and the University of Queensland | Triple P Positive Parenting Program | For parents and caregivers of children ages 0–16. It intents to inform parents and caregivers about strategies for promoting social competence and self-regulation in children. It is delivered through Community agency, outpatient clinic, school, adoptive home, birth-family home, foster or kinship home, hospital, or residential |
| National Selfcare Training and Research Center | SafeCare | It provides parent assessment to understand the characteristics and challenges in the family. Second, staff members help parents to use positive connections with their children coaching positive verbal and physical interactions. |
| PCIT International | Parent-Child Interaction Therapy | The main idea in this initiative is to instruct parents to learn a more positive parental style that can help children between ages 2 and 7 manage their behaviour. |

| | | |
|---|---|---|
| Center for Growth and Development | Nurturing Fathers Program | Focus on fathers and families at risk of experiencing moderate levels of dysfunction. It teaches parenting and nurturing skills to men through the promotion of healthy family relationships and knowledge of child development. It is delivered through the State or local community agency, school, church, prison, etc. |
| Incredible Years Inc | Incredible Years | Programs for parents or caregivers of children from birth through 12 years old, teachers of young children. To promote social and emotional competence and prevent, reduce, or treat behavioural and emotional problems in young children. Delivered through a community agency, outpatient clinic, school, birth-family home, foster or kinship home, hospital, or workplace. |
| The California Evidence-based Clearing House | Strong Communities Initiative | It Involves the whole community through voluntary assistance by neighbours for one another, especially for families of young children. |
| Duke Sanford Center for Child & Family Policy | The Durham Family Initiative | It provides resources like therapeutic and respite care, family education, and home-based services to high-risk families (Duke Sanford – Center for Child and Family Policy, n.d.). |

| | | |
|---|---|---|
| HRSA Maternal & Child Health | The Maternal, Infant, and Early Childhood Home Visiting Program | Home visits are provided to pregnant women and families in order to assess and provide resources. |
| United Nations Office on Drugs and Crime – UNODC | University Module Series Crime Prevention & Criminal Justice | Series of Modules for University Students, Module 12 Violence against Children |

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# Chapter 17: Relationship Violence Against Older Adults

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*Key Messages*

- The older adult population in Canada and around the world is increasing, and elder abuse is recognized as a public health, and a pervasive social issue.
- Relatives, friends and caregivers are often the perpetrators of elder abuse.
- Types of relationship violence with older adults include: physical, sexual, emotional or psychological, neglect, financial or exploitation, violation of Rights and Freedoms and systemic abuse.
- Many older adults experience social isolation. Social isolation is a common risk factor for RV.
- Protective and risk factors exist and intersect at the individual, relational, community and societal levels.
- Elder abuse prevention and intervention initiatives have not received enough research attention, so there are many recommendations, but very few evaluations done to understand its applicability and outcomes.

Relationship violence is any form of physical, emotional, spiritual and financial abuse, negative social control or coercion that is suffered by anyone that has a bond or relationship with the offender. In the literature, we find words such as intimate partner violence (IPV), neglect, dating violence, family violence, battery, child neglect, child abuse, bullying, seniors or elder abuse, male violence, stalking, cyberbullying, strangulation, technology-facilitated coercive control, honour killing, female genital mutilation gang violence and workplace violence. In couples, violence can be perpetrated by women and men in opposite-sex relationships (Carney et al., 2007), within same-sex relationships (Rollè et al., 2018) and in relationships where the victim is LGBTQ2SIA+ (lesbian, gay, bisexual, transgender, queer, Two-Spirit, intersex and asexual plus) (The Scottish Trans Alliance, 2010; Rollè et al., 2018). Relationship violence is a result of multiple impacts such as taken for granted inequalities, policies and practices that accept sexism, racism, ageism, xenophobia and homophobia. It can span the entire age spectrum. It may start in-utero and end with death. Relationship violence impacts the physical, psychological, economic and social wellbeing of those who are abused (see chapter 5), their families, communities and society. This chapter provides a closer look at elder abuse, risk factors and some resources.

## Relationship Violence in Older Adults – Elder Abuse

The older adult population in Canada and around the world is increasing, and relationship violence among this population group is recognized as a public health and pervasive social issue. Relationship violence against older adults is called elder abuse. It is defined as "a single, or repeated act, or lack of appropriate action, occurring within any relationship in which there is an expectation

of trust causing harm or distress to an older person—aged 60 years and older" (World Health Organization [WHO], 2017). Also, the terms elder maltreatment and elder mistreatment are used to describe elder abuse (Acierno et al., 2001). It is important to note that older adults are a heterogeneous population group, and risks of elder abuse might vary among different age groups.

## Definitions and Incidence

Elder abuse can be broken down into different types of abuse. **Physical abuse** refers to acts of violence or the use of physical force against an older adult; for instance, hitting, pushing, kicking, punching, grabbing or handled roughly and inappropriate use of drugs and physical restraints to exert control over an older individual.

In Canada, victims of physical abuse are often Aboriginal seniors, divorced older people, cognitively impaired or physically disabled, low-income seniors and those who live in rural areas (Brozowski1 & Hall, 2010; McDonald, 2011). Rates of physical abuse vary across the globe, and countries of Africa and Europe have the highest percentages; 15% in Nigeria, and 13% in the UK and Northern Island (WHO, 2017). Factors affecting the prevalence of physical abuse are also associated with gender. Research shows that older women and LGBTQ older adults are considerably affected by physical abuse, with estimates reaching up to 42% among LGBTQ seniors (MAP, 2009). Furthermore, physical violence against older adults is often accompanied by other forms of abuse, the most prevalent being psychological and financial abuse (Elder Abuse Organization, 2019).

**Psychological abuse** is sometimes called emotional abuse, and it is characterized by attempts to intimidate or belittle an older person using insults, verbal threats, ignoring, withholding critical support or service, trying to control their choices and freedom, treating them as a child and not allowing them to see family and

friends (WHO, 2019). The prevalence of psychological abuse is alarming around the world. Countries like the UK and Northern Island, China, Croatia, and Spain have the highest rates: 38%, 27%, 24%, and 15%, respectively (WHO, 2017). Psychological abuse is associated with low social support, financial strain and low education level. Countries that provide little or no social assistance to caregivers of vulnerable older adults have the highest rates of psychological abuse (Macassa et al., 2013). As it occurs with physical abuse among the LGBT older population, psychological abuse is extremely high in this population, especially among transgender older adults. A study reveals that almost 80% of transgender seniors report having suffered verbal violence (MAP, 2009).

**Sexual contact/abuse** or event that happens without the consent of an older adult, not being allowed to have personal privacy or verbal/suggestive behaviour is defined as sexual abuse.

Elder sexual abuse includes any unwanted sexual interaction like touching an older adult with sexual intention or someone touching him/herself sexually in front of an older adult, unwanted conversations with sexual content and sexual activity with an older adult who either does not consent or is unable to do so (WHO, 2019). Elder sexual abuse has been suggested to be less prevalent than other forms of violence (Acierno et al., 2010; WHO, 2019). However, the low number of studies on sexual abuse among the older population is a critical barrier to understanding its incidents and impact (WHO, 2017).

Bows (2018) reviewed published studies, and found rates of sexual violence vary between 0.9-8% for older women. Dong (2005) reported abuse across North and South America, 10% to 47.3% with a higher incidence for those with dementia. The National Council on Aging (n.d.) states that 1 in 10 older adults in the US suffers elder abuse. Burnes et al. (2019) estimated that only 15.4% report to the police, with fear of revictimization being cited as the most prevalent reason. Some other reasons are an embarrassment, fear, denial, isolation, lack of resources, or lack of knowledge about reporting procedures. Physically being capable of reporting is also a barrier

for some older adults as they may have to rely on others (their abusers) for mobility and to communicate due to age-related health issues.

**Financial abuse** is also known as financial exploitation. It is misuse or stealing money, property or other assets or possessions by tricking, threatening or persuading or miss using a power of attorney. It is a violation of rights and freedoms- not being able to make a choice that is protected under the law such as the end of life. The most common type of RV is financial (CNPEA, 2017; Weissberger et al., 2019).

Often, family members or people who have a close relationship with the older adult are the perpetrators who see the behaviour as acceptable due to their "sense of need, entitlement or greed" (HealthLinkBC, 2018). Financial abuse includes but is not limited to, illegal use of debit or credit cards, unauthorized cashing out of an older adult's pension or other forms of financial gain, deceiving an older person to signing documents with monetary value and controlling an older adult's financial resources (Lachs & Pillermer, 2015; NCEA, n.d.). Financial abuse has been associated with low-income population groups, and it is the most reported type of abuse and is expected to increase even more due to the increase in the older adult population (DeLiema et al., 2012; Jackson & Hafemeister, 2013). When an older adult is a victim of financial abuse, he/she might have their basic needs like food, shelter and medical care unmet, causing a significant negative impact on their health and quality of life (National Institute on Aging, 2016). Although some developing countries show the highest rates of financial elder abuse like Brazil (14,4%) and Nigeria (13%), Canada and the US have similar prevalence as India and Thailand with 5% and 6%, respectively (Santos et al., 2019; WHO, 2017).

In the United States, the health care cost of elder abuse is estimated at $5.3 billion (Dong, 2005). As with all RV, it is difficult to estimate the true scope of the issue because it is vastly under-reported. Savage (2018), based on Canadian Statistics of 2018, shows that from 12,202 police-reported cases—45% female versus 56%

male—33% were abused by a family member most often spouse, followed by an adult child. Reasons reported as triggers of abuse were linked to anger, frustration, despair and argument.

**Elder neglect** refers to either intentional or unintentional failing or refusal of a caregiver to meet an older person's physical, emotional and social needs. Caregivers might be a family member like a spouse, daughter, or son or a paid professional who is responsible for providing regular help to a person who needs personal and health care either in their home or at a care facility (Wister & McPherson, 2014). Some examples of elder neglect are failing to give medication, bathing, toileting, and dressing, stopping essential health treatment, consciously ignoring an older person and failing to provide appropriate food and water (NCEA, n.d.). Neglect is extremely common among older adults who have more complex health problems like dementia or decreased physical/psychological ability. There are significant discrepancies of neglect among different genders. For example, women and older adults who self identify as LGB are at the highest risk of elder neglect (Grossman et al., 2014; Lacher et al., 2016; McDonald, 2011). The higher life expectancy for women compared to men and the higher chances of requiring a caregiver are one reason for the gender difference between men and women (McDonald, 2011). In the case of LGB, Frazer (2009) suggests that caregivers' prejudice against LGB identity and homophobic views are considered crucial reasons of neglect among this population group.

Neglecting an older person's needs can lead to physical and emotional problems like malnutrition, serious health problems that require hospitalization, early institutionalization, and in severe cases, death (Del Carmen & LoFaso, 2014; Dong et al., 2011; Friedman et al., 2011; Rovi et al., 2009). It is essential to understand that older adults may engage in self-neglect and self-abuse behaviours. Although self-neglect and self-abuse are connected to family relationships and lack of social support, other complex issues may exist (McDonald, 2011).

**Spiritual abuse** is behaviours that prevent or "denigrate

individuals from practicing their cultural and spiritual beliefs" (The Grandmother Spirit Project, 2011 p.4). For example, every time an older family member wishes to go to the Gurdwara to worship, their family makes up an excuse for why they cannot drop him off and the person never gets to go to the Gurdwara.

**Systemic abuse** refers to institutional "rules, regulations, policies and social practices that harm or discriminate against older adults" (The Canadian Network for the Prevention of Elder Abuse, 2017). Although examples of systemic abuse are often associated with one of the more general criteria, for instance, using medication to control challenging behaviours due to lack of staff is related to physical abuse, systemic or institutionalized abuse represents a distinct issue. Practices and consequences of systemic abuse become normalized and justified creating an oppressive system that is challenging to recognize and contest. Consequently, institutionalized abuse turns into a pervasive and enduring issue.

Weissberger et al.'s (2019) frontline study, at a call centre where survivors only identified one form of abuse, found the rates of reporting were as follows: (49.5%) financial abuse, (13%) neglect, (12.5%) emotional abuse, (5.1%) reported physical abuse, sexual abuse (0.8%) and self-neglect (0.8%). Also, the same study found that 23% of the calls reported more than one type of abuse, in the following order: physical, emotional abuse, sexual abuse, neglect, self-neglect, and emotional abuse and quite often occurred with physical and financial; and neglect most often co-occurred with financial, followed by emotional abuse (Weissberger et al., 2019).

According to a systematic review by Viergever et al. (2018), 141 million older adults around the world are abused, in contrast with the figure of 1.4 billion women around the world. Yon et al. (2017) examined data from 28 countries and found that elder abuse is prevalent and under-reported. After assessing 52 publications, findings show a global prevalence of almost 16% between 2002 to 2015. Although this rate is considered critical, this number might be even higher due to significant gaps in estimating the prevalence of elder abuse. Disagreement in defining and measuring elder abuse

is suggested to be a key factor affecting variations in reported prevalence (Dong, 2005). Prevalence statistics are hard to predict because studies are often done on small and non-representative samples. Also, in many countries, crimes reported to the police are not labelled as elder abuse, nor do reports always include the victims' age (McDonald, 2011).

For many reasons, it may be difficult for an older adult to tell someone that they are being abused. For how to tell someone, click here (Seniors British Columbia, n.d.). Elder abuse is underreported and the consequences are ill health, hospital and care home admissions and death.

## Health Impacts

The abuse of older adults is considered a major public health problem that is associated with adverse health outcomes such as the increased risk of morbidity and mortality (Dong et al., 2011; Jerliu et al., 2013). Besides severe, long-lasting health consequences, inflicting harm to older individuals has significant implications for the health care and criminal justice systems that are costly to address (Aged Rights Advocacy Service [ARAS], 2019; Dong & Simon, 2013).

Yunus et al. (2017) conducted a systematic review to understand the consequences of elder abuse and neglect. They searched 7 data banks and eventually narrowed it to 19 studies. Within these studies, they found abuse can result in deaths, hospitalization, emergency room visits and use of health and social services. They also found that in some studies "older women, in general, were materially and socially disadvantaged compared to older men" and older women "had higher levels of severe disability and poorer living arrangements" (p. 209).

Below is a list of consequences of abuse from Yunus et al. (2017):

- Death
- Hospitalization
- emergency room visits
- Use of health and social services
- Decrease in
    - Physical health
    - Physical function
    - Mental health
    - Psychological health
    - Disability
    - Depressive symptomatology
    - Depression
    - Psychological distress
    - Negative emotional symptoms
    - Negative self-rated health
    - Musculoskeletal pain
    - Headache
    - Incontinence
    - Allergy
    - Stomach problems
    - Oerweight
    - Anxiety
    - Sleeping problems
    - Stress
    - Suicidal ideation
    - Suicidal attempt
    - Digestive problems
    - Metabolic syndrome
    - Chronic pain
    - Somatic complaints
    - Social dysfunction

## Risk Factors

It is important to understand the risk factors of RV in order to intervene and assist. They can be used to create prevention programs. It is important to recognize that the factors discussed below are what contributes to risk, they are not causes.

According to the Angus Reid Institute (2019), social isolation is experienced by 62% of all Canadians and that maybe even higher among older adults. Social isolation is a common risk factor for RV as the older adult may not wish to complain due to fear of losing their minimal social contacts and family members.

Blundell and Warren (2019) Australian study found that living in a rural and isolated community also increases risk as well as limits access to services. Crowder et al. (2019) conducted an integrative review of elder abuse in Indigenous populations in the US and found that substance abuse, mental health problems and caregiving were common risk factors. Caregivers get burned out and are at risk of abusing the person who they are caring for.

Storey (2019) conducted a meta-analysis to identify risk factors for elder abuse for those being abused and for perpetrators. She reviewed 198 studies and synthesized eight common risk factors for perpetrators:

- Challenges with physical health
- Challenges with mental health
- Substance use
- Stress and coping
- Dependency
- History of abuse
- Holding negative attitudes towards older adults
- Relationship problems

Risk factors among victims of elder abuse were identified as challenges with physical health, mental health, stress and coping, an

attitude of self-blame, a history of abuse, and relationship problems (Storey, 2019). It is interesting that four of the risk factors are the same for perpetrators and those being abused. Read her full review, click here.

The CDC (2019) has also identified both protective and risk factors and organized them as an individual, relational, community and societal, see below.

## Risk Factors for Perpetrators

**Individual**

- Current diagnosis of mental illness
- Current abuse of alcohol
- High levels of hostility
- Poor or inadequate preparation or training for caregiving responsibilities
- Assumption of caregiving responsibilities at an early age
- Inadequate coping skills
- Exposure to abuse as a child
- Relationship level
- High financial and emotional dependence upon vulnerable older adults
- Past experience of disruptive behaviour
- Lack of social support
- Lack of formal support

**Community Level**

Formal services, such as respite care for those providing care to older adults, are limited, inaccessible, or unavailable.

**Societal Level** – a culture in which:

- There is a high tolerance for, and acceptance of,

aggressive behaviour
- Health care personnel, guardians, and other agents are given greater freedom in routine care and decision making
- Family members are expected to care for older adults without seeking help from others
- Persons are encouraged to endure suffering or remain silent regarding their pains
- There are negative beliefs about aging and older adults

In addition to the above factors, there are specific characteristics of institutional settings that can increase the risk for perpetration of vulnerable older adults, including:

- Unsympathetic or negative staff attitudes toward residents
- Chronic staffing problems
- Lack of administrative oversight, staff burnout, and stressful working conditions

## Protective Factors for Perpetrators

Protective factors reduce the risk of perpetrating abuse and neglect. These protective factors have not been studied as extensively or rigorously as risk factors. However, identifying and understanding them are equally as important as researching risk factors. Research is needed to determine whether these factors do, indeed, buffer older adults from abuse.

**Relationship level**

- Having numerous, strong relationships with people of varying social status

**Community-level**

- Coordination of resources and services among community agencies and organizations that serve the older adult population and their caregivers
- Higher levels of community cohesion and a strong sense of community or community identity
- Higher levels of community functionality and greater collective efficacy

**Institutional setting**

- Effective monitoring systems
- Solid institutional policies and procedures regarding patient care
- Regular training on elder abuse and neglect for employees
- Education and clear guidance on the durable power of attorney, and how it is to be used (For BC, access The Adult Guardianship Act here. It included a specific section on Support and Assistance for Abused and Neglected Adults)
- Regular visits by family members, volunteers, and social workers (CDC, 2019)

Gerino and colleagues (2018) found that having social support, adopting help-seeking behaviours, and having access to community-based services are critical factors in addressing abuse experienced among older adults. Access the systematic literature review here.

Ryan and Roman (2019) did a review of studies that used a family centred approach because they asserted that abuse is done by families, but services are oriented towards professionals. They reviewed interventions for families and found that interventions that use a multisystem approach, address culture and involve community can be effective approaches.

## Initiatives and Resources

Elder abuse initiatives have not received enough research attention. Although there are many recommendations, there are very few evaluations done to understand their applicability and outcomes, especially in the prevention field (Ploeg et al., 2009; Sethi et al., 2011). Overall, initiatives include educational programs, legislation and policies, programs to increase detection and rehabilitation and emotional support to victims (Baker et al., 2016).

A systematic review that analyzed programs dated from 1982 – 2017 show that most (74%) were focused on educational interventions and 57% reported impacts. They found that many programs did not use a good study design and it was challenging to establish long-term impacts (Rosen et al., 2019). We recommend that those who design and implement programs work closely with researchers in order to design high-quality evaluations. Although we have stated that there are no published effective programs according to the meta-analysis done by Rosen et al. (2019), there are resources to get help.

## Resources/Programs BC

There are a number of resources for older adults. If there is imminent danger, call 911. If you just want to talk to someone and get resources, call the Seniors Abuse and Information Line call: 604-437-1940 or Toll-Free: 1-866-437-1940. You can call 7 days a week 8 AM – 8 PM in BC (Seniors First BC, 2019). You can also visit the Government of British Columbia's (n.d.) *Protection from Elder Abuse and Neglect website.*

It is assumed that adults are capable of making their own decisions unless, for some reason, they are impaired. To read about

guardianship click here, to read The Adult Guardianship Act, click here.

To find more information about how to support an older adult who discloses experiencing abuse, please, click here (**Responding to Elder Abuse**) for a quick note on how to respond and click here (**Responding Safely to Situations of Relationship Violence**) for a comprehensive learning module on how to learn how to respond (Government of British Columbia, n.d.).

There have been resources created specifically to educate about elder abuse in the LGBTQIA+ community. NEVR member Jennifer Marchbank was part of this project to create Canada's first educational materials on elder abuse in this demographic. Please, check this link (Simon Fraser University) to find information and download materials (Gerontology Research Centre Simon Fraser University, n.d.).

## Services and Organizations

**Table 16.1 – List of Programs in Canada**

| Agency | Program | Summary |
| --- | --- | --- |
| Seniors First British Columbia | Seniors First BC | This organization provides three main types of services, including education about elder abuse, programs to support victims, and legal support to low-income older adults (Seniors First British Columbia, n.d.). |

| | | |
|---|---|---|
| Canadian Network for the Prevention of Elder Abuse | CNPEA Project | The Canadian Network for the Prevention of Elder Abuse is a platform in Canada that includes a range of resources available on elder abuse. Information includes, but it is not limited to, reports on violence against women and older women, government strategies to address elder abuse, rights and legal information related to sexual assault, tools for the development of practices in community settings, and education on elder abuse among visible minority groups in Canada. All educational resources, like studies and webinars, are available for free online. Content of educational material includes seniors bullying, a guidebook to safety and security on streets and against scams, and legal toolkits that explain how the court system works and how to access it (CNPEA, 2017). |

| | | |
|---|---|---|
| International Institute for Restorative Practices | The Waterloo Restorative Justice Project | The Waterloo Restorative Justice Project is an initiative developed in Waterloo, ON Canada. This initiative focuses on mediating practices of reconciliation between victims and offenders. Through a restorative approach, it aims to increase reporting cases of elder abuse and supporting victims to deal with traumatic experiences. The Restorative Practices approach focuses on improving, repairing and developing healthier relationships between seniors and the community. The project includes community education to help seniors, families, and individuals who work with older adults to understand, recognize and know what can be done when an older adult is facing elder abuse (International Institute for Restorative Practices, n.d.). |

**Table 16.2 – List of Programs outside Canada**

| Agency | Program | Summary |
|---|---|---|
| Aged Rights Advocacy Service Inc. | Abuse Prevention | Through educational workshops to older adults and their families/friends, and training sessions to professionals who work with seniors, ARAS tries to raise awareness about the types of elder abuse, older adults' rights, and strategies to reduce and eliminate elder abuse cases (ARA, 2019) |
| Government of Australia | Older Persons Advocacy Network Programs | OPAN offers specific programs like the Elder Abuse Prevention program and advocacy in cases of elder abuse (Government of Australia, n.d.). |
| Bet Tzedek Legal Services | Elder Law Clinic | The Bet Tzedek Elder Law Clinic established in 1974 due to the high demand for legal service among older adults who survived the Holocaust, and other low-income seniors in the state of California, US (Bet Tzedek Legal Services (n.d.). |
| National Adult Protective Services Association | Vulnerable Elders Protection Team | It intends to identify elder abuse cases during a hospital visit. The service consists of offering consultations to physicians, nurses and social workers to support assessing and identifying signs of abuse among older patients (National Adult Protective Services Association, n.d.). |

| | | |
|---|---|---|
| NYC Elder Abuse Center | Elder Abuse Helpline for Concerned Persons | The service provides counselling and guidance to older adults, or any individual who might be concerned about an older adult is a victim of abuse (NYC Elder Abuse Center, n.d.). |
| University College London – UK | The START – Strategies for Relatives | The program includes weekly psychological therapy for a total of 8 weeks. Each session is delivered by a psychology graduate student who receives training and supervision assistance (Knapp et al., 2013). |
| Washington State Department of Health | Stay Active for Life Program | The SAIL is a falls prevention program designed to support older adults to stay active, healthy and independent (SAIL, n.d.). |

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# Chapter 18: Relationship Violence Against Men

BALBIR GURM; GLAUCIA SALGADO; AND JENNIFER MARCHBANK

*Key Messages*

- Meta-analysis of studies on relationship violence in which men are victims indicate psychological and physical violence seems to be the most prevalent form of RV experienced.
- Barriers to seeking help include fear of disclosure (shame, denial and embarrassment, fear of not being believed, nowhere to go and fear of losing children), challenge to masculinity, commitment to relationship, diminished confidence/despondency that inhibits action and invisibility/perception of services (victim not aware of services or thought they were inappropriate).
- Victims who seek out help may experience distress and secondary victimization when professionals and services are not prepared to provide support to this population group.

- Access to support services among male victims of intimate partner violence is typically considerably lower than services for women.
- Misconceptions about what it means to be a man often stand in the way of sexual abuse and other forms of abuse of males being recognized, acknowledged, and treated. Alcohol and drug abuse, family violence, suicide and social dysfunction are a few of the possible consequences.

Relationship violence is any form of physical, emotional, spiritual and financial abuse, negative social control or coercion that is suffered by anyone that has a bond or relationship with the offender. In the literature, we find words such as intimate partner violence (IPV), neglect, dating violence, family violence, battery, child neglect, child abuse, bullying, seniors or elder abuse, male violence, stalking, cyberbullying, strangulation, technology-facilitated coercive control, honour killing, female genital mutilation gang violence and workplace violence. In couples, violence can be perpetrated by women and men in opposite-sex relationships (Carney et al., 2007), within same-sex relationships (Rollè et al., 2018) and in relationships where the victim is LGBTQ2SIA+ (lesbian, gay, bisexual, transgender, queer, Two-Spirit, intersex and asexual plus) (The Scottish Trans Alliance, 2010; Rollè et al., 2018). Relationship violence is a result of multiple impacts such as taken for granted inequalities, policies and practices that accept sexism, racism, ageism, xenophobia and homophobia. It can span the entire age spectrum. It may start in-utero and end with death. Although

men are usually the perpetrators of RV, they can also be abused. This chapter illuminates the understandings of RV against men.

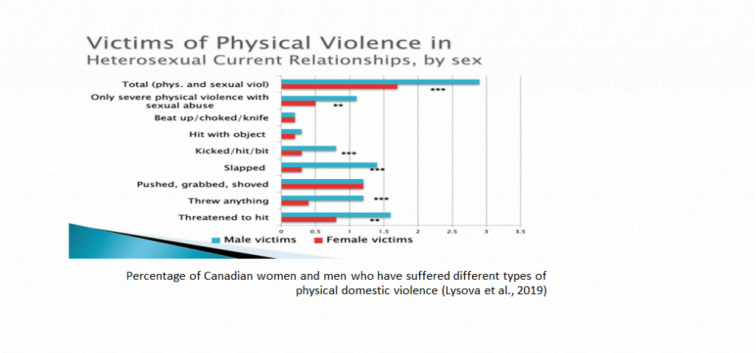
## Relationship Violence against Men

Relationship violence issues have typically been focused on violence committed against women and girls, particularly concerning intimate partner violence and sexual violence. As widely discussed previously, women and girls are vulnerable to violent acts with reasoning around issues related to patriarchy and imbalanced power relationships (Carter, 2015). Although this view has been conceptualized as a unilateral approach suggesting that men are the sole perpetrators of violence, and women the victims, studies assert that individuals from any gender can be victims of violence (Devries, 2013; Ferrales et al., 2016; Meyer, 2015). It is noteworthy that gender refers to socially and culturally constructed norms associated with being male or female. Sex assigned at birth does not always correspond with an individual's gender. Violence might occur with individuals who identify themselves as male, female, and LGBTQ2SIA+ (lesbian, gay, bisexual, trans, queer, Two-Spirit, intersex, asexual) (Bradley, 2013; Todahl et al., 2009; United Nations [UN], 1996). Although power and patriarchy are most frequently used to discuss violence against females, they are also recognized as critical factors affecting any group of vulnerable individuals. The reason for the extensive use of these concepts is connected to the fact that privilege, power, and dominance intersect with social status, race, ethnicity, and religion (Sidanius & Veniegas, 2013). Intersectionality theory explains how identity, experience and positionality overlap to create oppression that underpins relationship violence (Cramer and Plummer, 2009; Meyer, 2010).

To properly assess victimization it is vital to have protocols that contain specific questions about how violence is perpetrated which would be helpful to show how intimate partner violence affects all

genders. For instance, the General Survey Data (2016), used as a tool to understand differences among victims of physical violence in heterosexual relationships, shows that men experience physical violence at a greater or equal rate as women (Lysova et al., 2019). Figure 18.1 below reports that there are more male targets (victims) in severe physical violence with sexual abuse, hitting with an object, kicking, slapping, throwing things and slapping in heterosexual relationships. The same figure shows that being beaten/choked/knifed and being pushed/ shoved/grabbed are equally prevalent for men and women in heterosexual relationships. Although this study contradicts previous research that indicated that women were the majority of victims, it is critical to acknowledge that regardless of incidence rates, any group of people can experience relationship violence and nobody should have to suffer in silence.

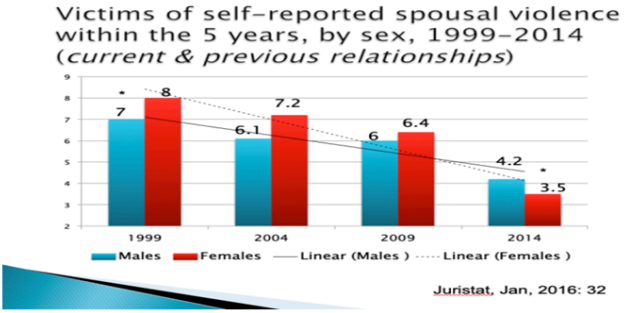
**Figure 18.1 – Victims of Physical Violence, by sex**




Statistical analyses have their place and they reveal important information. However, researchers have to be cautious with selective bias. What is essential is that innocent people are being abused, traumatized, and need healing. Additionally, all offenders must be identified, held accountable and provided with the resources to help understand and address the behaviour. Issues related to identifying, recognizing, and providing appropriate support to male victims are observed in the graph below (Lysova et

al., 2019). As studies and support services seem to be effective in reducing cases of relationship violence among women, male victims do not receive the same support. Intimate partner violence among men decreases at a slower rate suggesting important gaps in the knowledge and strategies to address violence among this population group. This slower decrease may be because men do not report and there are not many services specific to male survivors (as shown in Figure 18.2).

**Figure 18.2 – Victims of Self-reported Spousal Violence**




Spousal violence slowing down in Canada, but at a slower rate for men than women (Lysova et al., 2019).

In relationship violence, there are fewer studies on men as survivors and most studies address men as the perpetrators. Although though violence against men has been identified since the 1980s there is less media attention paid to men as victims than to women (Hines & Douglas, 2009). Hines & Douglas, (2010) reporting on the US note, "that best population-based surveys show that between 25% and 50% of victims of IPV (intimate partner violence) are men" (p. 575). Analysis of the 2014 Canadian General Social Survey on Victimization in Canada found "2.9% of men and 1.7% of women reported experiencing physical and/or sexual IPV" (Lysova et al., 2019, p. 206). "The odds of men reporting that they were physically assaulted were 1.7 times that of women ($X^2$ = 12.7, p< .001) and the odds of men reporting that they experienced severe physical

assault were 2.1 times that of women ($X^2 = 9$, $p < .01$)" (Lysova et al., 2019, p.208 ). "Men were more like to report being slapped, kicked, bit, hit, threatened with battery, or that something dangerous was thrown at them" but there was no significant difference in experiencing violence with the current heterosexual partner between men (42%) and women (39%) (Lyvosa et al., 2019, p.208). Police reported rates are contrary to this data, stating 79% of the cases are IPV against women (Burczycka & Conroy, 2018).

Intimate partner violence (IPV) perpetrated by women against a male partner is a topic of intense debate. Some theorists seem resistant to accept the fact that women can also be offenders of intimate partner violence, arguing that when women perpetrate violence, it is to act in self-defence (Houry et al., 2008; Kernsmith, 2005; Muftic et al., 2007). In this view, researchers turn once again to the view that "social power structures are reflected in interpersonal relationships" and men, as the socially dominant gender, are the ones who misuse this power by trying to oppress and become dominant (Hines et al., 2007, p.63). As the notion of power and dominance exerted by some male individuals towards a female partner is mentioned in many studies of IPV, this theory is not effective in explaining the complexity of intimate relationships and the dynamics that involve relationship violence perpetrated among any group of people. With a diverse population and types of relationships, some researchers have tried to propose theories that might help the understanding of RV. For instance, Johnson (2005, 2010) suggests that intimate partner violence is related to three main situations:

- One of the partners (male or female) feels the desire to take control over their partner
- Resistance to partner's attempts of control
- Stressful daily life situations leading to violent behaviours

Johnson (2010) categorizes these circumstances as intimate

terrorism, situational couple violence, mutual violent control and violent resistance.

- Intimate terrorism denotes a partner's attempts to control with the intention to dominate by employing negative coercive behaviours like emotional abuse (e.g., isolation, threats, humiliation) physical and sexual abuse against the partner.
- Situational couple violence refers to episodes of violence that occur due to conflict triggered by situations of everyday stress or discussions that might escalate to violence (Johnson & Leone 2008, p. 6).
- Lien & Lorentzen (2019) propose that mutual violent control and violent resistance denote two different patterns that can follow intimate terrorism and situational couple violence. While in mutual violent control, both partners are violent and attempt to exert control over each other, violent resistance refers to physical violence as a self-defence act that results from experiencing intimate terrorism.

Johnson's typology was initially connected to the notion that women experience IPV more frequently than men. Although different ways of counting IPV lead to different statistics on sex and victimhood (see chapter 5 for discussion of CTS) other studies show that Johnson's typology can be helpful when analyzing IPV among males (Hines & Saudino, 2003).

Lysova, Dim & Dutton (2019) analysis of a Canadian National Survey of Victimology found that of those reporting victimization 22% of male victims and 19% of female victims of IPV reported that they had experienced severe physical violence along with high controlling behaviours (Lysova et al. 2019). This survey found that of those reporting violence 50% were men but Lysova et al. (2019) surmise that as physical violence against men by women can be less injurious than vice versa that male victimology, outside of such surveys, is less visible as it results in fewer hospital visits or police reports. Even when the victimization of males is reported the

outcomes may not recognize the violence. In Scotland, in '2000 those who perpetrated domestic abuse against men were slightly less likely to have had their acts deemed criminal by the Scottish Police than those who perpetrated domestic abuse against women' Gadd et al., 2002, p.vi). In addition, those who perpetrated IPV against men were also a little less likely to be referred to the courts (Gadd et al., 2002).

In a report conducted for the Scottish Executive David Gadd et al. (2002) attempted to explain the discrepancies between the number of men who self-reported being survivors in the Scottish Crime Survey in 2000 with the considerably smaller number of reports men made to the Scottish police. Some of the discrepancies were that a number of men completing the survey misread or misunderstood 'domestic violence' (the term used in this report) and reported on physical violence from other sources. However, the authors also concluded that:

> Relative to female victims of domestic abuse, male victims, in general, were less likely to have been repeated victims of assault, to have been seriously injured, and to report feeling fearful in their own homes. These factors, coupled with the embarrassment many male victims felt, helped explain the infrequency with which male victims of domestic abuse came to the attention of the Scottish Police. Some of the male victims of domestic abuse identified in the Scottish Crime Survey 2000 were also assailants and therefore did not wish to draw themselves to the attention of the police. (Gadd, et al. 2002, p.vi)

These factors, further invisibalize the existence of male survivors of IPV.

Gadd et al. (2002) also conducted in-depth qualitative interviews with 22 men who did report being male survivors of IPV, which they divided into four categories:

- Primary instigators – they began the violence – n=1
- Equal combatants – those who reported being equally responsible – n=4
- Retaliators – those who used violence back but did not instigate it – n=8
- Non-retaliatory victims – n=9

Even amongst the nine non-retaliatory victims, not all saw their situation as being domestic violence, for example:

> Vince's ex-girlfriend had smashed a glass into his wrist and had punched him. In hindsight, Vince considered these incidents 'funny', although he did not see them this way at the time. Likewise, Zac belittled the actions of the three partners he claimed had abused him. Zac described the behaviour of these three women as 'amusing'.. (Gadd et al., 2002, p.42)

It may be that Zac's and Vince's responses stem from their understanding of their own masculinity, to see violent acts as 'funny' or 'amusing' is an attempt to diminish the severity, the threat and the violence of these actions. To show that as men they are capable of handling such incidences. If this is the case, we also have to factor in men's notion of proper masculine behaviour (that includes being in control, of being strong, of being social) when explaining why some men, like some women, do not perceive their victimhood as part of a systemic system of violence. Gadd et al. (2002: pvii) note:

> the qualitative research upon which this report is based shows that domestic abuse against men can take life-threatening forms and can have lasting effects. Some of the male victims interviewed experienced a range of abuses from their partners. This abuse took emotional, financial, and physical forms. However, many of the male victims in our sample described their partners' abuses as relatively rare and inconsequential in the longer term. Few men cited abuse as reasons for having left their partners. Abuse frequently occurred when relationships were in crisis or 'breaking up',

and/or when access to children had to be negotiated between partners who were living apart.

A Norwegian study (Lien & Lorentzen, 2019) provides some more information on men as victims. Lien & Lorentzen conducted in-depth qualitative interviews with 28 men recruited, primarily, from men accessing family protection services, attending crisis centres and from adult survivors of child sexual abuse and incest. In total, there were 18 interviews with men who had not suffered child sexual abuse. Of these 18, 1 grew up in a violent home but had not suffered IPV; 3 reported IPV from their male partners and the remainder are survivors of IPV from female partners. Although this is a small study it is useful as it provides information on the experiences and perspectives of men who have survived IPV. The study included Norwegian and foreign-born men. Of the Norwegian men, they tended to be young with some post-secondary education (i.e., about three years of university-level education)but the foreign-born men were not so educated.

Lien & Lorentzen (2019) found that their respondents reported being subjected to systemic harassment and humiliation by their female partners, which are characteristics of psychological dominance. These male survivors reported withdrawing themselves from their usual social circles, become isolated, and lonely (Lien & Lorentzen, 2019). The men in this study affirmed that they could handle the violence, could resolve the problem and denied that their circumstances are part of systemic violence (Lien & Lorentzen, 2019, p.79) matching the attitudes of Zac and Vince detailed above.

So, it can be seen that even when aggression occurs to men from their intimate partners they do not perceive it as something that deserves to be reported to the police. In reported cases, men rarely describe intimate partner violence as an act that invokes fear and control, even when there is an explicit mention of aggressive behaviours. Furthermore, police reports show that women who do aggress are more likely to use a weapon against the intimate male partner (Dim, 2017; Hester, 2012).

## Incidence Rates

There are debates regarding variations in incidence rates, as shown by Gadd et al. (2002). These variations can be due to differences in what is being counted and, as shown above, can also be from inaccurate reporting. However, US figures show that 1 in 4 women and 1 in 9 men have experienced intimate partner violence (Centers for Disease Control and Prevention [CDC], 2017) and these are consistent with surveys from other Western societies. In Canada, national surveys show that men represent 20% of IPV survivors (Statistics Canada, 2011). However, some studies contradict these estimates. Dim (2017) suggests that intimate partner violence is experienced at similar rates by females and males, arguing that the difference lies in the forms of violence and not in the number of cases. For instance, sexual violence in cases of IPV appears to affect more women and girls, while physical violence, in its many forms, appears to be higher amongst men. Similarly, a meta-analysis shows that in incidents with women as the offender, psychological and physical violence seems to be the most prevalent forms of IPV (Williams et al., 2008). Physical assault (e.g., pushing, slapping, punching, and using a weapon to cause severe harm) represents 87% of IPV against males in Canada (Statistics Canada, 2018). This high figure may also be due to the fact, as discussed above, less violent incidences of IPV may not be viewed as violence by male survivors.

## Barriers to Seeking Help

Although intimate partner violence is more prevalent and severe for women, it is also perpetrated against men. Men may suffer domestic violence from heterosexual relationships, same-sex relationships, former partners or other family members. A systematic review was

conducted on help-seeking experiences of male survivors of domestic violence by Huntley et al., (2019). They described barriers faced by males in seeking help and expertise of services. Trying to seek and receive help among male IPV victims is challenging, and those who exhibit negative psychological symptoms experience difficulty finding support services (Powney, 2019). Also, they experience distressing and secondary victimization as professionals and services are not prepared to provide support to this population group (Hines & Douglas, 2014; Tsui, 2014).

**Barriers to Seeking Help**

**Fear of disclosure** – shame, denial and embarrassment, fear of not being believed, nowhere to go and fear of losing children

**Challenge to masculinity** – stigma, fear of not being believed

**Commitment to relationship** – want to stay in the relationship but want abuse to stop

**Diminished confidence/despondency** – decreased confidence and depression/Post Traumatic Stress Disorder, reported abuse on open-ended surveys but did not disclose to anyone

**Invisibility/perception of services** – not aware of services or thought they were inappropriate

(Hines & Douglas, 2014)

**Male Survivor Experience (Huntley et al., 2019)**

Initial contact occurred following a crisis when a sense of urgency to report occurred and family members were generally viewed as supports.

Confidentiality or private space especially in healthcare settings is needed, and clergy are seen as those who may keep privacy by some

Appropriate professional approach- more comfortable with a consistent female professional

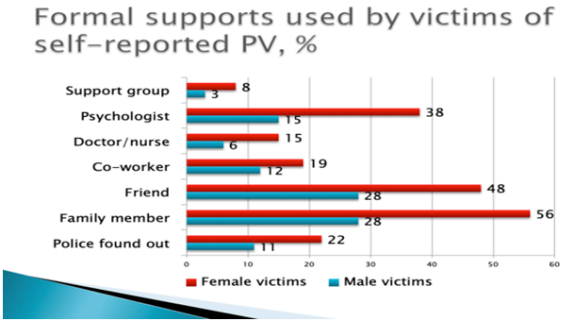
Inappropriate professional approaches- lesbian, gay, bisexual, and transgender (LGBT) survivors stated that service was heterosexual focused and professionals lacked understanding, and heterosexual men experienced both negative and positive experiences from the police.

The lack of services for male victims, or a lack of knowledge about them, are further barriers to male survivors seeking assistance. Although Gadd et al, (2002, p. vii) concluded that in Scotland no one, survivors or service providers, was making demands for male-specific services, nor even for shelters for men fleeing abuse, they also noted that "..there is some evidence to indicate that abused men are not making full use of the pre-existing support services available to them, perhaps suggesting that some service providers need to publicize their remit more widely'. This may also be because our society tends to still think of women as the victims and so abused men may not feel that they can access services which they perceive as primarily for women. See services available to men at the end of the chapter.

Male survivors have similar challenges as females. They under

report and do not seek help because they feel embarrassed that society will pressure them. They differ in that their embarrassment is from the societal belief that they will be seen to be less than and seen as not able to handle women. This internalization of hyper-masculinity as a norm may be the cause of their embarrassment and underreporting. They also have chronic conditions similar to female survivors. Even though outcomes of intimate partner violence are similar between the gender groups, males are at a great disadvantage in relation to the use of formal support services. Figure 18.3 compares use of formal services by gender and it is clear that men access every service at a lower rate than women. Access to support services among men victims of intimate partner violence is, in some cases, over 50% lower compared to women. Also, there are significant differences among family members and friends who seem to be more supportive of women than men victims (Lysova et al., 2019). Click here to listen to survivor stories of abuse.

**Figure 18.3 – Formal Supports used by Victims of Self-report Physical Violence**




Males are more reluctant than females to seek support after suffering domestic violence or abuse, or partner violence (Lysova et al., 2019)

## Sexual Violence

Although a higher number of females experience sexual violence, this is not to affirm that sexual violence affects women only, but it indicates a greater vulnerability of women to sexual assault and more cases reported to the criminal justice system (Dim, 2017; Statistics Canada, 2018). A US national-based study on IPV shows that 24.8% or 27.6 million males in the US have experienced some form of contact sexual violence, including rape, being made to engage in intercourse with someone else, sexual coercion, and unwanted sexual contact (CDC, 2015).

Yet sexual violence against men, by abusers of any gender, is under-discussed in our society, and when it is it is often with a sense of ridicule or disbelief for male rape is still regarded as taboo (Marchbank & Letherby, 2014). It is only relatively recently that sexual assault of (adult) males became recognized as a crime, for example, the necessary legislative changes did not happen in England and Wales until 1994 (Marchbank & Letherby, 2014). When sexual violence against males is recognized it is often in the context of war. Sexual violence in this context often includes rape and genital mutilation that occur concomitant to each other in the concentration camps (Lewis, 2009; Solangon & Pater, 2012). When these forms of crime are reported, they are described as "torture or degrading treatment" rather than rape, creating a gap in the justice system, lack of protection and intervention (Carpenter, 2006 p. 95; Lewis, 2010). "Constructions of masculinity are very present in such behaviours:.. the rapist takes a position of power… to torture, attack and brutalize the victims whom the rapist, or the policy. deems as inferior…The subjugation of the enemy as 'feminine' is central to masculinity the perpetrator conceives as superior" (Marchbank & Letherby, 2014, p. 307). A similar relationship between dominance and masculinity can be involved in the rape of men in prisons by other men who identify as heterosexual.

Don Wright, former executive director of the BC Society for Male Survivors of Sexual Abuse, states that men are also victims of sexual abuse. BC Society for Male Survivors of Sexual Abuse website has several articles by Don Wright that provide valuable information. Sexual abuse, for its most part, is greatly misunderstood, and it is generally believed that it involves an overt act, an unwilling party, and to be carried out by a male against a female. Although all of this is often true, it is only part of the picture. To recognize the real scope of sexual abuse and to address the trauma experienced by survivors, as well as the impact on society, it is essential to adhere to a broader definition of sexual abuse and a more global view of whom the offenders and survivors are in current days.

Misconceptions about what it means to be a man often stand in the way of sexual abuse of males being recognized, acknowledged, and treated. One myth is that males are always in control of their sexual experiences. This is not true for young boys, but it may also not be accurate for an adult male. Although studies indicate that more girls experience sexual abuse than boys, the disclosure rate among boys is lower than among girls. Riccardi (2010) suggests that although males can also be victims of rape, little consideration is given to this phenomenon and its consequences. Another misconception is that men do not experience the degree of emotional pain associated with sexual abuse, as do women – and further, if a man does have emotional pain, he can handle it alone. Alcohol and drug abuse, family violence, suicide, and social dysfunction are a few of the possible results of sexual abuse of males when it is not acknowledged and treated. This is not "handling" the pain (British Columbia Society for Male Survivors of Sexual Abuse, n.d.).

We do have some basic facts about men as victims:

- Rape of men more commonly committed by heterosexual men (McMullen, 1990)

- Sexual orientation of victims evenly distributed
- 66% of gang assaults on men also perpetrated by heterosexual men (Hodge & Canter, 1998)
- Female perpetrators involved in 40% of sexual assaults on males (Coxell et al., 2000)

Government estimates for the UK report that in 2010-2014 there were 78,000 rape victims, of whom 9,000 were men with 1,250 male rapes reported in 2011-12 alone (Badenoch, 2015) and that of the estimated 679,051 sexual assaults and rapes of males in 2010-2014 – 654,568 not reported to the police (Badenoch, 2015). Men, like other victims of sexual assault, also suffer psychological effects. Although we have few studies to cite we can assume that some common features to women's responses exist and start from there. Hodge & Canter's (1998) included 119 cases of men who had survived sexual assault. Sixty percent of these men (irrespective of sexuality) reported freezing and not fighting back; reported experiencing intense fear of death or harm – shock, numbness, disbelief and helplessness.

It seems that male survivors of sexual assault harbour fears of being perceived as being homosexual or may fear that they are if they became aroused during the attack. Stephanie Chester's (1998) study of men who had survived rape shows that "…in some cases of heterosexual men do not receive support when they confide in their spouse – instead they find themselves being accused of experimenting with homosexuality" (Chester, 1998 in Marchbank & Letherby, 2014, p. 304). Chester (1998, in Marchbank & Letherby, 2014) also found that other women left the relationship as they did not wish to remain with a man who they felt was now too emotionally vulnerable.

Male survivors of sexual assault are also more likely (than women) to be victims of greater physical trauma, held in captivity for longer and be raped by multiple assailants, sometimes more than once (Groth, 1980). Rapists of men also tend to use weapons more than

those who rape women (Donaldson, 1990) possibly due to the fact that the perpetrator and victim may be closer in physical strength than a man raping a woman or child. As already mentioned there are few services for male sexual assault survivors than for women and this, in combination with ideas around appropriate masculinity, leads to men being more likely to cope through denial and control – which makes them more prone to future psychiatric problems and further reduces help-seeking behaviours (Mezey, 1987).

Sexuality Abuse is a term that has come into more common use, and it mainly describes any behaviour that undermines the integrity of the individual's sexual identity or sexual safety. Sexuality abuse includes not only actions that are traditionally viewed as sexual abuse (i.e. criminal acts) but also covert sexual actions, not often recognized either by the courts or by the general population. Some examples are derogatory comments of a sexual nature, leering looks, age-inappropriate exposure to sexual information or imagery, or the lack of appropriate information. Although these and other examples may not result in criminal charges, nor be intentional, they may nevertheless result in long-term disturbance for the victim.

Victims and offenders of sexual abuse are increasingly seen as including a broader range of individuals. While it was once believed that a larger percentage of survivors are female than are male, recent studies indicate that the numbers are not as disparate as previously assumed. Sexual abuse of males of all ages is not rare. Statistics may be misleading if taken at face value: statements such as "…the majority of victims are female…" minimize the extent of victimization of males, or "…offenders are predominantly male…" may result in one overlooking female offenders.

Besides intimate partner violence, males experience other forms of relationship violence. Statistics Canada (2011) indicates that men are more vulnerable to violence perpetrated by friends and acquaintances (73,111 number of cases), and casual acquaintances (50,544 number of cases). "Physical assault was more common

among male victims (87% versus 74% of female victims)… It was almost twice as common for weapons to be present in intimate partner violence involving male victims as when the victim was female (23% versus 12%), a finding consistent for both spousal and dating violence" (Statistics Canada, 2018). When men are victims of p[hysical violence it is often more severe than for women (though not for transwomen) and men are more likely than women to be victims of the most serious violent acts such as homicide (WHO, 2017).

## IPV in Gangs

Gangs are critical social groups in which relationships violence occurs between gang members. Gangs have generally been classified as a group of people that engages, either individually or collectively, in illegal and non-political acts of violence. Although there are many arguments to better elaborate and expand this definition, researchers argue that there is a lack of adequate sociological analysis and low consensus on how to improve the meaning of gangs (Jingfors et al., 2015). The World Health Organization classifies gangs as an act of collective violence which refers to "the instrumental use of violence by people who identify themselves as members of a group—whether this group is transitory or has a more permanent identity—against another group or set of individuals, to achieve the economic or social objective" (WHO, 2002). Contrary to many countries in which gangs are associated with poverty and marginalization, gang groups in Canada are allied to affluence and status (Jingfors et al., 2015). The Canadian Criminal Code (section 467.1) defines gangs as:

> an organized group of three or more, that as one of its main purposes or main activities is the facilitation or commission of one or more serious offences, that, if committed, would likely result in the direct or indirect

> receipt of a material benefit, including a financial benefit, by the group or by anyone of the people who constitute the group and excluding cases of a single offence (Canadian Criminal Code R.S.C., 1985, c. C-46).

In British Columbia, gangs are involved in illegal activities like drug trafficking, firearms sales, extortion and the sex trade. These activities are all done with the intention to make a profit, and gang leaders have to find ways to launder their profits. These strategies often "present opportunities" to those who want to get involved with gang groups. The need to make a profit leads to territorial disputes among different gang groups that frequently lead to extreme acts of violence (Dandurand et al., 2019). Gangs often target male and female youth who get involved in the circles of violence in order to earn money and get recognition from gang members. Despite the presence of law enforcement bodies targeting gangs' activities gangs are difficult to suppress and helping young people extricate themselves from gangs is difficult. Historically, street gangs and business-oriented gangs have been organized along with a shared identity within specific neighbourhoods and provide a sense of belonging for their members. Therefore, finding ways to address this issue and prevent involvement should include a multifactorial approach, one that considers ethnicity and culture (McConnell, 2015).

Although gang-related homicides in Canada are relatively low compared to the US, gangs impact many communities and families, especially in western regions of Canada like British Columbia (BC). Young individuals are at the highest risk of becoming involved with gangs. Wortley & Tanner (2004) study shows the following significant risk factors.

- Low attachment to the community
- Over-reliance on anti-social peers
- Poor parental relationship
- Alcohol and drug abuse
- Poor educational or employment potential

- A need for recognition and belonging

Even though gang activities have been linked to sexual exploitation of girls, those who are often targeted are boys and young males. Boyce and Cotter (2013) suggest that youth gang members are connected to a great number of criminal behaviours like drug trafficking, frauds, assaults with weapons and homicides.

**Table 18.4 – Programs in Canada**

| Agency | Project | Summary |
|---|---|---|
| BC Society for Male Survivors of Sexual Abuse | BC Society for Male Survivor of Sexual Abuse | This is the only organization in British Columbia that focuses on male survivors. The British Columbia Society for Male Survivors of Sexual Abuse (BCSMSSA) is a non-profit society established to provide therapeutic services for males who have been sexually abused at some time in their lives. They offer individual and group therapy to men who had experienced sexual abuse. |
| Moving Forward Family Services | Counselling Services | This initiative was started by NEVR member Gary Thandi. They provide low barriers counselling support for survivors and families in the Vancouver Lower Mainland. Their head office is in Surry. |
| Canadian Centre for Male Survivors of Sexual Abuse | Healing, education, advocacy and research centre. | It has a list of treatment centres for male survivors of sexual abuse across Canada and links to resources such as books and podcasts. They are building a centre in Calgary, Alberta. |

| | | |
|---|---|---|
| Public Safety Canada | Crime Prevention through the Strengthening of Youth, Families and the Community Project | This initiative was started in 2014 in response to high incidence rates of violence among youth in Prince George, Canada. The project uses the Strengthening Families framework that aims to enhance parents' and child communication and relationships, reduce alcohol and drug use among youth, and teach social skills. |
| National Gang Center | Comprehensive Homicide Initiative | This initiative engages legal and police forces to investigate and enforce the law in areas of high homicide incidence in California, US. The initiative involves the apprehension of guns and drugs and the incarceration of criminals. The program uses the OJJDP Comprehensive Gang Model as a tool to understand risk factors, community vulnerability and support to promote safety. |
| Caring Dads | Caring Dads Initiative | Caring Dads is focused to support change practices to better include fathers in efforts to enhance the safety and well-being of their children. |

**Table 18.5 – Programs outside Canada**

| Agency | Project | Summary |
|---|---|---|
| After Silence | Online chat group | It is an online support group for survivors with resources for male survivors |
| RAINN | Sexual Assault of Men and Boys | It is an online support group for male survivors of sexual assault with resources. |
| ManKind Initiative | Males Victims of Domestic Abuse | This initiative serves men and their family members and friends who would like to find information for someone else. As an additional resource, MVDA provides training to police officers, hospital staff, local council, counsellors, and welfare community groups. |
| Abused Men in Scotland | Abused Men in Scotland | The initiative provides helpline support and face to face meetings during weekdays from 9 am to 4 pm to all UK areas. |

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# Chapter 19: Relationship Violence in Indigenous Populations

BALBIR GURM

*Key Messages*

- A disproportionate number of Indigenous families are investigated and their children placed in child welfare services and a disproportionate number of Indigenous adults are incarcerated. Sexual assaults and intimate partner violence against Indigenous women are significantly more likely compared to non-Indigenous women.
- Traditionally among Indigenous communities, women were valued and held leadership roles. Many of these cultural practices were disrupted by colonization. Many children endured physical, sexual and emotional abuse and neglect in the residential schools. The disconnection from their families, communities and culture had a long-term negative effect on many.
- The traumatic experience of residential schools, the Indian Act and other efforts to eradicate Indigenous cultural and familial practices and traditions, along with continued inequities, systemic

racism and lack of cultural safety within systems, has left many Indigenous populations at greater risk of perpetuating the relationship violence cycle.

- To understand the complexity of abuse in vulnerable groups such as in the Indigenous population, it is important to overlay the intersectionality framework.
- In order for programs for Indigenous peoples to be culturally appropriate and safe, they must draw upon Indigenous knowledge and experiences, be informed by Indigenous practitioners and elders, must restore connections to Indigenous identity, spirit and spirituality, value respect, wisdom, responsibility and relationships. Traditional beliefs such as connection to culture and incorporating the wisdom of elders and story-telling decrease trauma and grief and facilitate healing.

Relationship violence is any form of physical, emotional, spiritual and financial abuse, negative social control or coercion that is suffered by anyone that has a bond or relationship with the offender. In the literature, we find words such as intimate partner violence (IPV), neglect, dating violence, family violence, battery, child neglect, child abuse, bullying, seniors or elder abuse, male violence, stalking, cyberbullying, strangulation, technology-facilitated coercive control, honour killing, female genital mutilation gang violence and workplace violence. In couples, violence can be perpetrated by women and men in opposite-sex relationships (Carney et al., 2007), within same-sex relationships (Rollè et al., 2018) and in relationships where the victim is LGBTQ2SAI+ (lesbian, gay, bisexual, transgender, queer, Two-Spirit, intersex and asexual plus) (The Scottish Trans Alliance, 2010; Rollè et al., 2018).

Relationship violence is a result of multiple impacts such as taken for granted inequalities, policies and practices that accept sexism, racism, ageism, xenophobia and homophobia. It can span the entire age spectrum. It may start in-utero and end with death. This chapter is committed to the people to who's land we have immigrated to, Indigenous communities. Many of them suffer generational trauma and are at higher risk than the mainstream Canadian.

## Relationship Violence in Indigenous Populations

…harm did not end when they walked out the school doors for the last time. Rather, Indigenous societies and families continued to face trauma for generations after, trauma from which we are all still struggling to heal. Unfortunately, one of the lasting legacies is an alarmingly high rate of violence against Indigenous women and girls (Chief Wilton Littlechild in Mckay & Cree, n.d., p. 11).

Traditionally among Indigenous communities, women were valued and held leadership roles. With the arrival of colonizers, over time, Indigenous communities got disconnected from their culture. This group has commonalities with other groups, but there are specific differences.

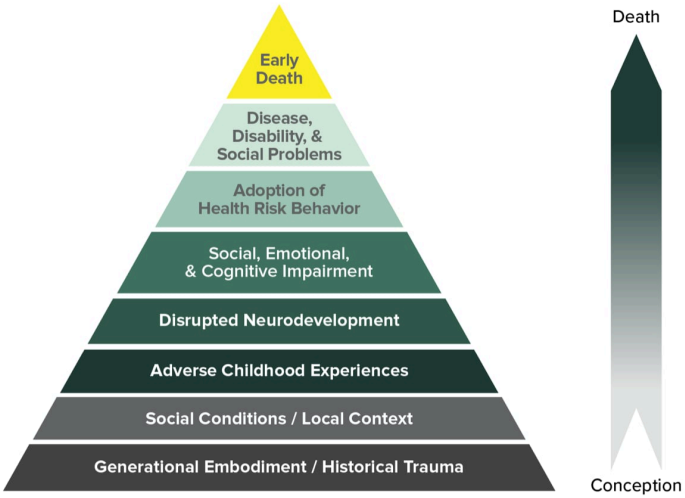
Indigenous women are three times more likely to be subject to sexual assaults than non-Indigenous women, and intimate partner violence is twice as likely compared to non-Indigenous women (Perreault, 2011). Indigenous people are grossly over-represented in the incarcerated population – in 2017 and 2018, Indigenous people made up 3% of the population yet constituted 27% of those in prison (Malakieh, 2019). It is important to note that 50% of those incarcerated were impacted by relationship violence as children (Bodkin et al., 2019).

It is important to keep in mind other experiences endured by Indigenous communities in Canada that impact relationships and can create both individual and community trauma. For example, the statistics for MMIWG (murdered and missing Indigenous women and girls) are shocking, with Indigenous women and girls twelve times more likely to be murdered and/or missing than any other group in Canada (The National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019). In addition, Indigenous children are apprehended by government authorities and placed in child welfare services at disproportionate rates (Canadian Domestic Homicide Prevention Initiative, 2018, p. 7), sometimes for reasons related to intergenerational trauma.

The Truth and Reconciliation Commission (TRC, 2015) captured the traumatic experiences Indigenous communities had to endure in the hands of the colonizers. This report also outlined how colonizers systematically and forcefully took Indigenous children away from their parents and communities and placed them in residential schools. Here, they were forced to learn the language and culture of the colonizers. Many children endured physical, sexual and emotional abuse and neglect in the residential schools. The disconnection from their families, communities and culture had a long-term negative effect on many. While there has been some progress in ensuring more culturally sensitive supports and services, according to a 2016 Canadian Human Rights Tribunal decision, there remains systemic discrimination against Indigenous people, for instance, the Canadian government has underfunded children and families on reserves compared to ministries of children and families in other jurisdictions. The long-lasting underfunding may have been a contributor to ongoing neglect and abuse among Indigenous communities which can also lead to intergenerational trauma. See video on intergenerational trauma (Historica Canada, 2020). Figure 19.1 shows the trajectory of health and social challenges when generational trauma such as residential schools is passed on at conception. It leads to multiple conditions such as adverse childhood experiences, disrupted neurodevelopment,

social, emotional and cognitive impairment, risky health behavior and chronic health conditions including RV and early death.

**Figure 19.1 Childhood Experiences Impact on Health & Well-being (CDC, 2020)**




Mechanism by which Adverse Childhood Experiences Influence Health and Well-being Throughout the Lifespan

The traumatic experience of residential schools left many Indigenous populations with greater risk perpetuating the relationship violence cycle. Many Indigenous people experienced sexual, emotional, physical, mental, spiritual and cultural abuse in residential schools and the TRC called the experience of Indigenous peoples in Canada cultural genocide (TRC, 2017, p. 10). The last federally funded residential school closed in 1996 so this is not an issue just of the past but also of our present as survivors are with us as are their descendants. To read a synopsis of the history of residential schools, click here (Legacy of Hope Foundation, n.d.).

Intergenerational trauma can result in:

- Negative parenting behaviours and these can be passed on

from generation to generation if the families are in a community where it is the norm
- Lack of parent-child bonding can impact brain development leading to decrease cognitive skills, lack of trust and social inadequacy resulting in psychological trauma that is also intergenerational
- Toxic stress which can also be passed on through generations (The Canadian Encyclopedia, 2020)

The National Inquiry into Missing and Murdered Indigenous Women and Girls tried to understand the staggering statistics and systemic causes of relationship violence against Indigenous women and girls. Apart from rates of RV being higher, many Indigenous communities face many inequities – inadequate supports and services, poverty, overcrowding, lack of housing, drug and alcohol abuse, mental health issues, low income and education that puts them at higher risk (National Inquiry into Missing and Murdered Indigenous Women Report, 2019).

Indigenous populations around the world report similar experiences and much has been documented about the experience of Aboriginal peoples of Australia and New Zealand (Bamblett et al., 2018). Similar to the TRC, the Australian Royal Commission inquiry into institutional responses to child sexual abuse found that most children had been sexually abused in faith-based institutions, mainly Catholic institutions. The majority of those reporting sexual abuse were boys (64.3%) with 50% of them reporting that the abuse occurred when they were 10-14 years old. Girls reported being abused at younger ages. In cases of abuse of both girls and boys, 93.8% of perpetrators were male.

The Center for Disease Control and Prevention (CDC, 2020) states that those who have suffered RV themselves are at greater risk. The risk factors for child abuse are the experiences endured at residential schools and systemic racism. They are not specific to Indigenous people but Indigenous people have increased likelihood

of facing these risks due to poverty, racism, living on reserves, being distant from services and supports, they include:

## Individual Risk Factors

- Parents' lack of understanding of children's needs, child development and parenting skills
- Parental history of child abuse and or neglect
- Substance abuse and/or mental health issues including depression in the family
- Parental characteristics such as young age, low education, single parenthood, a large number of dependent children, and low income
- Nonbiological, transient caregivers in the home (e.g., mother's male partner)
- Parental thoughts and emotions that tend to support or justify maltreatment behaviour

## Family Risk Factors

- Social isolation
- Family stress, separation or divorce, and violence, including intimate partner violence
- Parenting stress, poor parent-child relationships, and negative interactions

## Community Risk Factors

- Community violence

- Concentrated neighbourhood disadvantage (e.g., high poverty, high unemployment rates, and high density of alcohol outlets), and poor social connections (CDC, 2020)

According to the First Nations Health Authority (2020), during pandemics such as the COVID-19 when citizens are asked to stay home, RV is a serious threat to many women and girls. Risk factors that are exacerbated are:

- Stress
- Loss and separation of friends, family, co-workers
- Loss of livelihood / financial hardship
- Loss of homes and resources
- Personal loss
- Uncertainty and anxiety
- Change in housing arrangements
- Breakdown of norms, including loss of routines
- Loss of control (First Nations Health Authority, 2020)

## Intersectionality

To understand the complexity of abuse in vulnerable groups, such as in the Indigenous population, it is important to overlay the Intersectionality framework. Intersectionality theory explains how identity, experience and positionality intersect to create a matrix of oppression that underpins relationship violence (Cramer & Plummer, 2009; Meyer, 2010). See Intersecting Axes of Privilege, Domination & Oppression and place the person on the wheel to understand the totality of the person. Increased risk results from historical, political, and socioeconomic realities, and the normalization and generational transmission of violence that may lead to a culture that normalizes abuse. The history and impact of residential schools and the inadequate living conditions and the

code of silence to protect the family and community unity may all contribute to not reporting RV (Cooper, 2017).

Part of the intersectional framework is to become/remain aware of the effects of historical and current discrimination. For example, The Indian Act enshrined into law racially discriminatory policies, such as having to renounce Indian status to vote (Justice Laws, 2019). The Indian Act also stripped women of their Indian status if the 'married out'. The effects of this Act are still subject to challenges to the government today.

In addition to the above, economic dependency, poverty, lack of parenting skills, formal education, geographic isolation, government and historical structures in remote communities increase the risk of Indigenous peoples (Brassard et al., 2015). Across Canada, there is a history of colonialism, racism and white privilege. For many years, practitioners were told to become culturally competent and many books and articles were written on how to deal with Indigenous and other specific populations. However, generalizations were published about groups. When generalizations are applied to every single person of a given group, it leads to stereotyping. That is why oppressed people feel that the system and its services that are not informed by Indigenous knowledge revictimize them. This results in many Indigenous populations not having a sense of cultural safety.

## Cultural Safety

Systemic racism and power imbalances endured by any group can be addressed through cultural safety. In nursing education, cultural safety was first introduced by Irahapeti Ramsden (2002) a Maori nurse. In her doctoral dissertation, she addressed the historical oppressions that have led to higher rates of illness in the Maori population than in the general population of New Zealand/Aotearoa. Cultural safety examines prejudice, power and bicultural relations. It can be applied to any person or group that differs on any

axis of privilege, domination and oppression (age, ability, ethnicity, sexual orientation, migrant status, religious belief, socioeconomic status, education, etc.). Please, see chapter 6 for a fuller discussion. It is about the unique bicultural relationship of two people and the focus is on the service provider/employer/educator/boss to create a trusting environment and equal partnership with the person who is in an oppressed position. Only the recipient can decide if cultural safety has been achieved. The focus is on the one with the power to reflect on their power and assumptions in order not to stereotype but listen to and understand the other person. Cultural safety is practiced through cultural humility and the following occurs:

- Service providers become curious and reflective practitioners
- Practitioners reflect on their own biases and confront their prejudices
- Respectful communication that recognizes historical and systematic (organizational/societal) oppression
- Creating an equal partnership between those who are communicating with each other
- Creating a trusting environment

This can result in an environment that respects diversity and is free of racism and discrimination (Ramsden, 2002).

## Barriers

As with all groups many Indigenous survivors do not report incidences of IPV nor access services. The Public Health Agency of Canada (2012) lists several reasons for Indigenous people not accessing services:

- Low awareness of them
- Their distance from the home community

- The lack of transportation
- Poor relationships with the police
- Lack of faith in the effectiveness of the resources
- Lack of privacy in communities and the consequent shame about accessing resources
- Complex relationships among the victim, the abuser, their families and other community members
- The desire to keep the family intact at all costs because of fear of the unknown and of losing face, as well as the possibility of losing one's children, home and assets (Holmes & Hunt, 2017).

## Programs and Services

In order for programs for Indigenous peoples to be culturally appropriate and safe, they must draw upon Indigenous knowledge and experiences, and be informed by Indigenous practitioners and elders. In addition, they must restore connections to Indigenous identity, spirit and spirituality (Black et al., 2019; Puchala et al., 2010) and value respect, wisdom, responsibility and relationships (First Nation Health Authorities, n.d.). In addition, traditional beliefs such as connection to culture improve healing (Gilmour, 2013; Reeves & Stewart, 2015) and incorporating the wisdom of elders and story-telling decreases trauma and grief (Marsh et al., 2016; Puchala et al., 2010).

Policies written are not always policies practiced and sometimes change takes generations. There are several frameworks and action plans in existence, see agencies listed below.

**Table 19.1 List of Programs**

| Agency in Canada | Initiative | Summary |
|---|---|---|
| Government of Canada | Stop Family Violence | A one-stop resource for family violence that includes information on abuse across the lifespan, where to access help and locate shelters. |
| Public Health Agency of Canada | Violence Prevention | Best practices available at the Public Health Agency of Canada. |
| Government of Canada | National Collaborating Centre for Indigenous Health | A national centre to bring together knowledge and Indigenous communities to synthesize the best evidence. It is meant to be a one-stop-shop for Indigenous health. It has publications on family violence. |
| Canadian Women's Foundation | Canadian Domestic Homicide Prevention Initiative | It provides the history and current context of the Aboriginal community. It also provides effective assessment tools and programs. |
| Truth and Reconciliation Commission of Canada | Truth and Reconciliation Commission of Canada | It is a result of the Indian Residential Schools Settlement Agreement. The commission interviewed survivors of residential schools over a six-year period. A summary of the report describes the horrible atrocities endured by residential school survivors, as well as history, context and recommendations for healing. |

| | | |
|---|---|---|
| National Inquiry into Missing and Murdered Indigenous Women and Girls | National Inquiry into Missing and Murdered Indigenous Women and Girls | Interviews of over 6,000 people to understand the systemic causes of (relationship violence) sexual assault, child abuse, domestic violence, bullying and harassment, suicide, and self-harm and made recommendations. |
| National Aboriginal Circle Against Family Violence. | National Aboriginal Circle Against Family Violence | It has a number of resources for shelter workers. An important resource is the best practices for shelters. |
| National Aboriginal Circle Against Family Violence | **Ending Violence In Aboriginal Communities: Best Practices In Aboriginal Shelters and Communities** | A summary report based on consultations with twelve on-reserve women's shelters from across the country. In addition to best practices, the report also considers barriers and challenges, shelter profiles, observations and conclusions. |
| First Nations Health Authority | Traditional Healing | It provides a health and wellness framework that can be used by service providers. |
| Strength, Masculinities and Sexual Health | SMASH Initiative | Work with young boys and men to help formulate healthy gender identities and develop respect for all beings. They also have links to multiple resources. |

| | | |
|---|---|---|
| Fostering Open Expression among Youth | FOXY Program | Provide support to girls and gender diverse individuals that teach them about healthy relationships and sexual health. It is an award-winning program. |
| Ending Violence Association of BC | Indigenous Community Safety Project | Assist Indigenous communities and leadership understand the justice and family systems and child protection laws and policies that directly impact policy and government agency responses to relationship violence. |
| **Agency outside Canada** | **Initiative** | **Summary** |
| Healing Foundation – Australia | Healing Foundation – Community Healing | It has several programs that are deemed effective to address and prevent relationship violence as well as resources on intergenerational trauma. |

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# Chapter 20: Relationship Violence (IVP) in LGBQT2SIA+ Relationships

JENNIFER MARCHBANK

*Key Messages*

- Forms of abuse specific to LGBTQ2SIA+ communities include a perpetrator: questioning their partner's sexual or gender identity and right to be in the LGBTQ2SIA+ community; using transphobic, biphobic or homophobic slurs; controlling their partner's expression of their gender or sexual identity; forcing personal displays of affection (PDAs) in non-safe spaces; forcing PDAs in public to 'out' their partner; withholding hormones from their transgender partner; using their partner's identity as ammunition in child custody cases; threatening to 'out' their partner to children, family, employers, friends; engaging in financial abuse through identity theft; isolating their partner from the LGBTQ2SIA+ community; reinforcing internalized trans/bi/homophobia; and forcing them to have sex in ways that do not match their identity.
- Numerous factors at individual, familial and societal levels may prevent a victim from accessing help. For

example, a victim may: have internalized homo/trans/biphobia which may lead to a sense that 'this is what I deserve'; live in a jurisdiction where legal definitions of IPV do not include same-sex relationships; refrain from help-seeking for fear of being 'outed'; have poor community experiences with police and other services; fear potential homo/trans/biphobia from service providers/police; come across few if any resources or specific/specialized supports for LGBTQ2SIA+ communities, or come across materials that do not use inclusive language, so they have no confidence that an agency can actually understand and assist them, and have a concern that they may end up in a program with their abuser if the programs are based on gender rather than experience.

- PV among youth is a public health concern and illustrates how critical it is that schools, educators, youth service providers, and mental health practitioners educate and support diverse youth regarding healthy romantic relationships.
- LGBTQ2SIA+ elders lived through decades of outright discrimination and persecution and these experiences have taken a toll on their mental health.
- The lack of research and data on RV in LGBTQ2SIA+ communities have resulted in programs that offer limited benefits and support or even further marginalize victims within LGBTQ2SIA+ communities

Relationship violence is any form of physical, emotional, spiritual and financial abuse, negative social control or coercion that is suffered by anyone that has a bond or relationship with the

offender. In the literature, we find words such as intimate partner violence (IPV), neglect, dating violence, family violence, battery, child neglect, child abuse, bullying, seniors or elder abuse, male violence, stalking, cyberbullying, strangulation, technology-facilitated coercive control, honour killing, female genital mutilation gang violence and workplace violence. In couples, violence can be perpetrated by women and men in opposite-sex relationships (Carney et al., 2007), within same-sex relationships (Rollè et al., 2018) and in relationships where the victim is LGBTQ2SIA+ (lesbian, gay, bisexual, transgender, queer, Two-Spirit, intersex and asexual plus) (The Scottish Trans Alliance, 2010; Rollè et al., 2018). Relationship violence is a result of multiple impacts such as taken for granted inequalities, policies and practices that accept sexism, racism, ageism, xenophobia and homophobia. It can span the entire age spectrum. It may start in-utero and end with death. In this chapter, we bring together understandings of relationship violence on the LGBTQ2SIA+ community.

## Relationship Violence (Interpersonal Violence) and the LGBTQ2SIA+ Community

Like all other communities, relationship violence does happen among LGBTQ2SIA+ (lesbian, gay, bisexual, transgender, queer, Two-Spirit, intersex and asexual plus). There are some similarities with other groups but there are specific differences that service providers must be aware of and understand. Before going into a discussion of interpersonal violence in LGBTQ2SIA+ relationships, we summarize forms of abuse that are specific to this community.

Perpetrators in relationships with LGBTQ2SIA+ folks may, in addition to other behaviours:

- Question their partner's sexual or gender identity and right to be in the LGBTQ2SIA+ community
- Control their partner's expression of their gender or sexual identity, eg may force them to dress in ways that make them uncomfortable
- Use transphobic, biphobic or homophobic slurs
- Force personal displays of affection (PDAs) in non-safe spaces to scare their partner
- Force PDAs in public to 'out' their partner
- Deny that abuse can exist in same-sex relationships
- Accuse their partner of being equally guilty of abuse
- Withhold hormones from their transgender partner
- Use their partner's identity as ammunition in child custody cases
- Threaten to 'out' their partner to children, family, employers, friends
- Financial abuse can include identity theft which is easier if the partner is same-sex
- Isolate their partner from the LGBTQ2SIA+ community
- Reinforce internalized trans/bi/homophobia
- Force them to have sex in ways that do not match their identity (e.g., forcing a transman to have vaginal sex) (list created by Jen Marchbank)

Members of LGBQT2SIA+ community also face barriers to services in unique ways.

- May live in a jurisdiction where legal definitions of IPV do not include same-sex relationships
- May refrain from help-seeking for fear of being 'outed', with subsequent fear of rejection by family and friends
- Poor community experiences with police and other services
- Fear of 'washing dirty linen in public', that is of making the community look bad
- Fear potential homo/trans/biphobia from service providers/

police
- Materials on resources do not mention LGBTQ2SIA+, resulting in no confidence that the agency can actually understand and assist
- Materials do not use inclusive language
- Refusal of services based on identity (e.g., locally Vancouver Rape Relief will not provide services to transwomen)
- Lack of specific programs and services
- Concern that they may end up in a program with their or another's, abuser if programs are based on gender rather than experience
- Internalized homo/trans/biphobia may lead to a sense that 'this is what I deserve ' (list created by Jen Marchbank)

Every year, on the International Day against Homophobia, Transphobia and Biphobia, statements are made to raise awareness about the bullying and persecution the LGBTQ2SIA+ community faces, including children and youth. In May 2020, the BC Representative for Children and Youth, Dr. Jennifer Charlesworth, issued the following statement that can be found here.

## What data do we have?

Statistics Canada counts the number of same-sex police-reported incidents and discusses barriers to reporting but does not have any figures on rates of non-reporting by LGBTQ2SIA+ people. (Ibrahim, 2019).

Writing about the implications of a lack of data on violence in lesbian relationships Wurtzberg (2013) notes that:

> Lack of data translates into uninformed assistance, or no assistance by police, courts, shelters, and other service providers. A typical strategy, given the low number of applicable studies, has been to apply knowledge about the

> heterosexual intimate battery in a somewhat haphazard fashion to understanding LGBTQ family violence. This policy has been about as effective a helping tool as attempts from previous decades to use information about white, middle-class families for understanding domestic challenges for people of colour (p. 849).

Further, Ristock (2003) argues that practitioners cannot and should not rely on frameworks of understanding and practice that are based on heterosexual gender relations when trying to understand and provide services to those who are/have been in non-heterosexual relationships that were abusive. To provide appropriate services we need to understand what abuse looks like amongst non-heterosexual people, including elders and youth. As Loree Cook-Daniels, (2017) notes there is a dearth of studies of elder abuse among non-heterosexual people whilst Lisa Langenderfer-Magruder et al. (2016) note that "…sexual minority youth more often experience PV (partner violence) victimization than their heterosexual peers" (p. 57). As such, it is necessary that we understand violence and abuse in all our communities and sub-communities. This chapter addresses rates of violence and assault experienced by non-heterosexual members of society and also their use of abuse and violence in relationships.

We are probably all aware that LGBTQ2SIA+ people live in a world where homophobia and transphobia remain a threat to their rights and sometimes to their person. What is less well known is that this diverse group of diverse people is also more at risk for sexual and interpersonal violence, for example in Canada in 2014 the rate of victimization (of sexual assault, physical assault or robbery) was 69 per 1000 for heterosexual identified people; 142 per 1000 for lesbians and gay men and 267 per 1000 for bisexual people. Some of this is explained by the fact that those identifying as LGBTQ2SIA+ are a younger demographic than the remainder of the population and as such are at a higher risk due to their age (as they may more frequently occupy spaces that are unsafe, such as the street) but it is also explained by other social factors such as hidden

homelessness (Conroy & Cotter, 2017). Hidden homelessness means relying on the goodness of others to let one remain under their roof and this may come with an acceptance that to remain a person has to endure violence or sexual activity. Conroy & Cotter (2017) note that for the hidden homeless the rates of violent victimization are three times higher than for those who have stable housing. They cite rates of hidden homeless as follows:

**Table 20.1 – Victimization among Homeless among different sex identities**

| | |
|---|---|
| Heterosexuals | 8% |
| Lesbian and Gay | 12% |
| Bisexual | 18% |

There are not many studies on victimization and sexual and gender minority populations but research on lesbian, gays and bisexuals has been growing with Simpson (2018) collecting such data in recent years. There is even less on the experiences of transgender and non-binary people. Brown & Herman (2015) reviewed the findings of 42 studies, mostly from the USA, from 1989 to 2015 and found that for LGBTQ2SIA+ individuals there were certain trends that differed from those who identify as heterosexual, including higher rates of IPV (intimate partner violence) for both male and female bisexuals and a significantly heightened risk of IPSA (intimate partner sexual abuse) for bisexual women in particular. Waters et al. (2013) report on a randomized telephone survey of adults across the USA in 2010 conducted in both English and Spanish with a specific focus on those who identify as lesbian, gay and bisexual. They conclude that bisexual women have a significantly higher lifetime risk of rape/ sexual violence by any perpetrator than lesbians or heterosexual women.

**Table 20.2 – Prevalence Rates by Identity from the National Intimate Partner & Sexual Violence Study (NISVS), 2010 Findings, USA**

| | Lifetime IPV | Lifetime IPV | Lifetime IPSA | Lifetime IPSA |
|---|---|---|---|---|
| | Men % | Women % | Men % | Women % |
| General population | 28.1 | 32.9 | 8.0 | 15.9 |
| Heterosexual | 28.7 | 32.3 | * | 15.3 |
| Bisexual | 37.3 | 56.9 | * | 40.0^ |
| Gay, Lesbian | 25.2 | 40.4 | * | ** |

* estimate not reported, ** estimate not reported sample size too small, ^ statistically significant difference between bisexual and heterosexual women (Waters et al., 2013)

**Table 20.3 – Lifetime Prevalence Rape/Sexual Violence, 2010, USA**

| | Rape | Rape | Sexual Violence | Sexual Violence |
|---|---|---|---|---|
| | Women | Men | Women | Men |
| Lesbian, Gay | 13.1 | Too small | 46.4 | 40.2 |
| Bisexual | 46.1 | Too small | 74.9 | 47.4 |
| Heterosexual | 17.4 | 0.7 | 43.3 | 20.8 |

(Waters et al., 2013)

Assaults on bisexual and heterosexual women were reported to have been perpetrated by men at a rate of 98% (Waters et al., 2013), see Table 20.4.

**Table 20.4 – Sexual Assault other than Rape, % male perpetrators, 2010, USA**

| | Women | Men |
|---|---|---|
| Lesbian/Gay | 85.2 | 78.6 |
| Bisexual | 87.5 | 65.8 |
| Heterosexual | 94.7 | 28.6 male<br>54.8 female<br>16.6 male & female |

(Waters et al., 2013)

So, in Table 20.4 we see that for all groups, except heterosexual men, the vast majority of perpetrators of sexual assault are men. However, this means that at least a minority of reported sexual assaults in the USA are perpetrated by women. Coxell et al. (2000) note that female perpetrators were involved in 40% of the cases of rape of men in their study.

Looking at rates of violence by intimate partners that include rape, stalking and physical violence (see Table 20.5) we again see an increased prevalence experienced by bisexual people, particularly bisexual women. We also see that bisexual women and lesbians are also at an increased risk in comparison with heterosexual women, with gay men reporting the least level of victimization.

**Table 20.5 – Rates of IPV including rape, stalking, physical violence, 2010, USA**

| | Women | Men |
|---|---|---|
| Lesbian, Gay | 43.8 | 26 |
| Bisexual | 61.1 | 37.3 |
| Heterosexual | 35 | 29 |

(Waters et al., 2013)

Again, it is useful to examine who is perpetrating these violent

acts so as to better inform policy and practice. According to figures provided by Waters et al. (2013) we once again see that men are reported as perpetrators in almost, but not all, cases. See Table 20.6.

**Table 20.6 – Violence by sex of perpetrator and identity of the victim, 2010, USA**

| | Women | Men |
|---|---|---|
| Lesbian, Gay | 67.4 female perpetrator | 90.7 male |
| Bisexual | 89.5 male | 78.5 male |
| Heterosexual | 98.7 male | 99.5 female |

(Waters et al., 2013)

These figures indicate that in IPV in non-heterosexual relationships whilst a significant majority is perpetrated by men, women are also using violence in lesbian relationships, the dynamics of which are explored below.

EVABC our provincially funder gender-based organized conducted a webinar for service providers, Addressing Domestic Violence in LGBT2SQ+ Communities across BC earlier in 2020. It can be accessed here.

## LGBTQ2SIA+ Youth

LGBTQ2SIA+ youth and children can face violence within their families based on their gender and sexual identities, some are also forced out due to rejection by parents and other family members. A 2015 study of homeless youth seeking services in the USA, *Serving our Youth* – UCLA Williams Institute – found that 46% of the

LGBTQ2SIA+ youth seeking homeless services had left home due to family rejection with 32% of these youth reported physical, emotional and sexual abuse at home. This survey (and many others) have found LGBTQ2SIA+ youth are over-represented in the homelessness statistics, especially those who are the youth of colour. Transgender youth are most vulnerable with 67.1% of those surveyed stating that they had been forced out/run away due to their gender identity, compared to 55.3% for LGB youth.

In studies of LGBTQ2SIA+ youth and partner violence, the acronym PV is most frequently used to indicate that violence and abuse may occur in a relationship that does not necessarily involve sexual intimacy. As Martin-Storey (2015) and others have noted dating violence in adolescence has been linked to an increased likelihood of future IPV behaviours as an adult. There are also particular risk factors for LGBTQ2SIA+ youth that make them more likely than their heterosexual and cisgender peers to become victims of PV. These include depression, suicidal ideation, abuse, a lack of peer and familial support and acceptance and substance abuse (Langenderfer-Magruder et al., 2016; Vezina & Hebert, 2007). Also, Langenderfer-Magruder et al. (2016) found that although these factors exist amongst heterosexual and cisgender youth they are experienced at higher rates by LGBTQ2SIA+ youth, making LGBTQ2SIA+ youth more vulnerable to PV.

> [Risk] factors are often present at heightened levels in LGB youth populations, in large part because of the socially disconnected and discriminatory experiences they face—particularly upon exposure of their sexual orientation to family, friends, and classmates. In fact, up to half of LGB teens experience a negative reaction from parents when they reveal their sexual orientation (Dank et al., 2014, p. 847).

Langenderfer-Magruder et al. (2016) examined various risk factors and concluded that demographic variables such as ethnicity or socioeconomic status did not correlate with PV but that the existence of each risk factor did correlate. Indeed, Martin-Storey (2015) found that the self-reporting rates of youth in her study of

14-18-year-olds in the USA (n= 12,984) were consistently higher for LGBTQ2SIA+ youth than for their heterosexual peers – see Table 20.7.

**Table 20.7 – Rates of self-reporting victimization by the partner in youth 14-18, USA, percentage**

| | Girls | Boys |
|---|---|---|
| Lesbian/Gay | 42 | 32 |
| Bisexual | 42 | 20 |
| Unsure | 25 | 36 |
| Heterosexual | 16 | 6 |

(Martin-Storey, 2015)

Breaking down violence into different types reveals that the over-representation of lesbian, gay and bisexual youth in the violence figures remains in all categories, with transgender youth reporting a horrifically high figure of 88.9% victimization via physical violence in their dating relationships – see Table 20.8.

**Table 20.8 – Rates of dating violence, by type and identity, percentage**

| | Physical | Psychological | Online dating | Sexual coercion |
|---|---|---|---|---|
| LGB | 42.8 | 59.2 | 37.2 | 23.2 |
| Heterosexual | 29.0 | 46.4 | 25.7 | 12.3 |
| Transgender | 88.9 | 58.8 | 56.3 | 61.1 |
| Cisgender | 29.6 | 47.1 | 26.2 | 12.8 |

(Dank et al., 2014)

PV amongst LGBTQ2SIA+ is not just a concern about victimization, it is also a health concern:

> PV among youth is a public health concern, and the elevated rates among LGBQ youth, higher rates among transgender youth, and highest rates among youth who are both transgender and LGBQ illustrate how critical it is that schools, educators, youth service providers, and mental health practitioners educate and support diverse youth regarding healthy romantic relationships. All youth–but particularly LGBTQ youth–need to know how to seek help for PV when it occurs and must feel safe knowing that they will not be judged, shamed, or blamed for being victimized. Additionally, providers need to understand that lived experiences–including the accrual of risks–differ based on the intersection of multiple identities and educate themselves on how best to engage young adults in a manner that is culturally responsive (Walls et al., 2019, p. 91).

Other studies have looked at the role of minority stress (Wikipedia – Minority Stress, 2017), which is the stress experienced by those who are members of stigmatized groups, such as LGBTQ2SIA+ in relation not to victimhood but to perpetration. In their study, again from the USA, of college youth, Edwards & Sylaska (2013) found that

perpetrators of physical violence acted out of a desire to conceal their identity (to remain in the closet) and from internalized homonegativity whilst perpetrators of sexual assault did so from internalized homonegativity. They conclude that the greatest stress faced by LGBTQ2SIA+ college students is internalized homonegativity (IH). IH is the end result of a process in which LGBTQ2SIA+ people internalize societal messages regarding gender and sex, this is often unconscious like other cases of social learning. This can create negative self-images when they realize that they are LGBTQ2SIA+ (Herek, 2000) causing emotional, psychological and even physical harm. This is because negative internalized beliefs create a psychological dilemma between romantic desires and negative beliefs about the self; the disjuncture can lead to feelings of guilt and shame, low self-esteem, and other emotional difficulties (Berg et al., 2016, p. 541).

The risk factors and stressors facing gender and sexual minority youth result in higher rates of depression, low self-esteem, lower school grades and higher rates of school truancy. In the first national survey of LGBTQ students in Canada researchers for Egale Canada found that gender and sexual minority students faced verbal harassment, cyberbullying, physical harassment (reported by 40% of transgender respondents and 20% of LGB), with 95% of transgender students and 75% of LGB reporting that they felt UNSAFE in school (for heterosexual students this figure was 20%) (Taylor & Peter, 2011). Given these figures, it is not surprising that some LGBTQ2SIA+ youth have higher truancy rates and lower academic performance.

Crooks et al. (2020) highlighted two effective programs for LGBTQ2SIA+ youth. Gender-Sexuality Alliances (GSAs) "supported the needs of youth and increased their sense of connection with the LGBT2Q+ community and resources" and OK2BME "created a safe and supportive (environment), and enhanced their understanding of LGBT2Q+ related issues" (p. 19). As well, they stated that adaptations to heterosexual youth programs are possible. They provide an example of a program, "Healthy Relationships Program for LGBT2Q+ (Lesbian, Gay, Bisexual, Trans, Two-Spirit, Queer & Questioning)

Youth" that was successfully adapted from the "Healthy Relationships Plus Program" (HRP). Although this program was not specific to addressing relationship violence they recommend that when adapting programs, gender and sexually diverse youth be involved in the adaptation process, that it be carefully facilitated and that the unique challenges such as social norms, minority status, stress, etc be built into programs.

EVABC, our provincially funded gender-based organization is funded for a Safe Choices LGBT2SQ+ Support and Education Program. You can check their website for training opportunities.

This Practice Brief from the US Family Acceptance Project is a good resource on how families can be supported in supporting their LGBTQ2SIA+ child/teen and how to avoid using their identity negatively within families, by Dr. Caitlyn Ryan (2009) – click here to access.

## LGBTQ2SIA+ Elder Abuse

We wonder how many of us think of elder abuse in terms of sexual and gender identities. How many of us think about the safety of older gay men in care homes? Or of a transwoman requiring appropriate medical care? As Gutman et al. (2020) surmise:

> Though we don't know enough about LGBT elder abuse, what we do know is that any differences between LGBT elder abuse and elder abuse in the general population have been predicated and generated (at least partially) by the cultural context in which they emerged. As Westwood (2018) has pointed out, "the abuse of older people involves at its heart, an imbalance of power relations". In the case of older LGBT victims of abuse, these power relationships are strongly influenced by both historic and current factors, which not only include popular cultural attitudes, legislation, and social

> policies but also how these have been perceived by people who identify as LGBT (p. 149).

LGBTQ2SIA+ elders have been described as an invisible population (Brotman et al., 2003) which has partly been due to their fears of being public, such fears having been developed when their sexuality was criminalized or treated as a mental illness. Brotman et al. (2003) found that gay and lesbian patients of all ages still reported negative reactions from service providers, "ranging from condescension, excessive curiosity and pity, through embarrassment, hostility, and outright rejection" (Gutman et al., 2020, p.152). As such, these elders may delay disclosing their abuse for fear of 'outing' themselves and they also face many of the barriers listed at the beginning of this chapter. This fear also prevents many elders from entering care homes, whilst others fear that entering a communal living facility may necessitate a 'return to the closet'. These factors all add to the invisibility and silence of this demographic leaving them vulnerable to abuse.

There are a number of risk factors that LGBTQ2SIA+ elders face that are unique to them, these include a greater likelihood of being depressed and/or disabled (Fredriksen-Goldsen et al, 2013); they are less likely to have been married or to have children of their own which exposes them to greater rates of loneliness (Fredriksen-Goldsen et al., 2013) and if they do have children they might not be in a supportive relationship with them. Due to societal pressures, LGBTQ2SIA+ older adults are more likely than their heterosexual peers to have abused drugs and/or alcohol (Choi & Meyer, 2016). In addition, LGBTQ2SIA+ elders also face higher levels of poverty and are at a greater risk for financial abuse due to lifetime disparities in earnings (Choi & Meyer, 2016) and previously existing legal and social systems that discriminated against their ability to acquire financial security (such as not being able to claim their deceased partner's benefits and pensions). Although in many countries there is now technical legal equality and laws against discrimination, LGBTQ2SIA+ elders lived through decades of outright

discrimination and persecution and this takes a toll on their mental health (Brotman et al., 2001; Cabaj & Stein, 1996).

LGBTQ2SIA+ elders have lived through social exclusion, violence and oppression which has required them to be resilient. However, the years of experience of social stigma, marginalization and other oppressions have, for some, created IH (Internalized Homonegativity) resulting in feelings of shame and depressing self-esteem. We know that all abuse is an abuse of power, and that elder abuse is also the abuse of trust. Those with low self-esteem are "..prime targets … who might be easily convinced that they are worthless.." (Gutman et al., 2020, p. 153). The same threats that are listed at the beginning of this chapter apply to this population as well as to younger cohorts and they may less able than others to challenge them.

A team of researchers from Simon Fraser University and two community groups: Youth for A Change and QUIRK-e (queer riting and imaging kollective of elders) produced Canada's first educational materials on this issue which include 5 posters and 3 videos, all available for free at LGBT Elder Abuse. Further resources are available on these links:

AARP – US survey of older LGBTQ – mostly on plans for elder care & health, some good statistics

Maintaining Dignity: A survey of LGBT Adults Age 45 and older

Egale Canada – not about abuse BUT fear of homophobia in receiving care

Egale

Egale Canada Seniors' Consultation

Community Engagement Consult for LGBTQI2S Seniors

## Abuse in Same-Sex Relationships

At the beginning of the chapter, we listed several things that can be

specific to IPV in same-sex relationships or for trans and nonbinary folks. The article here provides some discussion of these factors:

The Atlantic – Same-sex Domestic Violence Epidemic Is Silent

There are a number of factors that need to be considered with regard to IPV in same-sex relationships. Firstly, as the domestic violence prevention movement and services have their roots in the battered women's movement of the 1970s (with some of the first shelters for women fleeing abuse opening in Western countries in that decade, (Marchbank & Letherby, 2014) the image of a survivor is often that of a heterosexual woman from a long term relationship or marriage. This serves to invisibilize any victim who does not fit this profile and also prevents the development of specific strategies and services for LGBTQ2SIA+ people. For example, the Center for Disease Control (CDC, 2018) in the USA acknowledges that IPV can occur in heterosexual and same-sex relationships but then promotes the same six strategies to deal with both scenarios as if there are no differences – Intimate Partner Violence.

Now, of course, many of the strategies presented on this site will assist with all kinds of violence in society but a model based on heterosexuality is not the best fit for nonheterosexual relationships. Ristock (2003) argues that you cannot rely on "… heterosexual gender-based frameworks for explaining abusive same-sex relationships" (p. 331). The frameworks may not fit, but we argue in chapter 6 that there are some overlapping risk factors that may be beneficial for RV prevention campaigns. As well, programs if made culturally safe with carefully facilitated input from this population may be able to be modified and used.

In her work on abuse within lesbian relationships, Ristock (2003) conducted 80 in-depth interviews with lesbians who had experienced IPV. She notes that previous studies have ".. concluded that lesbian partner battering occurs at the same or at an even higher rate than heterosexual partner violence"(p. 330). However, she argues for caution in accepting such figures given that the studies she is looking at are not randomized samples of respondents but self-selected respondents – which may be an over-

representation of the community. She advocates for adapting models and services away from the traditional model of abuse which sees female victim and male perpetrator pointing out that if this extant model is simply applied to lesbian relationships then either a) lesbian abuse becomes invisible or, b) the abuser comes to be seen as like a man. Neither of which are useful in providing support for the lesbian relationship.

One pattern that Ristock (2003) has uncovered is that 49% of victims in her study were abused in their first lesbian relationship. They were frequently younger than the abusive partner, had not been 'out' as long as their partner and had little access to the lesbian community. As such, these lesbians often relied on their partners to access the lesbian community and lesbian resources. In addition, the older abusive partner was friends with other lesbians longer and as such many of the younger women felt that they had no friends of their own in the community with whom to discuss what was happening in their relationship. However, Ristock (2003) looks beyond individuals for an explanation concluding that the "... pattern suggests that vulnerability to violence is not internal but is part of the cost of a heterosexist context where lesbians are isolated, unable to access meeting places, and often dependent on their first lover for information about lesbian culture" (p. 335).

Having noted this pattern Ristock (2003) points to ways in which services and information can be shaped to address this aspect of abuse in lesbian relationships:

> ... there may be ways of reducing violence in first relationships by having educational campaigns, "coming out" literature and LGBT services specifically address this context. Materials could be developed for women who are just coming out that dispute harmful, limiting stereotypes of lesbian relationships, define healthy relationships, and identify some troubling warning signs of which they could be aware (p. 339).

Gay men also face the difficulties of being invisible to service providers and society in general. However, sometimes gay men as

victims are hypervisible but not in a positive way. Rumney (2009) reports that some police officers hold attitudes that negate a gay man's reporting of rape/sexual assault either by a stranger or with a partner. He notes that these attitudes include '" highly questionable assumptions regarding credibility, trauma, and truthfulness" (Rumney, 2009, p. 238). The societal view that gay men are highly promiscuous also does not help when gay and bi men report assault resulting in victim-blaming (Jackson et al., 2017; Javaid, 2018a), as "… gay male rape victims are often seen as having 'asked for it' and are, therefore, blamed for their own rape" (Javaid, 2018b, p. 762). Meyer (2020) has found that attitudes of gay men towards police also differ. He found that, in the USA, gender-nonconforming gay men of colour report continuing racial and gender profiling; older white men did not hold expectations of being assisted by the police; gender-conforming gay men of colour were surprised to have their sexuality disparaged by police and that young white gay men expected to find support when reporting the assault.

Studies of men and their health show us that the concept of masculinity is relevant, for example, several studies show that men are reluctant to seek health-related services due to their internalized concept of masculinity, that is real men are stoical, healthy and can sort it out themselves (see Payne, 2006; Thompson & Lagendoerfer, 2016). With regard to reporting abuse and/or assault gay men's concepts of masculinity can also be a barrier, with IPV being normalized or hidden "…as part of male and manly sexual relationships and [gay men] covered up their experience of violence through masculine stoicism" (Oliffe et al., 2014, p. 574). Internalized homonegativity and homophobia can also play their part for as the dominant, hegemonic, discourses of masculinity include heterosexuality, then being gay means they do not fit. As such, societal "… heteronormativity can manifest itself as internalized homophobia to silence reports of IPV in gay men's relationships "(Oliffe et al., 2014, p. 571).

For a more detailed discussion see Anna Griffith's, 2013 doctoral thesis here An investigation into same-sex partner violence.

This chapter provides information on relationship violence in LGBTQ2SIA+ (lesbian, gay, bisexual, transgender, queer, Two-Spirit, intersex and asexual plus) communities. Violence is an issue faced by all groups in our society and among all ages. There are commonalities but there are also specific differences. Just as we need to ensure cultural safety when working with people with diverse social and cultural backgrounds we also need to ensure cultural safety when working with LGBTQ2SIA+ survivors and perpetrators. The chapter discusses the forms of abuse that are specific to this community and as shown in the research, it is important to look at what abuse looks like amongst non-heterosexual people. The unique barriers faced by these groups, the data available and the research on LGBTQ2SIA+ elders and abuse in same-sex relationships are provided. Like other chapters, it is important to note if there are limitations in research on select populations and identify where further action and advocacy are needed.

## Other Resources

Here is a link to AMIS, a Scottish leading charity for men who experience domestic abuse. They operate a national helpline, website and training services. – LGBT+ Domestic Abuse (AMIS, n.d.)

Another good resource is the SHIFT The Project to End Domestic Violence. It is a multi-agency effort to work on prevention. They have identified resources for Gender and Sexually Diverse Communities.

An excellent resource that provides information on risk reduction, competencies to reduce barriers and other resources is provided by *LearningNetwork* here: .http://www.vawlearningnetwork.ca/our-work/issuebased_newsletters/issue-12/12-Rainbow_Newsletter_Print_InHouse.pdf.

Elizabeth Fry is also a great resource that provides assistance with

shelter, family services, counselling, employment and educational support for transgender individuals who are at risk of violence.

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# Chapter 21: Relationship Violence (IPV) in Immigrant and Refugee Communities

GLAUCIA SALGADO AND BALBIR GURM

*Key Messages*

- While the act of migration itself does not cause RV, some factors may increase the risk of abuse. These may include post-migration strain and stigma, the stress associated with migration, geographic and social isolation, changes in socioeconomic status, power imbalances between partners, change in social networks and supports, loss of: culture, family structures, and community leaders; economic insecurity resulting from non-recognition of professional/educational credentials, changes in gender roles and responsibilities and unresolved pre-migration trauma.
- Although protective factors have been identified like the history of religious practices (e.g., Buddhist beliefs), they are often focused on individual factors, so the dynamics within families, physical and social environments are overlooked.

Relationship violence is any form of physical, emotional, spiritual

and financial abuse, negative social control or coercion that is suffered by anyone that has a bond or relationship with the offender. In the literature, we find words such as intimate partner violence (IPV), neglect, dating violence, family violence, battery, child neglect, child abuse, bullying, seniors or elder abuse, male violence, stalking, cyberbullying, strangulation, technology-facilitated coercive control, honour killing, female genital mutilation gang violence and workplace violence. In couples, violence can be perpetrated by women and men in opposite-sex relationships (Carney et al., 2007), within same-sex relationships (Rollè et al., 2018) and in relationships where the victim is LGBTQ2SIA+ (lesbian, gay, bisexual, transgender, queer, Two-Spirit, intersex and asexual plus) (The Scottish Trans Alliance, 2010; Rollè et al., 2018). Relationship violence is a result of multiple impacts such as taken for granted inequalities, policies and practices that accept sexism, racism, ageism, xenophobia and homophobia. It can span the entire age spectrum. It may start in-utero and end with death. In this chapter, we bring together understandings of relationship violence on the LGBTQ2SIA+ community.

Relationship violence is a result of multiple impacts such as taken for granted inequalities, policies and practices that accept sexism, racism, ageism, xenophobia and homophobia. It can span the entire age spectrum. It may start in-utero and end with death.

There are multiple factors called social determinants (see chapter 6) that contribute to relationship violence that are mediated by social norms and context. What puts people at risk for RV are:

- Social norms that:
    - Normalize heterosexual relationships and myths about male masculinity
    - Accept power and privilege
    - Accept violence
- Environments that:
    - Support inequity
    - Are exclusive

- Homelessness
- Conflict
- History of abuse
- Low socioeconomic status
- Violation of the Human Rights Act in Canada (Centers for Disease Control and Prevention [CDC], 2019; Public Health Agency of Canada, 2014)

Immigrants and refugees share the above characteristics (much of what is said in previous chapters (see chapter 1 for chapter summaries) will apply depending on the personal characteristics of those involved in RV, but also note there are differences within each group. Here we discuss the factors that may be unique to immigrants and refugees.

Immigrant refers to someone who migrates to a country other than one's original country voluntarily, and refugee refers to someone who has been forced to flee one's own original country due to violence, persecution or war (United Nations [UN], 2020). Immigrants who come to make Canada their permanent home through a legal immigration process are called immigrants, and after 5 years they can apply for citizenship. Some refugees, GARS (Government Assisted Refugees selected by UNHCR) arrive in Canada already with the status of landed-immigrant.

Canada also has a class of migrants called the non-immigrant population, which includes those who temporarily enter the country with a worker or student visa (Statistics Canada, 2016).

Some refugees are able to seek protection in another country. Seeking refuge is a complex process called asylum (i.e., legal process of seeking protection in a foreign country) that is guaranteed to those who are eligible according to the host country's immigration laws (Government of Canada, 2019). Others live in displacement settings like camps and collective centres (Ezard, 2014).

In 2017, Canada received almost two hundred thousand new migrants, including refugees (Statistics Canada, 2017). Of course, this number includes only official migration and undocumented

migrants may exist. The population that seeks migration is very diverse in their individual, economic and social factors. As with any group of people, some have healthy and unhealthy relationships. To read a literature review on immigrant, refugee and non-status women, click here. (Ending Violence Association [EVA], 2009).

Relationship violence among the immigrant population has been described through feminist and patriarchal theories. Besides these theories, experiences of RV among immigrants have been further explained through extenuated experiences linked to post-immigration situations like isolation, cultural changes and barriers, and marginalization (Caplan, 2007; Dow, 2011; Farris, 2002). Following immigration, individuals often experience loss of social networks and social support systems. For those who experience violence in an intimate relationship, losing contact with family members and friends impose a higher level of dependency on the abusive partner (Choncha et al., 2013). A couple who immigrates to another country often has to make new social ties while the previous ones are not available, they have to learn the language, a new way of life, start a new career, and financially support the family. These are considered substantial stressful factors that impact people's interactions, especially the ones who live in abusive relationships. Cho (2011) suggests that in heterosexual relationships, men who are at high-risk of violence may act more violently towards their partner due to the stress experienced after immigration. Although immigration seems to increase the risk of intimate partner violence among those who already live within abusive relationships, this is not to affirm that migration causes intimate partner violence. Rates of RV in immigrant populations are inconclusive because some studies state higher rates while other studies indicate they are lower compared to the host country (Tabibi et al., 2018). There are no conclusive rates for RV in children or older adult immigrants and refugees as compared to the general population.

Studies analyzing relationship violence and immigration indicate that both financial dependence and independence are connected to women's vulnerability to experiencing relationship violence from

their male partners. Han et al. (2010) suggest that economic dependency serves as a situational facilitator of violence, and men end up acting aggressively towards the female partner. Similarly, women who are financially independent post-immigration are perceived as a threat by their male partners, often increasing the occurrence of intimate partner violence. In this case, the explanation lies in the fact that men might perceive women's achievement as the loss of men's power (Morash et al., 2000).

Also, studies show that those with less than a high-school education and lack of literacy in the language of the receiving country face more financial challenges and end up earning very low wages. Immigrants without documented legal status are more likely to live in poverty and other stressful situations like isolation and marginalization that increase the risk of experiencing intimate partner violence (Li & Skop, 2007; Min, 2013).

In addition, cultures strongly linked to patriarchal power, and cultural acceptance of gender inequality play a critical role in the occurrence of intimate partner violence ( Midlarsky et al., 2006; Parish et al., 2004;Yoshioka et al., 2001). Although these are not directly related to immigration patterns, when immigration occurs, women from a visible minority background may face a high risk of intimate relationship violence.

As violence among any group of people is complex, immigrants are subject to relationship violence. This is especially true for couples in which the primary residence holder or the one with the immigration status responsibility is the perpetrator of violence. Although incidence rates are scarce in this field, immigrant couples from a visible minority background who are legally dependent on the violent partner are sometimes more likely to suffer not only domestic violence but also marginalization and social isolation in the receiving country. Since their residence status is dependent on the violent partner, they fear acting on or leaving the abusive relationship and consequently losing the legal status in the receiving country (Lien & Lozerten, 2019). In such cases, IPV may also include threats of deportation if the abusive partner has residency status

and the spouse does not. In the UK, in recognition of (mostly) women entering on spousal visas, immigration law was changed to recognize the potential for IPV in relationships. The Domestic Violence clause provides the legal right to remain in cases IPV – click here to access. In Canada immigrants with Permanent Residence are not required to leave if they leave their sponsoring spouse and options exist for those with temporary status also, click here to read more.

Some commonalities of immigrant and refugee populations that may increase the risk for abuse are:

- Post-migration strain and stigma
- Stress associated with migration
- Geographic and social isolation
- Changes in husband and wife's socioeconomic statuses
- Power imbalances between partners
- Change in social networks and supports
- Loss of culture, family structures, and community leaders
- Economic insecurity resulting from non-recognition of professional/educational credentials
- Change in gender roles and responsibilities
- Unresolved pre-migration trauma (Tabibi et al., 2018)

Most of the information on refugees and immigrants is about women. Some additional risks specific for refugee and immigrant include (Neighbours Friends, & Families, n.d.):

- The violence may include threatening to withdraw sponsorship
- May be at risk of RV from those who sponsored them
- May be at risk from anyone who is helping them or an employer (power position)

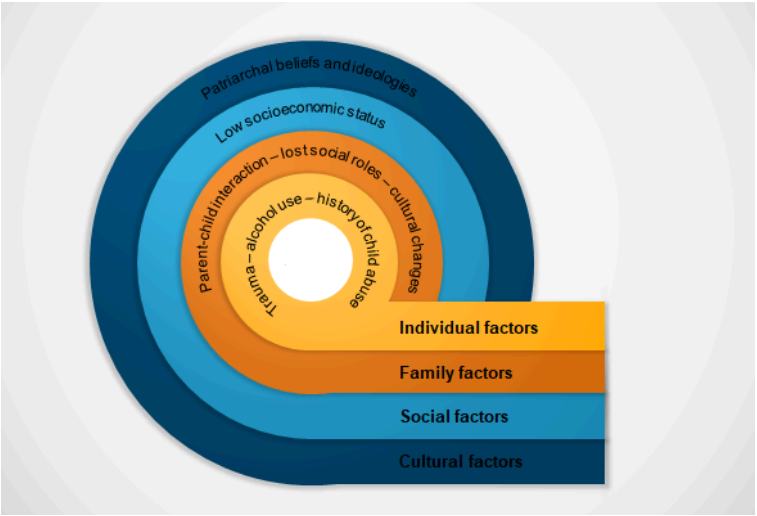
Refugees who live in camps and communal centres face many stressful situations. From traumas suffered in the original country to challenges related to the displacement and collective living.

Studies suggest that the displaced population is at higher risk of alcohol use that has been associated with higher chances of experiencing relationship violence, especially among intimate partners (Weaver & Roberts, 2010). Ezard (2014) shows that alcohol use tends to be extremely high among refugee men living in displacement centres. He explains that alcohol consumption was promoted and encouraged in refugee camps leading to alcohol-related violent behaviours towards female partners. Other than the alcohol effect in the experiences of RV, systematic reviews indicate that previous and current traumatic experiences, parental childhood experiences of child abuse, poor parent-child interaction, breakdown of social roles among men and women, low socioeconomic status, stress due to cultural changes, and patriarchal cultural norms and ideologies were strong factors associated with the incidence of relationship violence among refugees. These factors create an increased risk of experiencing relationship violence among family members, especially for women and children (Timshel et al., 2017). Many of these risks are identified for all groups (see chapter 6). Individual risk factors specific to immigrants are in figure 21.1: culture that accepts gender inequality, legal immigration status linked to one of the partners, low level of education and low financial status. Although these are risk factors, it does not mean that every single person who has these characteristics is going to be abused. These are generalizations based on data, but may not apply to any single person.

**Figure 21.1 – Risk Factors – Individual Level**

Although protective factors are identified like the history of religious practices (e.g., Buddhist beliefs), they are often focused on individual factors, so the dynamics within families, physical and social environment are overlooked (Timshel et al., 2017). From the NEVR model, protective factors are practices of human rights in law and policy. These need to be integrated into all social structures and processes.

**Figure 21.2 – Risk factors of Relationship Violence among Refugees**




It should not be assumed that all relationships are heterosexual for there are gender variant identities in all races, cultures, and societies. Immigrants and refugees also have multiple roles and realities (see chapter 6) and it is prudent to highlight the intersectionality of race and gender (see TED x on the Urgency of Intersectionality). All the social determinants of health are applicable overall but not all may be applicable to any one person. It is the role of those working with immigrants and refugees to use this information as background and practice cultural safety when

working with clients to understand their specific risks, needs and desires.

## Initiatives

There are many organizations in Canada that provide support to immigrant and refugee families. Most of the time services include not only violence prevention programs but also initiatives that support factors involved in relationship violence like unemployment and lack of social connectedness. There are many resources and successful programs including labs that are partnerships between universities, community agencies and businesses such as Simon Fraser University's Refugee Livelihood Lab.

Some resources are specific to immigrants and refugees in Canada, mostly BC & Lower Mainland are:

**Table 21.1 – List of programs available to Immigrants and Refugees in Canada**

| | | |
|---|---|---|
| DIVERSEcity Community Resources Society | DIVERSEcity Community Resources Society | This is a non-profit organization based in Surrey, British Columbia that offers services to newcomers in Canada. Services are offered for free in many languages like Punjabi, Hindi, Urdu, Arabic, Korean, Mandarin, Punjabi, Spanish, Farsi and English. They also have a specific program to support LGBTQ2SIA+ newcomers. |
| Options Community Services | Options | This is a non-profit organization based in Surrey, British Columbia. The have a variety of programs and services including 5 programs specifically for immigrants/refuges for settlement and RV in multiple languages including the Caring Dad's program in Punjabi. |
| MOSAIC | MOSAIC | This is one of the largest non-profit organizations serving newcomers with services in the lower mainland. This organization offers a range of services to immigrants and refugees in multiple languages. |

| | | |
|---|---|---|
| Vancouver & Lower Mainland Multicultural Family Support Services Society – VLMFSS | Vancouver & Lower Mainland Multicultural Family Support Services Society | VLMFSS is located in Burnaby and it is focused on offering services to immigrants, refugee women without immigration status and their family, and visible minority families. All services are free and confidential. Programs/services are offered in 20+ languages and include programs specific to RV as well as legal services |
| Ending Violence Association of BC – EVABC | The Safety of Immigrant Refugee and Non-Status Women Project | This is a project that EVABC developed in partnership with MOSAIC to consult, analyze and address issues related to the safety of immigrants, refugees and women who are in Canada without holding a legal status. |
| Progressive Intercultural Community Services – PICS | PICS | This is a non-profit society with their main office in Surrey, BC. They offer a number of employment and English training programs and are involved in the Senior's isolation project. |
| Neighbours, Friends and Families Immigrant & Refugee Communities | Violence Against Refugee Women | This website shows information about domestic violence among refugee women, characteristics of this violence and resources to support prevention. To contact the helpline, please call, 1 866 863 0511 / TTY 1 866 863 7868. |

| | | |
|---|---|---|
| Immigrant Services Society of BC | ISSofBC | This organization provides a variety of services to immigrants and refugees. Besides settlement aid, they also offer |
| S.U.C.C.E.S.S BC | S.U.C.C.E.S.S. BC | The largest non-profit that offers newcomer settlement, English-language training, employment and entrepreneurship, family, youth and seniors programming, health education, community development, affordable housing, and seniors care. It has multilingual staff and over 40 service centres across Canada and Asia |

**Table 21.2 – List of Programs outside Canada**

| Agency | Program | Summary |
|---|---|---|
| Refugee Women's Alliance | Refugee Women's Alliance | Refugee Women's Alliance (ReWA) is an award-winning, nationally recognized nonprofit that provides holistic services to help refugee and immigrant women and families thrive. In 35 years of work with multi-cultural communities, we have refined our services to most effectively promote integration and self-sufficiency. All of our services are designed to quickly and effectively stabilize clients, promote acculturation, increase language proficiency, and improve employability. |
| US Department of Health and Human Services | Office on Women's Health | This initiative provides information about violence against immigrant and refugee women. It also gives information about restraining orders and how to access resources in the community. |
| Child Welfare Information Gateway | Helping Immigrant Families | Resource with service provides information and how to access them |
| Multi-cultural Centre for Women's Health | On Her Way | Literature that contains information about fact and preventive programs against violence towards. immigrant and refugee women in Australia. |

| | | |
|---|---|---|
| ANROWS | ANROWS | Information about experiences of violence against immigrant and refugee women and preventive program resources. in Australia. |
| Futures without Violence Organization | Future without Violence | This initiative has many programs that provide information and support to different population groups including immigrant and refugee women and men. |

See general resources for RV in other chapters or go to the BC211 website.

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# Chapter 22: Relationship Violence in the Workplace

BALBIR GURM

*Key Messages*

- The most common forms of Relationship Violence in the workplace are physical, sexual, emotional, spiritual and financial. RV can be inflicted by those in an organization or those visiting it. RV in the workplace can start with minor incidents and escalate to physical and sexual violence.
- Many companies have implemented diversity and inclusion policies; however, even though there are guidelines against discrimination in many companies, barriers exist to address such discrimination.
- A person at higher risk of committing violence in the workplace may have some of the following traits: a history of violence, engage in threatening or intimidating behaviour, have increased personal stress, exhibit negative personality characteristics, marked changes in mood or behaviour, be socially isolated, has an obsessive involvement with his or her job, and/or abuses drugs or alcohol.

Relationship violence is any form of physical, emotional, spiritual and financial abuse, negative social control or coercion that is suffered by anyone that has a bond or relationship with the

offender. In the literature, we find words such as intimate partner violence (IPV), neglect, dating violence, family violence, battery, child neglect, child abuse, bullying, seniors or elder abuse, male violence, stalking, cyberbullying, strangulation, technology-facilitated coercive control, honour killing, female genital mutilation gang violence and workplace violence. In couples, violence can be perpetrated by women and men in opposite-sex relationships (Carney et al., 2007), within same-sex relationships (Rollè et al., 2018) and in relationships where the victim is LGBTQ2SAI+ (lesbian, gay, bisexual, transgender, queer, Two-Spirit, intersex and asexual plus) (The Scottish Trans Alliance, 2010; Rollè et al., 2018). Relationship violence is a result of multiple impacts such as taken for granted inequalities, policies and practices that accept sexism, racism, ageism, xenophobia and homophobia. It can span the entire age spectrum. It may start in-utero and end with death. In this chapter, we focus on the violence that occurs in the workplace between people that know each other.

## RV in the workplace

Relationship violence in the workplace can occur anytime during a business or organization's life/existence. RV in the workplace has been described as any type of abuse, threat, intimidation or assault that occurs in a place of employment (Canadian Centre for Occupational Health & Safety (CCOHS, 2020). The most common forms mentioned are physical, sexual, emotional, spiritual and financial. Work Safe BC (2000) divides relationship violence in the workplace as physical (workplace violence) and emotional (bullying and harassment). People spend a great deal of their lifetime at work so it is imperative that we create safety in the workplace. It is important that work environments foster respect, inclusion for the full diversity as outlined in the Human Rights Act (United Nations [UN], n.d.). Therefore, there should be no discrimination based on

a person's race, "national or ethnic origin, colour, religion, age, sex, sexual orientation, gender identity or expression, marital status, family status, genetic characteristics, disability and conviction for an offence for which a pardon has been granted or in respect of which a record suspension has been ordered" (Canadian Human Rights Act., R.S.C., 1985, c. H-6).

Discrimination creates an environment that privileges some employees more than others and sets up power dynamics that may lead to relationship violence. Some theorists believe that violence is a result of power and control or lack thereof (chapter 6) as well as hegemonic practices and policies that contribute to inequality. Since the terminology, 'discrimination' has received a more expanded definition in the efforts to embrace direct discrimination and its consequences, many companies have implemented diversity and inclusion policies. Such policies intend to support and address the exclusion of certain groups of individuals in the workplace (Sheppard, 2010). However, not all nations have proper laws to address discriminatory behaviours in the workplace, nor laws that are inclusive enough to include the range of diversity among people (Barak, 2016). Also, even though there are guidelines against discrimination in many companies, barriers exist to address discrimination (Sheppard, 2010). Discrimination and racism remain systemic. An example most recently is the death of George Floyd in the US. We are aware that some of you may find watching video of his murder disturbing so have not embedded it here but the video of the behaviour of the police officers leading up to his death can be accessed here video here (New York Times, 2020).

Many authors agree that the highest workplace violence is in the healthcare field (Arnetz al., 1996; Camerino et al., 2007; Campbell et al., 2015; Eker et al., 2012; Gerberich et al., 2004; Magnavita, 2013; Toscano & Weber, 1995). A systematic review found RV impacts 61.9% of employees, and most cases are connected with harassment, sexual harassment, and physical violence. Also, professionals working with unstable persons, the public, and those who provide health care or other care services

(e.g., care aides, counselling) and education are at higher risk of relationship violence (Liu et al., 2019; Employment and Social Development Canada, 2017). RV can be inflicted by those employed in an organization or those visiting it. In healthcare, relationship violence offenders can be patients, family members or caregivers, visitors, co-workers, managers/administrators.

The Canadian Federation of Nurses Unions (CFNU, 2020) include bullying and lateral violence (i.e., violence experienced from a co-worker) in their definition of workplace violence:

> [...] inappropriate, offensive, abusive, aggressive, negative, intimidating, or insulting work-related behaviour or abuse of power, which directly or indirectly undermines confidence, devalues ability, or lowers the self-esteem of a worker.

Our team considers the Canadian Federation of Nurses Unions' definition of violence in the workplace relevant and appropriate to be included in NEVR's definition of relationship violence in the workplace because it is between individuals that are known to each other.

Harassment data from 2016 indicate that 19% of women and 13% of men aged 15 to 64 reported that they experienced at least one type of harassment in the workplace in the past 12 months. Those in healthcare (which include nurses and doctors) had a 23% probability of reporting that they had been harassed in the workplace even after controlling for other factors. This likelihood was greater for women (27%) than for men (21%) (Statistics Canada, 2018). Besides the probability of reporting workplace harassment, half of all physicians in the US who work in emergency rooms have reported RV in the workplace (American College of Emergency Physicians, n.d.). Healthcare workers (snapshot of 2016) had more time lost due to workplace violence than police and corrections personnel (Canadian Federation of Nurses' Union, n.d.). Also, The Institute for Gender and the Economy (GATE, n.d.) works with industry partners to conduct studies on gender inequality and in one of their studies (How women are penalized at work for reporting sexual harassment)

found that if women reported harassment themselves it was detrimental to their success in the company, while if others in the organization reported it, it did not impact the woman's promotion opportunities. Further, in a 2017 Canadian study, 64% of women and 57% of men believed sexual harassment occurs at work (GATE, n.d.).

Chappel & Di Martino's (2006) interactive workplace model identifies that individual and workplace characteristics interact and create risk for RV. This is consistent with the NEVR model (chapter 6) that states individuals and systems and social determinants constantly interact to cause relationship violence. The cost to the survivor is stress, illness, economic losses, repercussions on the family, constant demeaning treatment, dismissal/transfer and suicide ideation or attempts. In a large, 80,000 person cohort analysis, it was found that the risk of getting coronary artery disease is 1.59 times higher for those who have suffered bullying and 1.25 times higher for those who have suffered abuse compared to individuals who have not suffered RV (Xu et al., 2019). Workplace RV is not only detrimental to employees, but there are also repercussions for the organization such as increased absenteeism, negative publicity, difficulty retaining staff due to increased stress and a violent atmosphere, the latter also affecting recruiting new staff (Chappel & Di Martino 2006).

## Warning Signs

Relationship violence in the workplace can start with minor incidents and escalate to physical and sexual violence. All employees need to pay attention to the following warning signs which may be present among their co-workers according to CCOHS (2020a):

- A change in their behaviour patterns
- Frequency and intensity of the behaviours are disruptive to the work environment

- The person is exhibiting many of these behaviours, rather than just a few
    - Crying, sulking or temper tantrums
    - Excessive absenteeism or lateness
    - Pushing the limits of acceptable conduct or disregarding the health and safety of others
    - Disrespect for authority
    - Increased mistakes or errors, or unsatisfactory work quality
    - Refusal to acknowledge job performance problems
    - Faulty decision making
    - Testing the limits to see what they can get away with
    - Swearing or emotional language
    - Handles criticism poorly
    - Making inappropriate statements
    - Forgetfulness, confusion and/or distraction
    - Inability to focus
    - Blaming others for mistakes
    - Complaints of unfair personal treatment
    - Talking about the same problems repeatedly without resolving them
    - Insistence that he or she is always right
    - Misinterpretation of communications from supervisors or co-workers
    - Social isolation
    - Personal hygiene is poor or ignored
    - Sudden and/or unpredictable change in energy level
    - Complaints of unusual and/or non-specific illnesses
    - Holds grudges, especially against his or her supervisor
    - Verbalizes hope that something negative will happen to the person against whom he or she has the grudge
    - Non-verbal signs or body language
    - Flushed or pale face
    - Sweating
    - Pacing, restless, or repetitive movements

- Signs of extreme fatigue (e.g., dark circles under the eyes)
- Trembling or shaking
- Clenched jaws or fists
- Exaggerated or violent gestures
- Change in voice
- Loud talking or chanting
- Shallow, rapid breathing
- Scowling, sneering or use of abusive language
- Glaring or avoiding eye contact
- Violating your personal space (they get too close)

These are potential warning signs. It does not mean that every single person who displays these signs is going to be violent. Some more hazardous signs you may notice with a co-worker or yourself are:

History of violence

- Fascinated with incidents of workplace violence
- Shows an extreme interest in, or obsession with, weapons
- Demonstrated violence towards inanimate objects
- Evidence of earlier violent behaviour

Threatening behaviour

- States intention to hurt someone (can be verbal or written)
- Holds grudges
- Excessive behaviour (e.g., phone calls, gift-giving)
- Escalating threats that appear well-planned
- Preoccupation with violence

Intimidating behaviour

- Argumentative or uncooperative
- Displays unwarranted anger

- Impulsive or easily frustrated
- Challenges peers and authority figures

Increase in personal stress

- An unreciprocated romantic obsession
- Serious family or financial problems
- Recent job loss or personal loss

Negative personality characteristics

- Suspicious of others
- Believes he or she is entitled to something
- Cannot take criticism
- Feels victimized
- Shows a lack of concern for the safety or well-being of others
- Blames others for his problems or mistakes
- Low self-esteem

Marked changes in mood or behaviour

- Extreme or bizarre behaviour
- Irrational beliefs and ideas
- Appears depressed or expresses hopelessness or heightened anxiety
- Marked decline in work performance
- Demonstrates a drastic change in belief systems

Socially isolated

- History of negative interpersonal relationships
- Few family or friends

Sees the company as a "family"

- Has an obsessive involvement with his or her job

Abuses drugs or alcohol (CCOHS, 2020b)

If you see any of the above signs in yourself or your co-worker, talk with your immediate supervisor if it is safe, call your human resources department or your employee assistance program. If your workplace does not have a workplace program to address RV, advocate for one. A program must include awareness, prevention, response, referrals to resources and communication about the program and processes between everyone in the organization.

## Relationship Violence with Intimate or Dating Partners Flows into the Workplace

Relationship violence by partners may continue into the workplace and result in workdays lost, estimated at $77.9 million yearly (Canadian Labour Congress [CLC] & Centre for Research and Education on Violence Against Women and Children [CREVAWC], 2014, p. 2). Workplaces try to address relationship violence that flows into the workplace as well as relationship violence that occurs by organizational members and visitors.

In 2014 the Centre for Research and Education on Violence Against Women and Children (CREVAWC) at Western University joined with the Canadian Labour Congress and surveyed nearly 8,500 workers on the relationship between domestic violence and work. One-third of respondents stated that they were currently in an abusive relationship and of those 82% reported that the RV had a negative impact on their work performance, 40% noted that the RV negatively affected their ability to get to work, 10% reported that they had lost employment in the past due to RV related factors. Respondents also stated that they believed 46.2%, almost half of their colleagues were involved in relationship violence, 34% were survivors and 11.8% perpetrators (CLC & CREVAWC, 2014, p. 5).

RV does not just affect the worker being abused by their partner, that partner's abuse may travel into the workplace, especially if the worker is employed in a public place. Other workers may witness abuse, maybe endanger themselves and/or become collateral damage.

Also, women who suffer relationship violence at home, suffer greater job instability. Also, they are harassed by their partners about going to work in order to keep the victim socially and financially dependent on the abuser, so that they will not have the independence to leave the relationship. Some of the tactics Chung et al. (2012, p. 19) quoted in their evidence review on workplace violence are:

- Destroying personal documents
- Preventing attendance at interviews and training
- Verbal harassment and assault when women are leaving home to go to work
- Offering to care for children and then not turning up
- Interfering with women at work, such as 'hanging around' outside the workplace
- Assault or threat of assault to women at work
- Abusive and threatening text messages and emails
- Damaging property or harming pets
- Verbal abuse and assault if women arrive home late from work
- 'Stalking' women to and from work and following them to new accommodation and employment

## Legislation

In 2018, the federal government passed changes to permit those fleeing RV to have up to 10 days leave, with five of those paid leave. This affects 900,000 private-sector workers employed in federally regulated industries such as banks, air and rail travel etc. (Cross,

2018). The BC government passed similar legislation, click here (Government of British Columbia, 2020) to read the government press release and to read the coverage by CBC of Harry Bains, Minister of Labour's announcement, click here (CBC News, 2020).

The legislation that covers relationship violence in the workplace in BC is below.

Canadian Human Rights Act., R.S.C., 1985, c. H-6

British Columbia Human Rights Code [RSBC 1996] CHAPTER 210

British Columbia Laws Bill 14 – The Workers Compensation Act, R.S.B.C. 1996, c. 492

The Occupational Health and Safety Policies for BC (WorkSafe BC, n.d.).

## What can be done?

There are a number of guides and tools that can be downloaded and used by workplaces. As well, we have adapted 7 workplace initiatives that have been identified in the literature review by the Victorian Health Promotion Foundation (Chung, et al., 2012):

- Organizational development strategies -build employee skills to implement prevention strategies
- Community strengthening -address community risk factors from chapter 6 and question hegemonic practices that privilege one group over another
- Communications and social marketing—create a media campaign that highlights practices to prevent violence in the workplace
- Advocacy—become a community champion– learn to recognize abuse, intervene safely and help get the person to resources, legislative and workplace policy reform and research
- Conduct social audits to understand the current situation of

how well the human rights code and cultural safety is practiced and then set benchmarks for improvements in the practice of legislation and policy and research
- Monitoring and evaluation—make incremental changes, monitor improvements and build on success

All forms of violence in the workplace involving two or more people that know each other are included in our definition of relationship violence (RV). Every worker has a right to a relationship violence-free workspace. A number of resources are listed below.

## Resources

### Publications

EVA BC as BC's provincial organization on gender-based violence that is mainly funded by the provincial government has most recently created a policy document Gender-Based Violence, Harassment and Bullying: Workplace Policy Guidelines for Response and Prevention. This document is created for those in leadership positions to create appropriate, policies, training and responses in the workplace.

There is also a Comprehensive website that addresses harassment and workplace violence (WPV, n.d.).

Violence in the Workplace Prevention Guide (CCOHS, 2020g)

Human Resources and Skills Development Canada (2009) has a guide to workplace prevention. The website covers definitions, policies and what is required of employers to eliminate workplace violence.

Toward a Respectful Workplace: a handbook on preventing and addressing workplace bullying and harassment (WorkSafe BC, 2013). A number of other resources are available at *WorkSafeBC*.

Framework Guidelines for Addressing Workplace Violence (World Health Organization (2002).

### Courses

Workplace Violence in the Canadian Federal Jurisdiction: Establish a Prevention Program (CCOHS, 2020c)
Bullying in the Workplace (CCOHS, 2020d)
Domestic Violence in the Workplace (CCOHS, 2020e)
Violence in the Workplace: Awareness FREE! (CCOHS, 2020f)

### Posters

See Signs of Violence at Your Workplace? (CCOHS, 2019a)
Bullying is Not Part of the Job (CCOHS, 2019b)

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# Chapter 23: Relationship Violence in Post-Secondary Institutions

BALBIR GURM AND JENNIFER MARCHBANK

*Key Messages*

- Research and literature indicate that post-secondary students are vulnerable to RV. "Rape culture" and other attitudes condoning or promoting RV continue to persist, and social media often exacerbate these concerns.
- Students experiencing RV may experience low mood, anxiety, preoccupation, feeling unsafe and concentration difficulties. These symptoms lead to reduced engagement in classes, difficulties completing assignments, dropping courses/changing topic of study, as well as reduced social engagement with peers. They also encounter difficulties accessing support and services, experience stigma, have increased apathy, and may have changed attitudes about their own educational and career futures.
- Post-secondary institutions are sources of great potential for changing societal attitudes toward RV, through research, student- or faculty-led RV prevention initiatives, and by collaborating with

community and government services that work in the RV prevention and intervention fields.

Relationship violence is any form of physical, emotional, spiritual and financial abuse, negative social control or coercion that is suffered by anyone that has a bond or relationship with the offender. In the literature, we find words such as intimate partner violence (IPV), neglect, dating violence, family violence, battery, child neglect, child abuse, bullying, seniors or elder abuse, male violence, stalking, cyberbullying, strangulation, technology-facilitated coercive control, honour killing, female genital mutilation gang violence and workplace violence. In couples, violence can be perpetrated by women and men in opposite-sex relationships (Carney et al., 2007), within same-sex relationships (Rollè et al., 2018) and in relationships where the victim is LGBTQ2SIA+ (lesbian, gay, bisexual, transgender, queer, Two-Spirit, intersex and asexual plus) (The Scottish Trans Alliance, 2010; Rollè et al., 2018). Relationship violence is a result of multiple impacts such as taken for granted inequalities, policies and practices that accept sexism, racism, ageism, xenophobia and homophobia. It can span the entire age spectrum. It may start in-utero and end with death. This chapter focuses on RV on post-secondary campuses and mostly on sexual assault.

# RV Against Post-Secondary Students

## Scope and Consequences

Relationship violence prevalence on campuses and at institutions of higher learning is difficult to estimate due to the variations in the design of different surveys (see chapter 5). There is also variation in how each institution may define RV however, there is some agreement that students, like other sectors of the population, are at risk and do experience RV (Cantor et al., 2019; Fass et al., 2008; Knowledge Networks 2011; Sinozich & Langton, 2014).

Some earlier studies on female students suggest the rate of RV is 1 in 4 in both Canada and the US (Dekeseredy & Kelly, 1993; Koss et al., 1987; Fisher et al., 2000) which is in line with incidence rates for women in the general population. However, the Canadian National Survey (2014) showed that the general results for Canadian women were rather higher with incidence rates of 37 in 100 or 37% (i.e., 1.48 in 4) (Conroy & Carter, 2017). Certain groups have a higher risk of being victimized "Indigenous, 2SLGBTQIA, people with disabilities, minorities, and international students are at higher risk of sexual violence" and one-third of first-year students have experienced RV (Magnussen & Shanker, 2019, p. 93). It is not just females that are at risk, Krebs et al. (2007) estimate that approximately 6% of college males are impacted by RV. These are the same groups that are at greater risk in the general population and the rates of RV are similar to the general population (chapter 5). As stated in earlier chapters, RV is normalized and tolerated in many contexts including on university campuses.

RV results in psychological and emotional consequences, and chronic health challenges (see chapter 5). Much of what has been said in other chapters, applies to this population depending on their characteristics (see chapter 1 for chapter summaries) but there are some specific factors to consider.

Molyen et al. (2019) reviewed the National College Health Assessment data collected from students from 474 campuses from 2011-2014 and looked for correlations between factors on campus and incidences of IPV and sexual assault. Using regression analysis they found that sexual assault was correlated with the following factors: binge drinking, younger mean age and higher rates of students reporting experiencing discrimination. IPV was correlated with a higher number of intimate partners, lower binge drinking, older mean age and a higher number of part-time students. Please note correlation does not mean causation, correlation means there is a statistically significant relationship between factors.

Sexual assault of post-secondary students results in many similar impacts as with other groups but plays out in relation to the ability to study, some impacts for women survivors in post-secondary are:

> …common trauma symptoms such as low mood, anxiety, preoccupation, and concentration difficulties as leading to reduced engagement in classes, difficulties completing assignments, and dropping courses. They described feeling physically unsafe—both with regards to proximity to the specific perpetrator and to males in general—as leading to missing classes; participating less in class discussions; avoiding courses, events, and social engagements involving males or occurring at night; requesting less academic help from male professors and teaching assistants; and even considering changes in study field or career. They also described important interactions among difficulties accessing support or services, stigma, increased apathy and changed attitudes about their own educational and career futures, which in turn may also have compounded academic performance (Quinlan et al., 2017, p. 37)

As well, physical health impacts from sexual abuse can be: sexually-transmitted diseases, vaginal bleeding and infections, fibroids, decreased sexual drive, pain during intercourse and urinary tract infections.

## Post-Secondary Campus Culture

RV flourishes in environments that do not challenge it. Universities, like other organizations, need to challenge attitudes that accept violence, especially violence against women. In Canada, we remember the misogynist massacre of 14 female engineering students at l'École Polytechnique de Montréal in 1989. You can read more about it here. This is not the only instance of 'rape culture' on Canada's campuses. In the last decade, we have heard of other incidents across Canada:

- In 2013 at St Mary's University student president resigned for a chant about consensual sex with underage girls. It resulted in a Task Force on how to prevent sexual violence and create safer campuses.
- At UBC, a few days after the incident at St. Mary's University, a similar chant was heard that had apparently been used for over 20 years. This resulted in the establishment of a task force at UBC on Intersectional Gender-Based Violence and Aboriginal Stereotypes to recommend actions.
- At Lakehead University later the same year, a student went to the media and stated she had been assaulted on campus by a student the year before. This resulted in a task force at Lakehead University. whose goal was to address sexual violence and recommend policy change.
- In 2014, a female dental student at Dalhousie University told her administration that a male dental student's Facebook group was promoting sexual violence against the female dental students and she was told by the administration not to file a formal complaint. The snapshots of the Facebook messages were posted on social media which resulted in a petition to expel the student. The petition launched in December 2015 obtained over 50,000 signatures by mid-January. The pressure led to the students being expelled from their regular offerings

but being able to take the courses online. While professional dental associations asked for the names of the 13 male students in the Facebook group, the university administration failed to provide the names citing privacy and allowed the students to graduate. Fourth-year female dental students wrote an open letter to the president that resulted in a task force.

Over the years a number of task forces have been set up across universities in Canada and the United States and policies written, but RV persists. Survivors on campuses, just as others around the world, hesitate to report for similar reasons (see chapter 8). For students, the lack of response from university administrations creates another barrier to reporting. Universities need to act quickly and be proactive to prevent sexual assault and other violations. In their study of first-year female students at Canadian universities, Senn et al. (2014) found that a large proportion of female students arrive at campus already with a history of sexual victimization, indicating that campuses need to be able to provide services to these young women. They also found that young female students (17-24 years old) were also unprepared to deal with on-campus perpetrators and that there is an urgent need for rape prevention programs on campuses.

## Actions

Some provinces introduced legislation to address RV on campuses. For example, BC passed Bill 23: Sexual Violence and Misconduct Policy requiring all post-secondary institutions to have a policy on sexual misconduct and develop the complaint process and evaluate it on a three-year cycle. Similar bills were passed in other provinces – Manitoba recently passed Bill 15: The Sexual Violence Awareness and Prevention Act, and Ontario passed Ontario Bill 132: The Sexual Violence and Harassment Action Plan Act. BC's bill requires that data

be reported to the public and Manitoba's bill also addresses minority groups. These have resulted in policies and prevention programs in universities/colleges being established, some universities have also established specific sexual violence units (see SFU) whilst others have only policy statements.

To be effective, policies need clear procedures that allow for investigation and for confidential and anonymous reporting, services for survivors (Gonzales et al., 2015) that are student-centred, include assaults when students are off-campus, allow for data collection and evaluation and are easily communicated (Gunraj et al., 2014; Gonzales et al., 2015). While the legislation addresses violence against students, good policies should also address all employees and visitors to the campus, define consent and be developed with students (Gunraj et al., 2014). Policies also need to be resourced, frequently reviewed and include student and staff input.

Sexual assault complaints can be reported to university administration and/or to the police, only reporting to the police may lead to a criminal trial.

**Figure 24.1 Legal framework for sexual assault complaints on campus**

From Gunraj et al. ( 2014, p. 13-14) it is important to understand the Canadian legal context that applies to adjudication processes in post-secondary institutions. A university or college campus hearing that deals with a sexual assault complaint are very different from a criminal trial. The provincial statute or Act that incorporates a university or college is what creates the basic legal framework that allows for campus hearings. The statute may set out specific procedures for the university or college to follow to ensure the hearing

process is fair. Therefore, elements of "procedural fairness" that may be required in a sexual assault hearing are first dictated by the statute. But if the statute does not include specific rules, common law principles of procedural fairness fill the gap. Under common law, a "duty of fairness" usually applies in decision-making settings where an individual's rights, interests or privileges are affected. Once it is determined that there is a duty of fairness, the actual procedures that must be followed to ensure fairness vary according to context, considering the following factors:

- nature of the decision and the process followed—the more the process resembles a judicial hearing, the more "trial-like" procedures are required
- nature of the statutory scheme—if the decision is final rather than preliminary or there is no chance for appeal, the greater the requirement for procedures to ensure fairness
- importance of the decision to the individual affected—the more important the decision and its impact is to the people involved, the greater the requirement for procedures to ensure fairness
- legitimate expectations of involved people about the process that will be followed
- the procedure chosen by the tribunal—for example, if a tribunal chooses a procedure related to its expertise, that will be taken into consideration

Common law rules for university and college hearings into complaints of sexual assault are fairly clear with respect to the rights of the respondent—that is, the person accused of sexual assault. Some procedures which have been required to protect the rights and interests of a respondent include:

- disclosure of the case against them
- opportunity to respond to allegations before a decision is made
- in-person hearing when credibility is an issue
- legal representation
- opportunity to cross-examine witnesses when credibility is an issue
- access to reasons for the decision
- impartial decision-maker(s)

Rules are less clear with respect to ensuring fairness for and protecting the interests of the complainant. Issues that may be relevant for the complainant include the right to:

- hear and reply to the respondent's defence
- choose to attend or not attend a hearing with the respondent
- be assisted or represented by a support person or lawyer
- cross-examine the respondent and witnesses
- privacy
- receive reasons for the decision
- have an impartial decision-maker(s)

In addition to common law rules, human rights laws

might also apply to an institution's hearing process. For instance, if the general process does not show sensitivity to issues of gender and leads to a negative impact on female complainants, it may be seen as "adverse effect discrimination" based on sex under the Ontario Human Rights Code.

An institution may also go beyond minimum legal requirements for procedural fairness and establish additional best practices for hearings into a sexual assault to respect the interests of both the complainant and respondent. A useful practice could be to require all students to accept and follow a code of conduct as a condition of admission to the institution. Expectations for the conduct, an explanation of individual rights and duties and the complaint process for sexual assault should be communicated clearly and broadly to all campus community members on a regular basis.

When addressing violence, survivors usually want offender accountability and support. As with the incident at Dalhousie mentioned above, post-secondary institutions are reluctant to expel perpetrators, yet if there was an incidence of plagiarism, immediate expulsion may be a consequence in many institutions. There is a public reporting requirement in BC and the University of British Columbia (UBC) the largest university in BC, has sexual assault statistics on its campus security website. It is noteworthy that the reporting numbers were higher prior to the sexual assault legislation for post-secondary institutions. Click here to access the table. What could the reasons be? Quinlan et al. (2017) report that students are encouraged not to file formal complaints. To learn

about the sexual assault policies/responses, visit the UBC Sexual Violence Prevention and Response Office by clicking here.

Post-secondary institutions have developed task forces and policies on RV consent, reporting and investigation. For example, Simon Fraser University (SFU) in BC has developed videos on consent: Consent Matters: Busting the myth of Sexual Violence and Promoting a Culture of Consent in SFU Residence. Kwantlen Polytechnic University (KPU) also in BC has a policy (2019) that addresses all those who work and study at KPU, it can be found here. From looking at various university websites, it appears that there may not be specialized support services at post-secondary institutions and campus security seems to be tasked with responding to incidents on campus. We are not sure if campus security has the training to respond to RV and sexual assault. Post-secondary institutions in the Vancouver Lower Mainland may consider either partnering with their local health authorities, RV service agencies or with the SMART program like the one at Surrey Women's Centre (discussed in chapter 10). We agree with Quinlan et al. (2017) that post-secondary institutions (PSI) need to have partnerships where community members are equally valued and maybe even provided compensation to work with PSI's (see chapter 6, for NEVR's action model). As a minimum, campus security, if they remain the first call, need to have training on addressing RV situations.

A two year funded project the Courage to Act's goals are to address and prevent gender-based violence on post-secondary campuses in Canada by working collaboratively with communities to create national resources and strategies. In 2019, they released a comprehensive report, a must read for anyone wanting to address violence on campuses, Courage to Act: Developing a National Framework to Address and Prevent Gender-Based Violence. As well, this organization has a number of helpful webinars that can be accessed here. You can access communities of practice, here and a comprehensive list of publications here.

As well, METRAC, an organization that works to eliminate gender-

based violence has created a safety audit (Watch a video on safety here) that may be used by Canadian Universities. You can read about campus safety here. (METRAC, n.d.). You will find how administration, faculty, staff and students (all stakeholders) can work together. METRAC helps take action on campuses from assessment to report writing, they also conduct audits of campuses to inform policy and practice.

For prevention, we suggest bystander programs. One with some success in universities is the Green Dot program, read about it here. It was most recently implemented by Carleton University in Canada. NEVR has been promoting a theory-based program, Community Champion that can be downloaded for free. As well, EVABC has the Be More than a Bystander, to learn more click here.

The United Nations Global Programme for the Implementation of the Doha Declaration created the University Module series on Crime Prevention & Criminal Justice (United Nations Office on Drugs and Crime [UNODC], 2020). NEVR member Yvon Dandurand was part of the United Nations Team that created these modules using the best available evidence and expert knowledge. The modules provide lectures, slides, in-class exercises for university faculty to use free of charge to combat injustices. Please, access the series here.

## Conclusion

Just like RV in the general population more confidential and cross-cultural resources and services need to be available for those who are on post-secondary campuses. As well, survivors need to be assisted using a cultural safety approach (see chapter 6) and be allowed to report anonymously and get assistance. Post-secondary institutions need step by step investigation processes that are clearly articulated and communicated to all stakeholders and available on websites. Post-secondary institutions also need to

develop policies that are flexible to support a survivor's ongoing studies and life on campus, for instance, providing non-punitive study leave, permitting late course withdrawal, offering alternative modes of learning.

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# Chapter 24: Caring for Those Who Care

BALBIR GURM

*Key Messages*

- We need to care for our workers who work on the front lines so that they do not burnout.
- Those who provide support for survivors of relationship violence may be at risk of burnout, compassion fatigue or secondary trauma. They may also suffer from RV themselves. While burnout can occur with any occupation, vicarious or secondary trauma and compassion fatigue are specific to those workers who address trauma and stress in their jobs.
- It appears that mindfulness interventions and art interventions can increase resilience and decrease compassion fatigue.
- A trauma-informed organization will have policies and practices that: do not demean or disempower; do not further re-traumatize the survivor; and have appropriate and accessible services. A trauma-informed organization may also enable staff to better understand their own stress symptoms and promote self-care.
- Organizations can also create cultures that are safe. They can ensure adequate staffing levels and other

resources so staff get breaks, have the resources to provide good care, provide support and recognition, and have policies and practices that promote trust. They may also provide debriefing for staff.

Relationship violence is any form of physical, emotional, spiritual and financial abuse, negative social control or coercion that is suffered by anyone that has a bond or relationship with the offender. In the literature, we find words such as intimate partner violence (IPV), neglect, dating violence, family violence, battery, child neglect, child abuse, bullying, seniors or elder abuse, male violence, stalking, cyberbullying, strangulation, technology-facilitated coercive control, honour killing, female genital mutilation gang violence and workplace violence. In couples, violence can be perpetrated by women and men in opposite-sex relationships (Carney et al., 2007), within same-sex relationships (Rollè et al., 2018) and in relationships where the victim is LGBTQ2SIA+ (lesbian, gay, bisexual, transgender, queer, Two-Spirit, intersex and asexual plus) (The Scottish Trans Alliance, 2010; Rollè et al., 2018). Relationship violence is a result of multiple impacts such as taken for granted inequalities, policies and practices that accept sexism, racism, ageism, xenophobia and homophobia. It can span the entire age spectrum. It may start in-utero and end with death.

Our service providers put their hearts and soul into their work. We need to care for our workers who work on the front lines so that they do not burnout. This chapter is about caring for those who care.

## Caring for the caregiver

It is recognized that survivors of abuse can suffer emotionally, financially, spiritually, mentally and physically all of which can impact their safety and health and the well-being of their families. Survivors can develop medically-unexplained symptoms and suffer from chronic health challenges such as asthma, diabetes, anxiety depression, PTSD, drug misuse, etc. (Cocker & Joss, 2016; Ellsberg et al.,2008; Trevillion et al., 2012). Those who provide support for survivors of relationship violence may also suffer from abuse and burnout (Baird & Jenkins, 2003; Kitchingman et al., 2018; Taylor et al., 2019), compassion fatigue or secondary trauma (Cohen & Collens, 2013; Figley, 2002, Ray et al., 2013). Burnout is experienced by many.

According to the International Classification of Diseases,

> Burn-out is a syndrome conceptualized as resulting from chronic workplace stress that has not been successfully managed. It is characterized by three dimensions: 1) feelings of energy depletion or exhaustion; 2) increased mental distance from one's job, or feelings of negativism or cynicism related to one's job; and 3) reduced professional efficacy (World Health Organization, [WHO], 2018).

and it can occur with any occupation.

While burnout can occur with any occupation, vicarious or secondary trauma or compassion fatigue or residual stress and compassion satisfaction, are specific to those workers who address trauma and stress in their jobs such as frontline mental health workers (Figley, 2002, Ray et al., 2013), so it applies to sexual assault and domestic violence staff (Baird & Jenkins, 2003), thus all staff who work with survivors of relationship violence. Compassion fatigue is stress resulting from exposure to a traumatized individual rather from exposure to the trauma itself (Figley, 2002) and when empathy in the service provider changes to stress or compassion, satisfaction with work improves (Lynch & Lobo, 2012). Compassion

fatigue (CF) can impact standards of patient (client) care, relationships with colleagues, or lead to more serious mental and physical health conditions. Compassion satisfaction is defined as the personal fulfillment of a job well done (Figley, 2002, Baird & Jenkins, 2003). CF is the convergence of secondary traumatic stress (STS) and cumulative burnout (BO) that results in physical and mental exhaustion caused by a depleted ability to cope with one's everyday environment and not being able to handle the stress of caregiving (Cocker & Joss, 2016). In a meta-analysis of 21 studies to measure stress in nurses, Zhang et al. (2018) found the rates of compassion satisfaction (47.55) and compassion fatigue (52.55%) and burnout (51.98%) are about the same and that the presence of higher education is correlated with decreased compassion fatigue.

Signs of CF include:

- Exhaustion
- Reduced ability to feel sympathy and empathy
- Anger and irritability
- Increased use of alcohol and drugs
- Dread of working with certain clients/patients
- Diminished sense of enjoyment of a career
- Disruption to the world view
- Heightened anxiety or irrational fears
- Intrusive imagery of dissociation
- Hypersensitivity or insensitivity to emotional material
- Difficulty separating work life from personal life
- Absenteeism – missing work, taking many sick days
- Impaired ability to make decisions and care for clients/patients
- Problems with intimacy and personal relationships (Mathieu, 2018)
- Restlessness; irritability; oversensitivity; anxiety; excessive use of nicotine, alcohol or illicit drugs; depression; anger and resentment; loss of objectivity; memory issues; and poor concentration, focus, and judgement (Lombardo & Eyre, 2011)

- Headaches, digestive problems (diarrhea, constipation and upset stomach), muscular tension, sleep disturbances (inability to sleep, insomnia, and too much sleep), fatigue and cardiac symptoms like chest pain or pressure, palpitations and tachycardia (Lombardo & Eyre, 2011)
- Poor resilience (Ray et al., 2013)

The organizational factors that may lead to CF are:

- workload intensity, inadequate rest time periods between shifts, task repetitiveness (Baranowsky & Gentry, 1999)
- low control and low job satisfaction (Kelly & Spencer, 2015)
- lack of meaningful recognition, and poor managerial support (Ray et al., 2013)

The Professional Quality of Life Scale (PROQOL) is a tool that was developed to measure compassion fatigue (CF). You can self-administer the PROQOL and assess your level of CF by clicking here (Stamm, 2009). Once you have self-identified as having compassion fatigue you need to take action, but it would be better if, it could be prevented in the first place.

## Effective Programs

It is important that caregivers have resilience as this can not only mitigate the effects of CF but can also prevent CF from developing. It appears that mindfulness interventions and art interventions can increase resilience and decrease CF. Cocker & Joss (2016) conducted a meta-analysis to try to identify effective programs to address CF in nurses. They found the most effective programs were those that focused on increasing resilience. They suggest that employers need to invest in programs such as Accelerated Program for Compassion Relief (ARP) because CF is inevitable in some occupations (Cocker

& Joss, 2016). This program helps workers identify triggers and address CF.

Delaney (2018) piloted an eight-step Mindfulness Self-Compassion based program using a pre-post test design and found it significantly increased resilience and compassion satisfaction, and reduced burnout and secondary stress. This is consistent with other studies that find that mindfulness based interventions are helpful in decreasing stress and healing in a variety of situations including caregiving roles (Fortney et al., 2013; Olson et al., 2015; Shapiro et al., 2005).

Dr. Jon Kabat-Zinn developed an eight-week Mindful-Based Stress Reduction Program (MBSR) in his MBSR Clinic that over the years has shown (multiple studies) (more studies) to improve many cognitive, behavioural and self-regulation skills and to decrease stress and improve healing. Listen to a 3-minute synopsis of MBSR studies. It is an internationally accepted program that may also be used with formal and informal caregivers (also offenders and survivors). Access the program based on Dr. Jon Kabat-Zinn's MBSR Clinic. He is Professor of Medicine emeritus at the University of Massachusetts Medical School (and made his program free upon his retirement).

Philips & Becker (2020) conducted a systematic review of the impact of expressive arts therapy. They found improved outcomes in 13/14 studies reviewed and found that the art format is also relevant – they found greater improvements on well-being from music and art-based interventions than from narrative and storytelling interventions.

In recent years, trauma-informed care (TIC) has become a buzz word in the social sciences and many social workers, nurses and counsellors use this approach. TIC makes an assumption that the likelihood of having suffered trauma is greater than not and that all clients should be approached as if they have suffered a trauma. It is an approach that does not blame but seeks to understand the experience of the person and the role trauma has played in their life and role of the service provider. A TIC organization will have

policies and practices that do not demean or disempower and do not further re-traumatize the survivor and have appropriate and accessible services (The Institute on Trauma and Trauma-Informed Care, n.d.). Schmid et al (2020) found that not only is trauma-informed care the standard for working with youth in the social service sector but it also improves the well-being of the service providers. They also used a biological measure of stress (cortisol levels in hair samples) and found stress levels decreased in the youth and welfare staff who were using TIC. They believe that it is the operational principles of TIC that lead staff to better understand their own stress symptoms and promote self-care so they recommend that all agencies invest resources in using a TIC approach (Schmid et al., 2020).

The Public Health Agency of Canada has a web site for trauma-informed approaches. It can be accessed here. Also to access a report on becoming a trauma-informed organization, click here.

There are many resources to support trauma-informed practice with children, youth and families such as the one developed in BC. It can be accessed here.

Organizations can also create cultures that are safe. They can ensure adequate staffing levels and other resources so staff get breaks and have the resources to provide good care, provide support and recognition, and policies and practices that promote trust. They may also introduce debriefing practices for staff members, including for those doing the debriefing.

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# Chapter 25: Final Thoughts

BALBIR GURM AND JENNIFER MARCHBANK

Relationship violence is a global pandemic that is a violation of human rights with grave consequences for health and well-being. Yet, it does not get the resources and attention that are given to other pandemics (e.g., COVID-19). The majority of resources directed at RV are to support women survivors of abuse in heterosexual relationships, however, this further invisiblizes the experience of other survivors and as such these groups LGBTQ2SIA+; men; Indigenous; immigrant (to name just a few) receive not just less attention but also fewer resources. RV services also primarily focus on IPV and not on other practices such as honour killings and genital mutilation. We believe it is essential to address all relationship violence. How do we tackle this issue? How do we create a violence-free society?

As a global pandemic, RV is very complex and requires citizens, all levels of government, academics, non-profit, public and private sector agencies to work together. It is a severe social health challenge, a pandemic that requires an intersectional and global response. Although the World Health Organization (WHO), unions and non-profit organizations have called for societal responses, there is no unified response such as that which occurs with other pandemics. Is it because relationship violence is seen as more prevalent in females and vulnerable populations and is seen as an issue for women or those specific populations that are considered not privileged? Is it because those in power (mainly men) lack the will to change the status quo, or is it just ingrained in our society? It is most likely a combination of all these factors.

Since RV can impact anyone, anywhere, we postulate that RV is a result of internalized cultural norms (understandings) of power and privilege and relationships that are perpetuated through complex societal systems. Drawing on the work of Foucault (1977), there is

an interplay between what is considered true or knowledge, and power and privilege. Quite often those with power and privilege decide what is truth and perpetuate that truth. Then, this truth is internalized and reproduced by all of society (including legislation) at which point it becomes an accepted fact.

> …this power is not exercised simply as an obligation or a prohibition on those who 'do not have it'; it invests them, is transmitted by them and through them; it exerts pressure upon them, just as they themselves, in their struggle against it, resist the grip it has on them. This means that these relations go right down into the depths of society, that they are not localized in the relations between the state and its citizens or on the frontier between classes and that they do not merely reproduce, at the level of individuals, bodies, gestures and behaviour, the general form of the law or government; that, although there is continuity, they are indeed articulated on this form through a whole series of complex mechanisms (Foucault, 1977, p. 27).

Relationship violence is entangled in power and privilege that is embedded in every aspect of society. If there is a relationship between power and knowledge, then how can we address this issue? Many who have experienced racism and witnessed RV and tried to address it over decades believe it will not be eliminated for centuries to come (Gurm, 2018). This belief stems from the fact that RV is woven into every fabric of our society, and therefore, a global will and global action on changing society from one of power and privilege to equal power will be required. What is needed is for everyone to value each other's knowledge and come to understand each other, what Gadamer (2004) called a "fusion of horizons" (p. 304). From a Gadamerian hermeneutic perspective, a horizon is an understanding a person is trying to have, to see better, to look beyond at the context within a larger society. We need to understand our own historical consciousness (and unconscious bias) and that of the other (Gadamer, 1989, p. 304). We need to try to constantly understand and see the prejudices that are in our society.

If there is a societal will, and we do this for generations, we can work toward eliminating relationship violence from our structures, beliefs and our language.

Since this solution is very long term, for the short term, we need to use the socio-environmental model of health through intersectionality theory and cultural safety (see chapter 6) to address primary, secondary and tertiary prevention.

We brought together a common understanding of relationship violence across the lifespan and resources/links on one site. There are hundreds of thousands of publications and multimedia resources that are available through the internet in journals, books, organizations and government literature, so not all material could be included. We believe that we need to work with our technology experts to comb the sites and analyze the findings. There is good work being done in Canada to address RV, and we need to continue and do more. A few examples are:

Promoting Relationships and Eliminating Violence Network Canada's collaboration site for bullying at Queens University. It is an example of an organization that has members from diverse academic fields and organizations. It has excellent information. This information needs a communication path for all organizations involved in the RV sector.

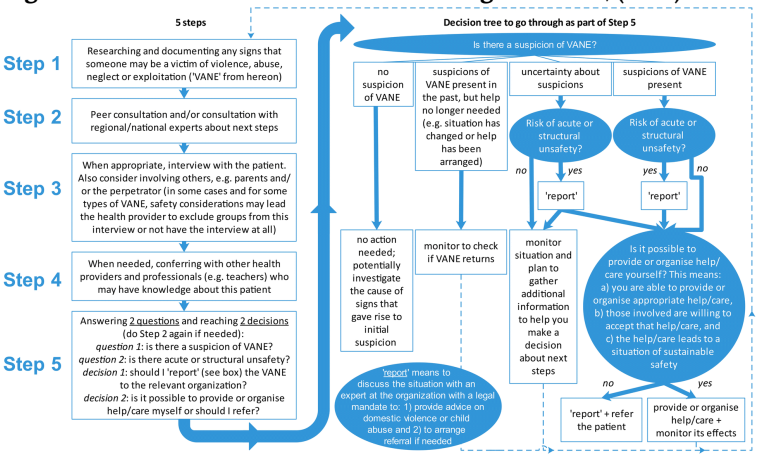
National Collaboration Centre for Indigenous Health is funded by the Public Health Agency of Canada. It is located at the University of Northern British Columbia. It brings together a multi-disciplinary team and Indigenous community to create resources to improve health outcomes. This is a good example of working across disciplines with communities.

Shift– is a centre to prevent domestic violence at the University of Calgary. It has a multi-disciplinary team that researches to create prevention initiatives; an excellent example of working across disciplines

The Canadian Domestic Homicide Prevention Initiative brings together the provinces to look at homicides. It is also an excellent resource and example of provinces working together.

Viergever et al. (2018) suggest that healthcare can take the lead and identify, support and refer individuals. They suggest that healthcare professionals answer two questions about the situation. "1) Is there a suspicion of VANE (V=violence, A=abuse, N=neglect, E=exploitation) and 2) is there acute or structural unsafety" (p. 2)? Not only should healthcare professionals ask these two questions, but all service providers should, and all should follow the decision tree below. If you answer no, there is no further action needed. If you answer yes to acute or structural unsafety, you need to report it to someone who can help or you need to gather further evidence and gather support yourself that the persons involved are willing to accept. See figure 25.1 for the steps.

**Figure 25.1 Decision tree for RV from Viergever et al., (2018).**




In the above figure, VANE is used where we have consistently used the term RV. These are the five steps that should be used by all service providers. They are based on the Netherlands but are applicable to our Canadian context and, like the Netherlands, we have mandatory reporting for children and for adults if there is imminent danger.

Crooks et al. (2020) agree that we need to collaborate. The various centres for relationship violence need to collaborate among themselves and ensure there is membership from multiple disciplines. Not only do we need to collaborate across disciplines,

but we also need to collaborate with service providers, survivors and offenders. We need committees, like NEVR, but with resources and supports because it is difficult to get consistent attendance from service providers. Quite often, they are too busy providing services and can not fit one more thing into their busy day. As well, centres need to be linked to provincial, territorial and federal networks to ensure the development of effective, and resourced, policies.

We need to use technology to create a plan that analyzes the different resources and helps us identify best practices. Technology companies and experts can be strong allies and help create these programs to assist agencies and committees on the ground. This will help all stakeholders to be virtually connected with provinces, territories and countries and globally to address relationship violence. We need primary prevention programs for high risk pregnant moms and their families. As well, we need screening to identify and refer clients, and campaigns/media to promote healthy relationships and anti-violence programs until we have a violence-free society.

Looking back at the last decade we (society in general) have made progress in creating awareness about relationship violence, more specifically gender-based violence and its impacts on society. We have seen increased collaboration between diverse stakeholders and much more diversity among allies. There is a great deal more that needs to be done and we believe together we can create a society where everyone is respected and there is inclusion of diverse ideas and perspectives to create legislation, policies and multi-disciplinary interventions. This will lead to a violence-free and just society where human rights are respected.

We ask all of you to join us in these efforts. Together, we can make a difference.

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# Book Launch

The book was launched on Zoom, July 22, 2020. All thirteen individuals involved in the book were interviewed. The launch was hosted by one of the co-editors Sobhana Jaya-Madhavan who is also one of the co-editors. To listen to the authors, reviewers, editors and the person who wrote the forward, click below.

https://media.kpu.ca/media/zoom_Making+sense+of+a+global+pandemic+launch/0_zffbec9h

# PROJECT TEAM

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# Balbir Gurm


Balbir Gurm, RN, BSN, MA, EdD. is a seasoned nurse educator at KPU, a consultant on cultural safety (diversity & inclusion) and community leader. Dr. Gurm co-led change across KPU's four campuses (now five campuses) as the university representative on the Carnegie Foundation for the Advancement of Teaching's Leadership Cluster Program to create scholarly communities. From this initiative she co-founded Transformative Dialogues: Teaching and Learning Journal and is its editor-in-chief. It is a cross-disciplinary journal that publishes student and faculty submissions on learning environments in order for all academic disciplines to share and learn from each other.

She has developed many projects with organizations to address health inequities and social justice issues such as gender inequality and racism. This includes providing workshops for/with the Canada Pension Plan and Review Tribunal, BC Parole Board, City of Burnaby and the Association of Multicultural Societies of BC.

She has organized, facilitated and presented at conferences across disciplines (Union of BC Municipalities Annual Convention, Canadian Nursing Association Conference, International Society for the Scholarship of Teaching and Learning and International Nursing Conference) and been a keynote speaker both internationally (Iberian Congress on Higher Education Change: Tensions and Possibilities (Ensino Superior em Mudança: Tensões e Possibilidades Congresso Ibérico) Braga, Portugal) and locally (BC Police Chiefs annual meeting) ). Dr. Gurm has written articles both for academic and community audiences. She is a known leader in the Surrey and South Asian community due to her frequent appearances on television and radio, rallies and community gatherings where she brings forward issues of social justice.

She is driven by her passion to create a just society by influencing others to change systemic oppressive practices to more culturally

safe ones and her strong belief that academics are in privileged positions and they need to use their positions to improve communities. Because of this ingrained philosophy, she has served and helped create policy and strategic plans for many organizations including: president (Moving Forward Family Services, VIRSA, Indo-Canadian Women's Organization) vice-president (Canada-India Education Society) director (Canadian Cancer Society) and member of advisory committees (Government of BC- Health Goals Advisory Committee, City of Surrey- Diversity Committee & Surrey Coalition Against Domestic Abuse and Surrey Board of Trade- Social Policy Committee). As chair of the Canadian Punjabi Legacy project she traveled the province and conducted focus groups to understand how the Panjabis in BC wanted their history represented for she believes those who are the subjects or focus of actions need to have an equal voice. For this project she helped secure a large grant to create materials that highlight the diverse history of British Columbia in hopes that understandings will decrease racism.

As founding member and facilitator for the Network to Eliminate Violence (NEVR) she continues to work with frontline service providers to create resources and facilitate workshops to create a violence free society. She advocates for system change to governments and works with media to bring academic knowledge to the community.

As an educator and community leader she has received many honours including the: Award of Excellence in Nursing Education, NISODS Teaching Excellence Award, Canadian Cancer Society Volunteer Leadership, Shakti Education Award, Times of Canada Award for Education and Soroptimist Ruby Awards for lifetime commitment to improving the lives of women.

Dr. Gurm has a strong work and volunteer ethic that she contributes to her upbringing. She has lived most of her life in the Vancouver area. She currently lives in Surrey with her husband and three adult children. In her personal time she finds time to hike, jog and participate in yoga.

# Glaucia Salgado

Glaucia Salgado is a Master of Arts Candidate at Simon Fraser University, Vancouver, Canada. She holds an undergraduate degree in Physical Education from the Adventist University of Sao Paulo, Brazil, in 2004 and successfully defended a thesis about older adults, physical exercises and self-concept. After receiving her bachelor's degree in Brazil, Glaucia Salgado went to Simon Fraser University to obtain a post-baccalaureate diploma in Gerontology. She has worked with older adults as a physical education instructor between 2004-2019.

Glaucia has also worked as a research assistant at the Canadian Longitudinal Study on Aging (2015) and at the Older Adults Digital Storytelling project (2016-2019) at Simon Fraser University Faculty of Education. Since 2016 she has worked with visible minority older adults on wellness projects at Neighbourhood Houses. She is currently working on a digital open book about violence among minority groups. Glaucia has received six awards for academic excellence and is currently finishing her thesis on the role of Neighbourhood Houses on the wellness of immigrants from visible minority older adults.

# Jennifer Marchbank

Dr. Jennifer Marchbank (BA (Hons), MA, PhD, FHEA) is a Professor of Gender, Sexuality & Women's Studies at Simon Fraser University where she teaches on interpersonal and gendered violence and resistance, masculinity, feminist theory amongst other topics. Her academic background is in history and politics and she is a Fellow of the Higher Education Association (UK). She is an interdisciplinary scholar who works closely with the community on issues of social justice including LGBTQ2SIA+ youth and elders; LGBTQ2SIA+ refugees and immigrants; refugee settlement; childcare and 'mail order' brides. She is a community activist and co-founded and co-facilitates the award winning activist group Youth for A Change. She is the recipient of the SFU Excellence in Teaching Award, 2019 and of the Shakti Award of Academic Excellence, 2020 and the Surrey Pride Community Service Award, 2017. She is the author of *Women, Power and Politics* (2000), co-author of *Introduction to Gender: Social Science Perspectives* (2014), and co-editor of *States of Conflict: Gender, Violence and Resistance* (2000) and *Basically Queer: An intergenerational guide to LGBTQ2SIA+ lives* (2017). She is also author of 38 other publications including book chapters, peer-reviewed journal articles, and has written reports for DIVERSEcity, Immigrant Services Society of BC, The Children's Society (UK) and Clackmannan District Women & Girls' Resource Project (UK). She is the former Co-Chair of the Feminist and Women's Studies Association of UK and Ireland.

# Sobhana Jaya-Madhavan

**Sobhana Jaya-Madhavan, MSW**

Born in Malaysia and raised in India, Sobhana has an undergraduate degree in Philosophy and a postgraduate degree in Social Work. Sobhana completed her doctoral coursework in Child and Youth Care from the University of Victoria (UVic) and also taught the undergraduate Child Welfare Specialization Course at UVic. Sobhana worked with the Government of British Columbia serving in various front line and senior management positions for two decades. Sobhana worked with federal and provincial governments to address complex social issues, including poverty, child abuse and domestic violence. In 2015, Sobhana was appointed as the first Executive Director of the Provincial Office of Domestic Violence. In 2017, Sobhana joined Simon Fraser University (SFU) as

Associate Vice President, External Relations. Sobhana engages with all levels of government and diverse organizations and communities to strengthen relationships and partnerships. At SFU, Sobhana was the institutional lead for Women Deliver 2019, represents SFU on the United Way cabinet and helps advance reconciliation, equity, diversity and inclusion. In 2019, Sobhana was recognized by the global Women Economic Forum (WEF) with a Woman of the Decade Award. Sobhana is passionate about the pursuit of peace in all spheres of life.

# Daljit Gill-Badesha

Daljit Gill-Badesha, EdD Candidate in the Faculty of Education (University of British Columbia) is a seasoned advocate and experienced leader in the non-profit and government sectors, providing leadership locally and provincially. Her expertise spans across different age groups and issue areas with focus policy initiatives, strategic frameworks, and multi-lingual translation tools that have helped to scale programs and policy across the Province and beyond. These cross-cutting and systemic strategies have often been the first of a kind for organizations. Her passion for multi-organization collaboration has led a pursuit of doctoral education in this area.

She has designed innovative and strategic frameworks leading to game-changing advances. She is a well-rounded expert in brain development in children and youth development, with clinical counselling programs supporting newcomers, reducing violence and addressing trauma.

# Julie Czeck

Julie holds a Bachelor of Arts in Criminal Justice from the University of the Fraser Valley (UFV), and a Master of Arts in Dispute Resolution (Public Administration) from the University of Victoria (UVIC). She immigrated as a child from Romania, and is strongly connected to her culture and family.

Over the last decade she has worked for the Abbotsford Restorative Justice and Advocacy Association, Global Affairs Canada, the Provincial Office of Domestic Violence, and most recently, as the Director of Strategic Initiatives in the Ministry of Children and Family Development.

Her varied work experience includes managing complex social justice portfolios and building strategic alliances with diverse cross-government and community organizations (including local governments, police, federal and provincial government partners, businesses, oversight bodies, academic institutions, Indigenous leaders and the private sector) to implement provincial initiatives and strategies.

Julie's knowledge of youth issues, stakeholder relations, domestic violence, child welfare, restorative justice, global development and applied research continue to drive her passion for social change.

In her personal life, Julie enjoys spending time with her husband and two year old daughter, Geneva, home decor, hiking, and reading a good book by the ocean.

# Gary Thandi

**Gary Thandi BSW, MSW**

Gary has 20 years' experience, having worked as a probation officer, counsellor, hospital social worker, program manager, researcher, clinical supervisor and Executive Director. He is currently the Executive Director and Clinical Supervisor of a non-profit collaborative called Moving Forward Family Services (MFFS), which provides low barrier counselling and support services to residents of Metro Vancouver and the Fraser Valley.

MFFS is a mentorship agency – providing counselling and social work practice opportunities to interns and new graduates beginning private practice. The agency employs supervisors, who are able to provide supervision and support to a team of 125 part-time counsellors, social workers and interns on post-secondary

practicums, who then provide thousands of hours of support per month to vulnerable communities. The agency's unique model allows it to offer timely, affordable (including free) counselling and support without being bound by restrictions based on gender, age, geography or presenting issues. It also allows MFFS to complement existing services (as opposed to competing with them for the same pools of traditional funding) thus reducing pressures on these services.

Gary is a widowed father of two boys and lives in Surrey, British Columbia.

# Sheila Dawn Early

**Sheila Dawn Early, RN, BScN**

Sheila has served in health care for decades, spanning roles in Clinical, Administrative and Education. She graduated with Distinction from the University of Saskatchewan in 1969. Currently she is owner of SDE Consulting Forensic Nursing Education Services having recently retired as Coordinator Forensic Health Sciences Program British Columbia Institute of Technology ( BCIT) Some of her accomplishments include:

- Co founder (1993) First Sexual Assault Nurse Examiner Program in B.C at Surrey Memorial Hospital . First nurse to perform a medical forensic examination in sexual assault in BC.
- Developed (2005-6) first Canadian Certificate in Forensic Health Sciences (FHS) at BCIT. Co developer first Canadian Graduate Certificate in FHS at BCIT (2018)
- Co founder (2007) Canadian Forensic Nurses Association. Currently, President Elect.
- The first non USA member to be elected President of the International Association of Forensic Nurses ( 2014)
- National Emergency Nurses Association Director ( 2000)
- Author and co author of book chapters and articles on Emergency Nursing and Forensic Nursing
- Presenter provincially, nationally, internationally
- NEVR member
- Recipient of Awards in Nursing, Emergency Nursing, Forensic Nursing and Education

- Attendee at WHO Violence Prevention Alliance Milestone meetings (Geneva 2015 and Ottawa 2017)

# Jim Cessford

Jim Cessford is the former Chief of Police with the Delta Police Department. He previously served in the Edmonton Police Service (where he started the Domestic Violence Unit ) and has been a police officer for 47 years. He was formerly the President of the BC Association of Chiefs of Police and the B.C. Municipal Chiefs of Police. He was a former member of the homicide and major crimes investigation team with the Edmonton Police Service. He has a wealth of experience in homicide investigations and Police Victim Services.

He is a member of the Network to Eliminate Violence in Relationships (NEVR), Delta Opposes Violence Everywhere (DOVE) and he is the Vice Chair of the B.C. Bereavement Helpline.

Jim is a member of Order of Merit for Policing (MOM). In 2009, he was named Delta's Citizen of the Year in recognition of his professional achievements and community service contributions.

With his busy schedule, Jim still finds time to coach and mentor for many sporting teams and for high school students who are graduating and moving on to the next phase of their lives.

# Andrea Alexon

Andrea Alexon is a survivor of intimate partner violence and the author of *Broken Teapots* (FREDA, 1997), a collection of poems that chronicles her experience with domestic violence and the court system, and *Broken Teapots, Second Edition* (Amazon-Kindle, 2020), a retrospective and contemporary examination of the long-term impact of domestic violence. She has given presentations, poetry readings, and lectures at universities and regional, national, and international conferences, and her poetry has been published in anti-violence periodicals. Alexon has a graphic art and fine art education and background, and recently returned to producing art as part of her agenda of creating awareness about relationship violence. *Broken Teapots*, the art show, is a visual/verbal presentation in which Alexon explores those everyday objects within our domestic spaces that we consider ordinary, comforting, familiar, and innocent – and she juxtaposes these objects with her voice – the voice of an abused woman – via her disturbing poetry. Thus, she illustrates the disjunct between our perceptions of family and home as synonymous with love, nurturing, and even beauty, and the reality that for abused women and their children, home is not a safe place. She holds a MA from University of British Columbia in English literature studies and works as an English teacher and writer. Her novel, *The Before*, will be published on Amazon-Kindle in 2020.

# Sonia Andhi Bilkhu

Sonia Andhi Bilkhu is the founder of Shakti Society and Shakti Awards. She is a social worker, mental health counsellor, researcher, community organizer, broadcaster and a politically engaged resident of the unceded territory of the Coast Salish peoples, now called Surrey. She holds a Bachelor's Degree in Public Administration, Bachelors and Masters Degrees in Social Work and Fellowships of Human SecurityX, Caux, Switzerland and of the Global Social Impact House, University of Pennsylvania.

Sonia's paid work is with Project Parent Fraser South, a program of Family Services of Greater Vancouver, private practice and social work with the Fraser Health Authority. In her volunteer roles, Sonia currently sits on the Finance Committee of the North American Association of Social Work Boards, Virginia; the Social Equity and Diversity Committee, City of Surrey; the BC College of Social Workers and is the Media Chair of NEVR – Network to Eliminate Violence in Relationships. She is also a delegate for her union to the New Westminster District Labour Council.

She is the winner of the Surrey Board of Trade Women in Business – Social Trailblazer Award, was the Finalist of Surrey Board of Trade Women in Business – Top Professional Category, is currently a finalist in the YWCA Women of Distinction Awards and has been a 3 Time Nominee of the BC Multiculturalism and Anti-Racism Award.

# CJ Rowe

For nearly twenty years, Dr. CJ Rowe (they/them/their) has worked with organizations, lobbying, developing educational campaigns and research projects to critically engage with such issues as marriage equality, transgender justice, LGBTQ2S youth leadership, violence prevention and trauma-informed services. CJ is a genderqueer butch who currently lives and works on the unceded territory of the Musqueam, Squamish, Tsleil-Waututh and Kwikwetlem First Nations. CJ holds a PhD in Education from UBC, an MA in Legal Studies from Carleton University and a BA in Sociology from Acadia University. Presently, CJ is the Director of Simon Fraser University's Sexual Violence Support & Prevention Office where they work with a team to support individuals impacted by sexual violence and sexual misconduct, develop sexual violence intervention and prevention educational campaigns, learning opportunities and initiatives and works closely with the University to implement and operationalize policy. CJ is also the Co-Director of Courage to Act, a two-year national initiative to address and prevent gender-based violence on post-secondary campuses. For more information visit www.couragetoact.ca.

# Amarjit S. Sahota

Born in India and raised in England from an early age, Amarjit has a Bachelors Degree in Social Work.

He emigrated to Canada in 1991 and worked for the Government of British Columbia in various positions from front line to senior leadership. In his most recent role, he was the Director of Practice for the Ministry of Children and Family Development (MCFD) until January of this year when he was appointed as the Vice President of Sophie's Place Child and Youth Advocacy Centre.

Throughout his career with the Provincial Government, he has played a key role in service transformation initiatives; the development and delivery of related training and leading a team of Consultants to support Ministry staff in responding to the most complex child protection cases. In recent years, he was instrumental in shaping the Ministry's approach to intimate partner violence (IPV) both at a local and provincial level. This included the establishment of the Surrey Domestic Violence Unit and the creation of the only child protection program in BC focused on engaging male perpetrators of IPV. He was also the Ministry lead in the creation of Sophie's Place which was one of the first Child and Youth Advocacy Centres established in BC and was short listed as a finalist for the Premier's Award in 2017.

Amarjit is a strong proponent of culturally responsive services and collaborative practice across sectors.