



Migrant Clinicians Network

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*There are people
who want to help.*

ADDRESSING DOMESTIC VIOLENCE
IN A CLINICAL SETTING

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In a Clinical Setting

Portions of this manual are excerpted from:

*Family Violence Resource Manual:
A primary health care provider's guide*

By Annie Lewis O'Connor, MSN, MPH

Migrant Health Provider: Orientation Manual

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*Monograph: Domestic Violence in the
Farmworker Population*

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Training Manual on Domestic Violence
Migrant Clinicians Network

*Passport to Independence:
Assisting Battered Immigrant Women*
Texas Council on Family Violence

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domestic violence.**

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This manual is dedicated to the teams of clinicians that serve the migrant community, and to the many migrant workers who experience domestic violence in their lives. The Migrant Clinicians Network (MCN) wishes to thank the U.S. Department of Justice, Office for Victims of Crime for their support and guidance throughout this project. Thanks to Annie Lewis O'Connor, whose outstanding body of information on health care providers and domestic violence served as an excellent foundation for the manual; and to Jennifer Corrigan at the Texas Council on Family Violence and Leticia Camacho, whose expertise on legal issues pertaining to immigrant and migrant women was invaluable. Our sincerest thanks to the MCN Board of Directors for lending their expertise throughout the project. Finally, MCN would like to thank Anne Harpe at Micro•Pix Graphics for her outstanding work in the layout and design of this manual.

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Introduction

More than twenty years have passed since beginning the first large-scale effort to confront the issue of domestic violence. During this time, in an effort to demonstrate that no woman is immune to violence, advocates have attempted to minimize the differences among women experiencing violence. We are now beginning to understand that, although all women can be subject to intimate partner violence, their life situations vary considerably. In order to address domestic violence in diverse populations effectively, it is important to recognize the impact of distinctive social, cultural, and economic circumstances.

Migrant and immigrant women face unique challenges that heighten barriers to prevention and intervention services, and which magnify the effects of intimate partner violence. Due to the distinctive life style of migrant farmworkers, the stress of travel, low income and language barriers are potential factors for abuse. Lacking access to health services, fearing deportation, and living in isolated environments, farmworker women often are forced to endure the violence rather than finding a means of escape.

This manual is designed for **health care providers** working with migrant and immigrant women, and addresses issues unique to this population. It also stresses the importance of screening and documentation for *all* patients.

- Chapter One* provides a general overview of the migrant population as well as a section that addresses the responsibilities of migrant health providers.
- Chapter Two* provides a general overview of important characteristics of family and intimate partner domestic violence, with an emphasis on migrant and immigrant battered women.
- Chapter Three* provides a practical screening guideline for use in a health care setting.
- Chapter Four* addresses the development and implementation of safety plans.
- Chapter Five* deals with the important topic of documenting evidence when you see a case of abuse.
- Chapter Six* outlines legal remedies for domestic violence, particularly in an immigrant community.

THE FARMWORKER POPULATION¹

The following chapter provides a general overview of migrant farmworkers including a history of farmworkers in the United States, socioeconomic conditions, patterns of migration, and the responsibilities of migrant health providers.

History of Migrant Farm Labor and the Migrant Health System

America has long benefited from inexpensive and plentifully available produce on market shelves, yet few Americans realize how the produce they consume reaches them. The reality is that American agriculture is highly dependent on the hand labor of migrant and seasonal farmworkers.

Massive availability of migrant labor began in earnest during the Great Depression when many people lost their small, independently run family farms and had few other options for economic survival. At the same time, those far away from the farm were increasingly able to buy fresh produce as industrial advances made distance and temperature less of a barrier to transportation.

The history of migrant labor has long been dominated by images of forlorn sharecroppers and hopeful Mexican men allowed entrance to the United States through the Bracero Act (during the labor shortages of World War II). As President Truman said in 1951, “We depend on misfortune to build up our force of migratory workers and when the supply is low because there is not enough misfortune at home, we rely on misfortune abroad to replenish the supply.” Truman’s observation is still true as farm laborers continue to function as the bottom rung of the American economic ladder. Those working in farm labor tend to be either newly arrived immigrants with few connections or individuals with limited opportunities or skills who rely on farm labor for survival.

The United States has had a spotty history of providing a consistent level of health care, housing, and sanitation for migrant farmworkers. For most Americans, the plight of farmworkers was kept hidden until Edward R. Murrow produced a documentary entitled *Harvest of Shame*, which broadcast a graphic picture of the miserable living and working condition the farmworkers endured into millions of warm, comfortable living rooms on Thanksgiving Day, 1961.

The public outcry created by *Harvest of Shame* motivated U.S. Congress to enact the Migrant Health Act, which went into effect on September 25, 1962. Among other provisions, this act called for the development of health care clinics for farmworkers and their families.

The Migrant/Seasonal Farmworker

Today, migrant farmworkers still suffer mortality and morbidity rates greater than the vast majority of the American population, due in part to the combination of poverty, limited access to health care, and hazardous working conditions. Farmwork is listed as the second most dangerous occupation in the United States behind mining.

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A migrant farmworker is defined as an individual who is required to be absent from a permanent place of residence for the purpose of seeking employment in agricultural work.

A migrant farmworker is defined as an individual who is required to be absent from a permanent place of residence for the purpose of seeking employment in agricultural work. Seasonal farmworkers are individuals who are employed in farm work but do not move from their permanent residence to seek farm work; they may also have other sources of employment.

Most farmworkers earn annual incomes below the poverty level and half earn below \$7,500 per year. Rarely do they have access to occupational rehabilitation or disability benefits; but many are eligible for Medicaid, food stamps, and WIC if they live in one area long enough to secure these benefits. However, with the new changes in welfare laws, many farmworkers will lose their eligibility for these programs. Many who have paid into Social Security are unable to prove their claim for payments. While undocumented immigrants are not eligible to receive most forms of public assistance, they do have protected rights with regard to wages, health, safety standards and workers compensation.

Migrant workers are predominantly Latino, although many are African-American, Haitian, Anglo and Asian. While the farmworker population is racially and culturally diverse, the majority of migrant and seasonal farmworkers are U.S. citizens, or legal permanent or temporary residents of the United States. The U.S. Department of Labor permits foreign workers to enter the country to perform farm work when there are not enough available or qualified workers to satisfy the demand for labor. This temporary foreign certification program is called the H-2A program.

The U.S. Public Health Service estimates a total of 3.5 million migrant and seasonal farmworkers living in the United States. This includes families with children, single men, and some older men and women. Migrant farmworkers travel far from their permanent homes, many times without their families. Almost half have less than a ninth grade education, and many speak little or no English. Migrant farmworkers usually have their permanent residence, or homebase, in the South, primarily in California, Texas, Florida, Mexico and Puerto Rico. From there they move across the nation as each new crop is ready for harvest.

Housing is often problematic for farmworkers, in part because the laws that regulate housing in some states are precise (for example, limiting the number of persons per square foot of living space). Workers many times live in a van or car until they can find a house or trailer to rent where there are no occupancy limits.

Migrant farmworkers continue to be one of the most impoverished and underserved populations in the United States. However, a number of committed and creative health care providers have dedicated themselves to caring for this population. Scattered across the country and in Puerto Rico, hundreds of clinicians with decades of training and experience are working to help farmworkers become equal partners in health care.

The map on the following page describes general patterns of migration for work in the United States. It is important to understand these patterns in working with migrant patients.

Patterns of Migration:

1) Restricted Circuit:

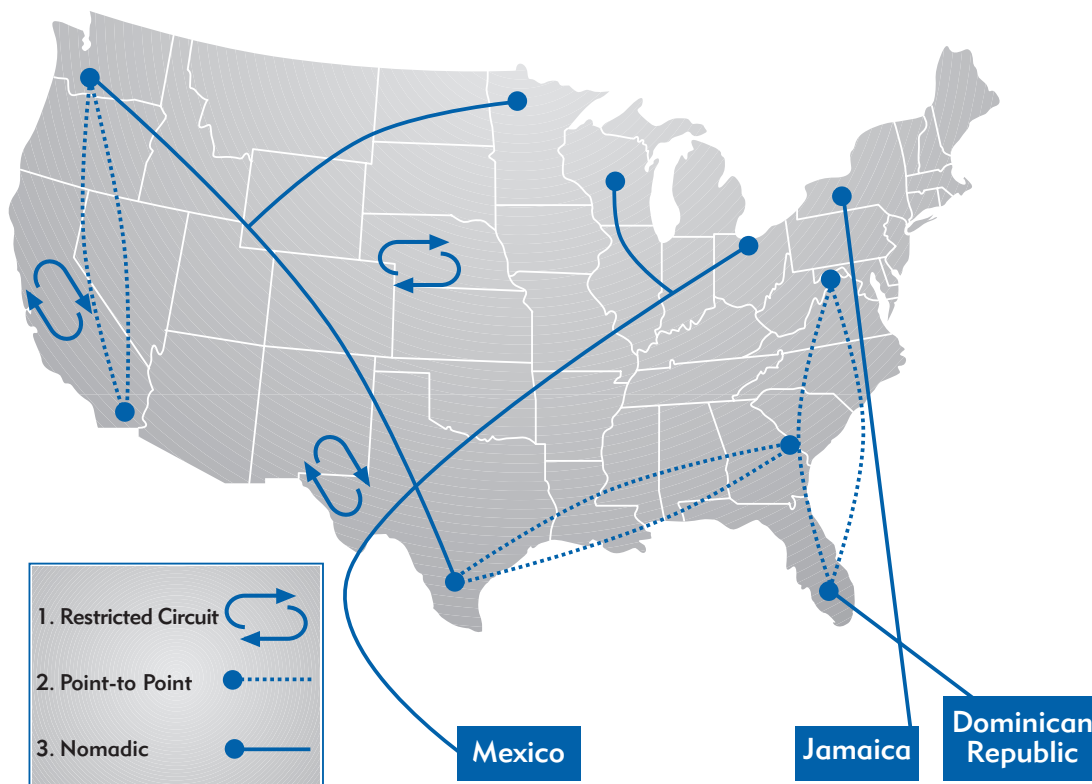
Many people travel throughout a season within a relatively small geographic area. Examples of this include: the Central Valley in California; the El Paso/Las Cruces/Ciudad Juarez area; and, Nebraska along Interstate 80.

2) Point-to-Point:

Another group of people will travel to the same place or series of places along a route during the course of a season. These people tend to live in Florida, Texas, Mexico, Puerto Rico, or California and travel for part of the year working in agriculture. The routes marked by the dotted lines on the map show just a few of many regular routes that people travel during the season.

3) Nomadic:

Still others travel away from home for a period of years working from farm to farm and crop to crop, usually relying on word-of-mouth about potential jobs. Some of these people may eventually "settle out" in an area to which they have migrated while others eventually return to their homebase.



Migrant farmworkers continue to be one of the most impoverished and underserved populations in the United States.

Unique Responsibilities of Migrant Health Care Providers²

The primary responsibility of health care providers is to furnish the highest quality health care to their patients. Within the boundaries imposed by lack of available time, facilities, and financial resources, providers have certain non-medical responsibilities that directly affect the quality of care.

Involving the Family

The cultural groups predominant in migrant farm work place a premium on the family unit. This means that the majority of treatment in migrant health centers, especially the treatment of children, will involve the family, whether or not the provider is aware of this involvement. Family decisions, including compliance with therapy, are not solely made on the basis of an individual's needs, but on the needs and the resources of the entire family group. The best way to assure compliance with a patient's treatment is to make sure that the entire family is involved in the process. With a child's treatment, it is crucial to involve both parents.

Utilizing the Whole Health Care Team

Primary care is best delivered by a team of people who cover all aspects of delivering care to migrant families. No single individual can or should try to do it all. What is unique about this team approach is the level of responsibility that staff other than a physician or dentist have for making things work. In contrast, many traditional medical settings expect a physician to organize and direct everyone's efforts.

These functions include transportation, outreach, social services, translation, and transfer of patient medical records. In a health center serving migrant patients, with its built-in diversity of cultural populations, staff providing ancillary services may become the most important sources of vital information about a patient's medical or dental needs. They assure that health education needed by patients gets done, and that the providers' recommendations for treatment are followed correctly. These team members are important resources for identifying and solving patient problems caused by misunderstandings or cultural differences.

A brief medical or dental examination rarely provides time for successful and in-depth patient education. Health education is more effective when there is sufficient time to assure that an exchange of knowledge occurs. When education is needed another team member who has both the time and the cultural background to educate the patient should receive the referral.

Avoiding Stereotyping

Providers in a migrant health center have a social responsibility to avoid stereotyping. There is a strong human tendency to seek general patterns. This trait is part of the mapping process of all cultures, and can be useful when it reduces the amount of diversity that has to be accommodated within a culture. Between cultural, ethnic or racial groups, however, stereotyping is counterproductive.

Many counterproductive stereotypes about particular ethnic or cultural groups include migrants. Stereotyping leads to treating everyone the same, and routinely treating them badly. In migrant health, as in all health care settings, it is necessary to treat everyone as an individual.

Primary care is best delivered by a team of people who cover all aspects of delivering care to migrant families.

Cultural Sensitivity

Respect means acknowledging the right of another person to act or behave as they are used to without judging them. Farmworkers from other countries are learning the ways and customs of the United States. Clinicians also need to learn something about the cultures of farmworkers. Your initial contact with a new culture may present things that you don't really understand. Take time to learn - ask questions, watch people interact, and take notice of situations you haven't seen before. As you allow people to be comfortable and be themselves around you, you will pick up information that will help you make respectful suggestions and decisions in the future.

Although a smile may be universal, eye contact and handshakes are not. Being friendly and observing the subtleties of communication, both verbal and non-verbal, is usually a good start. The best idea is to be as professional as possible, telling farmworkers who you are and what your purpose is. You will learn the proper greeting terms, body gestures, etc. as you proceed.

Confidentiality

Confidentiality is an absolute requirement. This is a legal and ethical issue that must be thought through carefully and be a permanent part of your mindset. Breaches in confidentiality are not usually deliberate, but occur as "slips of the tongue" or lack of care in transferring or storing paperwork. Information about an individual's health status or personal concerns are to be held in confidence unless the person has agreed to your sharing the information for the purpose of referral or consultation. Verbal discussion within an outreach team or among clinic staff about a problem or concern must be conducted discreetly so as not to be overheard or misconstrued by others. Your respect for confidentiality will set the tone both in the field and in the clinic setting and will result in greater trust and openness in sharing concerns.

Advocacy

Advocacy may be seen as bridging the gaps in understanding that cause farmworkers to be underserved or even mistreated by certain groups or individuals. As a migrant health clinician, you are in an ideal position to educate the public and raise the level of tolerance. You can advocate on many levels. Frequently just noticing a grimace or disrespectful remark and taking the opportunity to engage an individual in open discussion about their attitude can open the door to better understanding. You may also advocate in your workplace by offering speakers, videos or discussions for in-service presentations. In the community at large, you may be involved in media coverage or programs for specific groups, e.g. schools, churches, professional organizations. Advocacy is a tough job. Don't expect to know what to say in every situation, but note the specifics to review with a colleague so you will be prepared next time!

Clinicians ... need to learn something about the cultures of farmworkers.

¹ Migrant Clinicians Network, *Migrant Health Provider Manual*. Second Edition, 2000.

² Robert T Trotter, *Orientation to Multicultural Health Care in Migrant Programs, Orientation Manual*, North Carolina Outreach Task Force, 1995.

FAMILY AND INTIMATE VIOLENCE¹

Domestic violence is now identified as a significant health problem for migrant workers. Clinicians and farmworker women describe countless incidents of violence at the hands of their male partners. Because battered migrant and immigrant women face unique legal, social, and economic issues, the National Advisory Council on Migrant Health, the United States Department of Health and Human Services, the Bureau of Primary Health Care and the Office of Migrant Health have prioritized domestic violence as a problem that needs to be addressed.

Domestic violence (also referred to as spousal abuse, battering, partner abuse and wife beating, among other terms) can be defined as intentional violent or controlling behavior by a person who is currently, or was previously, in an intimate relationship with the survivor. Methods of coercion and control include humiliation, intimidation, fear, and often-intentional physical, emotional or sexual injury.

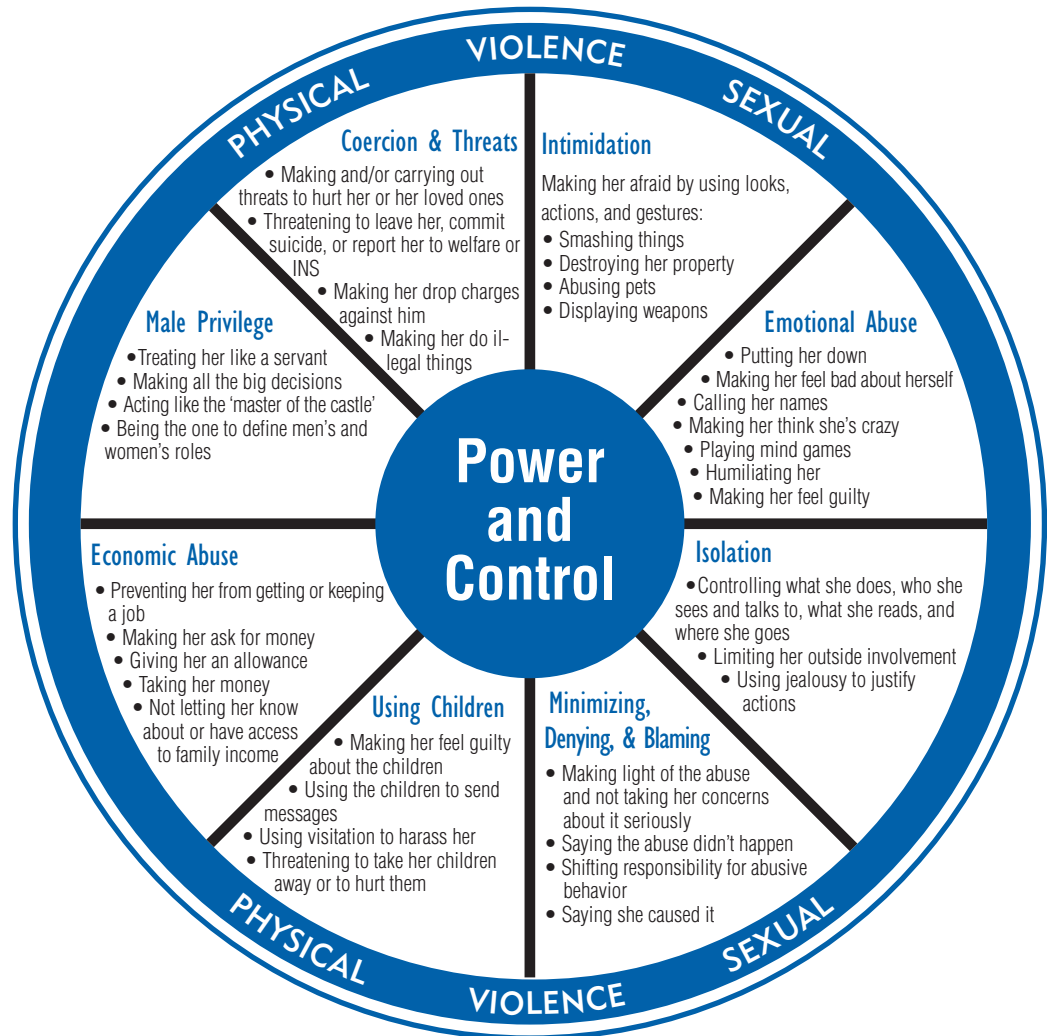
Power and Control

Over 200 battered women in Duluth, Minnesota in the mid-eighties participated in the design of the Power and Control Wheel, which is used all over the world today to depict abusive behaviors many victims experience. Domestic violence tends to occur in a cycle. The Power and Control Wheel, found on the following page, illustrates the cycle that can leave the abused woman feeling trapped and alone.

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Power and Control Wheel

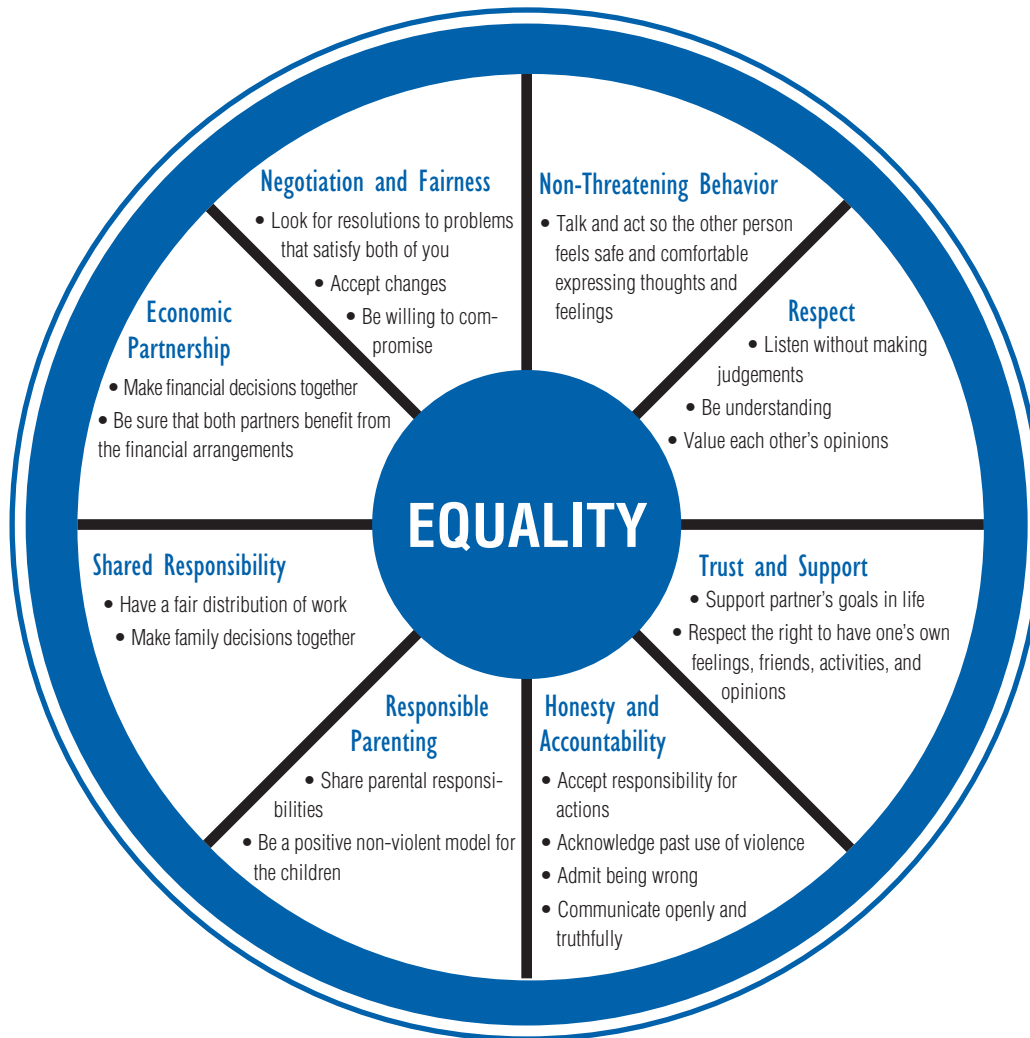
The Power and Control Wheel illustrates the cycle that can leave the abused woman feeling trapped and alone.



Developed by the Domestic Abuse Prevention Project
 206 West Fourth Street
 Duluth, Minnesota 55806
 (218) 722-4134

Physical and sexual violence and threats of violence form a ring around the other abusive behaviors. Violence and threats can serve to keep the entire system of abuse in operation. The Circle of Equality wheel, found on the following page, gives a parallel example of behaviors in a healthy relationship.

Circle of Equality



Developed by the Domestic Abuse Prevention Project
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Domestic violence can result in severe physical and emotional trauma for victims and their children. Being a victim of or a witness to violence has also been linked to increased rates of drug and alcohol abuse, increased rates of suicide and homicide, and an increased incidence of anxiety and depression among victims and their children. In addition to personal costs, there are also profound societal costs. These include increased rates of homelessness, increased use of medical services due to higher rates of medical problems, and financial costs to employers from lost productivity, absenteeism, and job turnover.

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Myths about domestic violence are particularly difficult to eradicate due to the extremely personal nature of the crime.

How Prevalent is Domestic Violence?

Women are more likely to be assaulted, beaten, or killed in their own homes by loved ones than anywhere else by anyone else.² According to the Centers for Disease Control (CDC), a woman is in nine times more danger in her own home than on the streets.³

Estimates of the prevalence of domestic violence vary widely. Rates are difficult to measure both because domestic violence usually occurs in private, and because victims are often reluctant to report it. Victims may be ashamed to discuss the abuse, and they may fear retaliation or escalation of violence by the offender if they report it. Because of these measurement difficulties, estimates of national prevalence vary greatly.

Approximately 20% of 1001 migrant women surveyed (19.9%, N=190) reported experiencing either physical or sexual abuse within a year of being interviewed. The average age of a woman reporting abuse was 31.6 years. Over 80% of the women experiencing abuse were in their childbearing years and 50% of battered women were pregnant at the time of the abuse. Eight hundred and thirty out of the 1001 respondents were Hispanic (91.3%). Haitians made up only 2.9% of the women surveyed although they made up 10.7% of the total battered women. Drug and alcohol abuse was significantly correlated with fear of partner and physical and sexual abuse. Seventy-three percent of abused women reported that their partner used drugs or alcohol. If a woman reported that her partner uses drugs or alcohol she was 55 times more likely to be afraid of him. Furthermore, 91.6% of women who expressed fear of their partners were also battered. Approximately 70% (69.6%) of women reporting abuse lived with their partners.⁴

Dispelling Myths of Violence

In our culture, many myths exist surrounding the issue of domestic violence. One source depicts the harm that myths cause in perpetuating violence.

“Myths serve to explain some phenomenon by diverting attention from real issues. Myths about domestic violence perpetuate bias against women and prohibit the development and dissemination (and acceptance) of accurate information. Eradication of these myths will help focus on the reality of domestic violence.”⁵

Myths about domestic violence are particularly difficult to eradicate due to the extremely personal nature of the crime. Many myths are closely connected with stereotypes of the “typical batterer” and the “typical survivor.” While some populations are at higher risk for domestic violence than others, it is important to keep in mind that anyone can be a batterer just as anyone can be a survivor.

Myths	Facts
<p>Domestic violence does not affect many people.</p>	<p>Domestic violence is a public health crisis of epidemic proportions. 20-30% of women experience domestic violence at some point in their lives, with 2-4 million women physically battered each year.⁶</p>
<p>Domestic violence occurs only in poor and/or minority families.</p>	<p>No one is immune from domestic violence. Studies looking at police reports and court documents show that perpetrators and survivors come from all socioeconomic and ethnic backgrounds. Rates of domestic violence are about the same among White, Black, and Hispanic women.⁷</p>
<p>Only men batter.</p>	<p>While 91% of all spousal violence involves males as perpetrators,⁸ women can batter their male partners, their female partners, or their children.</p>
<p>Once a batterer, always a batterer.</p>	<p>Although the prognosis for change is dim, some men do stop their violent behavior. Men have more success at stopping physical violence than they do at stopping verbal and emotional violence. It is estimated that it will take between three and five years of weekly therapy for a man to make a significant, lasting change in all aspects of his violent behavior.⁹</p>

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Men who abuse family members ... are typically extremely possessive and jealous, seeking to control the behavior of their partner by exerting power over them.

Myths	Facts
<p>Domestic violence does not affect the children. They do not pay attention to such things.</p>	<p>Violence in the home definitely affects children. A very high percentage of men who beat their wives witnessed their own mothers being beaten by their fathers. Violence between spouses serves as an example to children and they might very well learn from it. It is very possible that if your children witness this in their own home, they will grow up to beat their wives or be victims of abuse. Living in a home that frequently erupts in violence, can cause children to have problems at school. Even though your kids don't talk about violence, they know it exists and it affects them profoundly.¹⁰</p>
<p>If he works, brings money home, and he is good with the children, a woman should not demand any more. She should forgive his weaknesses.</p>	<p>We should not forgive violence just because a man is good with the children and because he brings money to the household. Domestic violence should not be allowed to happen for any reason. Wives should be treated kindly like any other member of the family. Nobody would say that it is alright for a woman to remain with a man because he only abuses the children.¹¹</p>
<p>Battered women can/should just leave their abusers.</p>	<p>Many factors keep women in abusive relationships. Women are often at greater risk of homicide or severe physical abuse when they separate from their abusers. A woman may also be dependent on her abuser for housing/economic support of herself and her children, and may have been isolated from her family and friends by her abuser. In addition to these practical considerations, the decision to leave can be further complicated by love for the partner, the hope and belief that the relationship will change, feelings of guilt/shame, and depression.</p>

Characteristics of Abusers

One of the most commonly asked questions about domestic violence is why abused women do not simply leave their abusers. We believe that the more important question to ask is *why men batter*. Domestic violence has traditionally been considered a woman's issue. However, most violence is initiated and perpetrated by men. Thus, any real solutions to the problem must come first from an understanding of why men batter and the common characteristics of batterers.

Understanding the behavior of perpetrators also deepens our understanding of the obstacles faced by women who want to leave an abusive relationship.

Characteristics of Domestic Violence¹²

Domestic violence IS a behavior that is learned through:

- observation
- experience and reinforcement
- family
- communities: schools, peer groups, etc.
- culture

Domestic violence IS NOT caused by:

- illness
- genetics
- alcohol and drugs
- out-of-control behavior
- anger
- stress
- behavior of the victim/survivor
- problems in the relationship

Why Men Batter

Men who abuse family members often feel a sense of entitlement, privilege, or ownership of their partner or children. They are typically extremely possessive and jealous, seeking to control the behavior of their partner by exerting power over them. These men usually have low self-esteem and poor communication skills; many find violence the most natural way of expressing frustration or insecurity.

Power and Control

Most batterers feel that they have very little control over their lives. Often, the only way they know to gain and maintain a sense of control is to exert their power where they can—over their partners and/or their children. Some of the ways that batterers can power within the family include greater physical size/strength, greater economic resources, and emotional manipulation.

Learned Behavior from Family

Many abusers were abused themselves as children, or witnessed abuse within their families as children. As with other behaviors, we learn from our parents how to interact with partners, how to cope with anger, and how to resolve conflict. Particularly for those who lack positive role models for resolving conflict and coping with daily stress and anger, it is common to repeat violent behaviors in future relationships.¹³

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Women don't leave abusive relationships, they escape from them. Escape is something which requires courage, a detailed plan, and resources.

Sense of Entitlement and Male Privilege

In over 90% of the cases of partner abuse, the perpetrator is male. For centuries, it has been acceptable for husbands to discipline their wives and children to “keep them in line.” In the colonial days a woman could be disciplined with a stick no larger than the thumb—hence we have the term “rule of thumb.” Remnants of this patriarchal society still exist in the attitudes of some men, who feel entitled to control their families and resolve disputes with physical violence.

Lack of Social/Legal Consequences

Many men batter their partners because they can get away with it. We live in a society in which family violence is often considered “a private matter.” Police, health care professionals, neighbors, friends, and others often hesitate to get involved or to condemn the violent behavior. Many feel as though a little bit of violence in a relationship is normal. Most do not buy into the idea of zero tolerance of family violence.

Rather than blaming the violence on the perpetrator, we often ask what the victim may have done to trigger the violence. If these men were violent with their co-workers, they would certainly lose their jobs and the respect of their peers. Our failure to impose serious negative consequences on perpetrators of family violence is a form of societal acceptance of this behavior, and enables it to continue.

Living in a Violent Culture

Our patriarchal culture perpetuates a social behavioral model that allows young boys and men to resolve conflicts with physical violence. Violence is often reinforced and glorified as a viable problem solving method on television, in movies, comic books, and in sports (such as football and boxing).

Why Women Stay

Women don't *leave* abusive relationships, they *escape* from them. Escape is something that requires courage, a detailed plan, and resources. Rather than asking women why they don't leave, it is more constructive to look at their *specific obstacles to leaving*. Providers who understand these barriers to leaving will be able to respond better to the needs of patients seeking to eventually lead a life free from violence and fear.

Fear of Retaliation

Many women have realistic fears that the batterer will carry out his threats to kill her, her children, family or friends. Women who leave their abusers are at 75% greater risk of being killed by their abusers than those who stay. Oftentimes, staying allows the victim to monitor the abuser's behavior, which is much more unpredictable when the victim leaves.

Economic, Housing, and Other Practical Constraints

Many survivors are dependent on their abusers for economic support and support of the children. Batterers often pay for medical insurance, rent or mortgage and other living expenses. Financial dependence, especially when a woman has little job training, makes it very difficult to leave a relationship. Without independent resources, she may be unable to find a job, save the first and last month's rent and a security deposit for a new place to live, or pay for child care and cover daily living expenses. In addition, shelters are often full, and friends and family do not always want to get involved by offering a

survivor temporary housing. Migrant and immigrant battered women may find that a shelter is unwilling to open its door for them due to language barriers.

Promises of Change

Most battered women love their partners in spite of their abusive behavior. After an explosive incident, a batterer's loving behavior, apologies, and promises to stop the abuse often give the victim hope that he will change or that she can help him change. This hope may delay and/or complicate her decision to leave the relationship.

Social Isolation

The batterer often isolates his partner from her friends and family, effectively reducing her support network. He may threaten to beat her if she sees friends and family, threaten her friends or family directly, or alienate them. With other support cut off, she may have nowhere to go and no social support system to help her transition out of the relationship.

Feelings of Shame, Failure, and other Emotional Factors

Many victims of domestic abuse feel a sense of failure as wives and mothers for being unable to put an end to the abuse and keep their families together. Women may feel ashamed that they have "allowed" the abuse to occur and thus feel embarrassed about confiding in anyone. The batterers' constant criticism and degrading treatment of their partners lowers women's self-esteem over time, and many women come to believe they deserve the abuse. Other emotional effects of battering include guilt, depression, fatigue, denial, disempowerment, learned helplessness, and physical and emotional exhaustion. These emotional factors combined pose significant obstacles to women deciding to seek a better life for themselves and their families.

Unsupportive System

Many social institutions take a victim-blaming approach to domestic violence and are unsympathetic to the plight of battered women. Religious leaders who are educated about domestic violence will inform survivors that there is no covenant in marriage where there is domestic abuse. The majority of clergy, however, receive no education about domestic abuse; they may be unaware of the serious danger women face and thus try to keep couples together through religious or couples counseling. Employers are often unsympathetic about lost work time due to the psychological and physical consequences of domestic violence. They may consider the violence a personal issue, and hesitate to get involved. Health care providers often do not screen for domestic violence, fail to recognize warning signs of abuse, and are not equipped to respond to clear cases of abuse. The police and the judicial system may fail to take complaints of domestic abuse seriously, treating family violence as a conflict rather than a crime and failing to hold offenders accountable for violent acts committed against their families. Women who have previously sought help and not been taken seriously or have been blamed may hesitate to confide in someone again; the feeling that no one empathizes with them often leads to increased feelings of helplessness, vulnerability, and being trapped in the cycle of abuse.

Family Pressure and Cultural Beliefs

Many families consider marriage a sacred vow that should never be broken, even when there is violence in the relationship. Families may pressure a woman to stay in the

Many families consider marriage a sacred vow that should never be broken, even when there is violence in the relationship.

Most battered immigrant women do not know that domestic violence is a crime. In their native countries, domestic violence may be legal, and in many countries people are fearful of the police.

relationship “for the sake of the children,” or to ride out the “difficulties” (“Every marriage/relationship has its ups and downs”). Cultural beliefs that the man should be dominant in a relationship, and that some violence in relationships is normal, may contribute to the family’s desire to keep the couple together. In addition, because of language barriers, cultural barriers, and immigration status, some immigrant families may feel a powerful desire to fit in, stick together, and not make waves. All of these attitudes create additional pressures for women to stay in an abusive relationship

Personal History

Many battered women were abused as children or witnessed partner abuse in their families. This early experience of domestic violence may make abuse in a relationship seem acceptable or normal.

Fear of Deportation

Many battered immigrant women are not familiar with the laws in the United States and fear they may be deported if they report the abuse to the law.

Abuse of Non-English Speaking Immigrant Women

Identification of domestic violence in non-English speaking immigrant women presents a challenge that requires cultural sensitivity and awareness from the provider. While all battered women face many of the same obstacles, battered immigrant women face obstacles that are further complicated by cultural differences, varying language capabilities, and immigration status. Below are examples of types of abuse that are specific to an immigrant woman:¹⁴

- Calling her racist names, calling her a prostitute or a “mail order bride,” telling her that, “as a matter of law” in the United States, she must have sex with him whenever he wants;
- Threatening to report her to the Immigration and Naturalization Service (INS) and get her deported, threatening to report her children to the INS, telling her he will have her deported and he will keep the children, threatening not to file or to withdraw immigration papers to legalize her immigration status, failing to file papers to legalize her immigration status;
- Forcing her to sign papers in English that she does not understand (court papers, Internal Revenue Service forms, immigrations papers), convincing her that if she seeks help from the courts or the police, the U.S. legal system will give him custody of the children (men are given legal control over the children in many countries), telling her that the police will arrest her for being undocumented if she calls them for help, convincing her that his violent actions against her are not criminal unless they occur in public;
- Forcing her to work “illegally” when she does not have a work permit, threatening to report her to the INS if she works “under the table,” not letting her learn English, get job training, or go to school;
- Taking money that she was planning to send back home to support her children or other family members, threatening to have someone harm her family members in her home country, threatening to remove her children from the United States;

- Hiding or destroying important documents and papers (e.g. her passport, her children’s passports, ID cards, health care cards), destroying the only property she has from her home country, destroying photographs of her family members, threatening to do or say something that will shame her family or cause them to “lose face”;
- Isolating her from friends and family, not allowing her to learn English, being the only person through whom she can communicate in English, not allowing her to meet with social workers and other support persons, cutting off her subscriptions or destroying newspapers and magazines in her language, not allowing her to meet with people who speak her language or who are from her community, culture, or country.

Most battered immigrant women do not know that domestic violence is a crime. In their native countries, domestic violence may be legal, and in many countries people are fearful of the police. Immigrant women often lack access to information about laws that can help them. Their knowledge about what the legal system can do for them usually comes from their abuser. Battered immigrant women may not know that legal, medical and social service systems can help them even if they continue to live with the abuser.

Both documented and undocumented immigrants commonly fear deportation, making threats related to deportation very powerful. Women who are legal immigrants often believe that if the abusive spouse helped them to get a green card, he can take it away. This is untrue. They may be concerned that seeking help could interfere with support of their families by causing the abuser to be jailed, lose a job, or be deported. Undocumented battered immigrant women additionally may fear deportation if they involve legal or support systems such as the police, the courts, hospitals, or health centers. They also may be afraid of losing custody of their children through deportation or other legal action.

Battered immigrant women often work two jobs and do not have time to learn English even if their abusers allow them to do so. They are isolated from friends, do not have access to social service providers who speak their language, and may believe that they cannot receive help from police or courts. In their home country, it may be that the person with the most money and the strongest political connections wins—usually the man.

Religious beliefs and cultural expectations about the role of men in society also may pose large barriers to a battered immigrant woman’s ability to flee a violent home. Leaving home may be counter to her belief system about her role as wife, mother and homemaker. In many cultures, women are responsible for keeping the family unit intact. She may be blamed for family disintegration, and shunned by friends and family members for talking about the abuse.

In addition, as families begin to assimilate into American culture, traditional gender roles may change, contributing to ongoing violence within a relationship. For example, immigrant women may have increased social and economic opportunities in American culture, sometimes surpassing a partner’s mastery of English, accessing better jobs than the partner, and taking over the bread-winning role in the family.

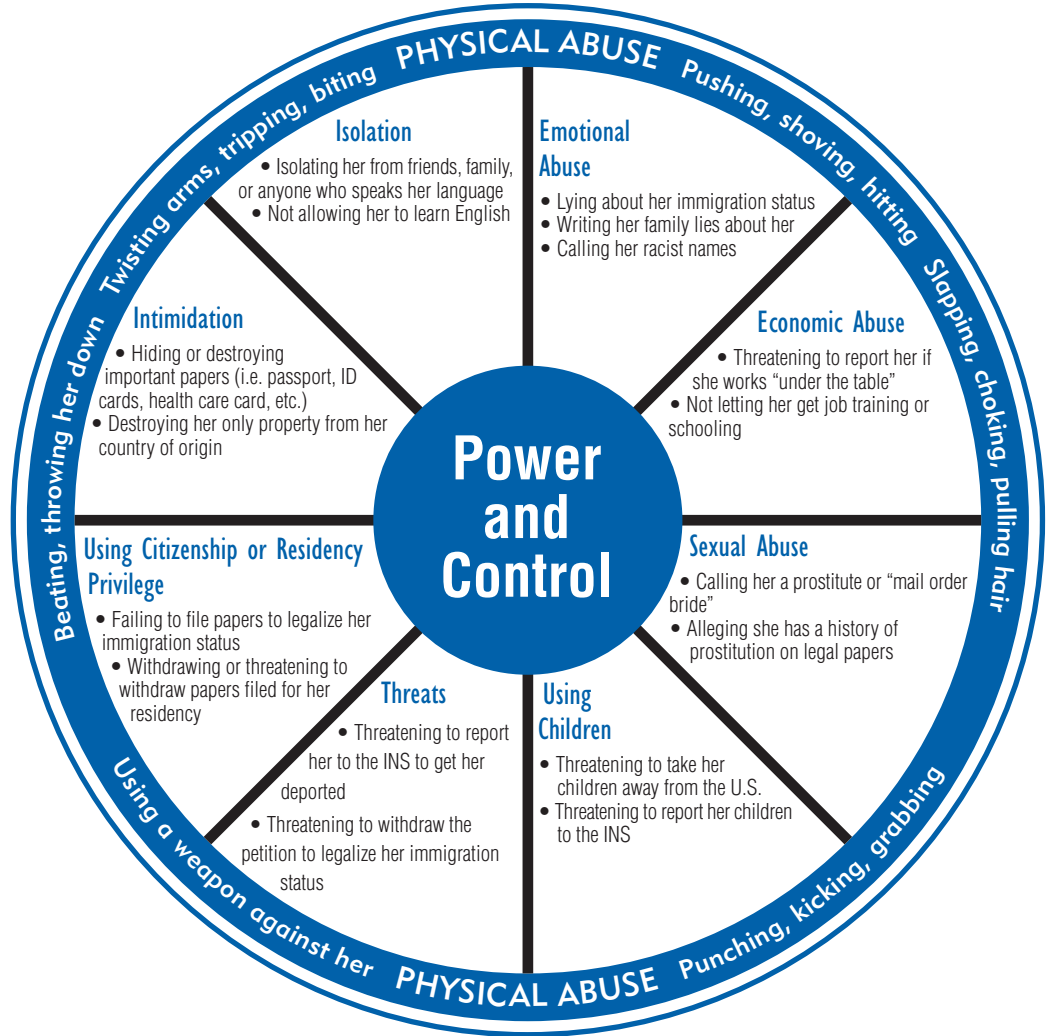
When helping battered immigrant women, it is important that health care providers resist myths about the acceptance of domestic violence in other cultures. Providers should *not* assume that abuse is acceptable in certain cultures because women are more docile or passive than in the United States. In addition, providers should not assume that some cultures have more domestic violence than others.

...as families begin to assimilate into American culture, traditional gender roles may change, contributing to ongoing violence within a relationship.

Providers should not assume that abuse is acceptable in certain cultures because women are more docile or passive than in the United States.

The Immigrant Power and Control Wheel demonstrates the struggle for power and control within immigrant relationships, such as the fear of deportation or destroying personal property from a woman’s homeland. In any unique population the abuse may be very different than what is seen in the mainstream.

Immigrant Power and Control Wheel



Adapted by the Family Violence Prevention Fund from the Power and Control Wheel developed by the Domestic Abuse Intervention Project
 206 West Fourth Street
 Duluth, Minnesota 55806
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- ¹ This material was excerpted and adapted from the publication entitled “Family Violence Resource Manual – A Primary Health Care Provider’s Guide” produced by Neighborhood Health Plan, written and compiled by Annie Lewis O’Conner, MSN, MPH with assistance from Kathleen Bennett, MD, Trudy Brown-Ripin, MPH, Katy Kehoe and Lisa Taich-Daly.
- ² R.J. Gelles, and M.A. Strauss, *Intimate Violence: the Causes and Consequences of Abuse in the American Family*. New York: Simon and Schuster, 1988.
- ³ Chambliss, Bay and Jones, “Domestic Violence: An Educational Imperative?” *Am J Obstet Gynecol*, 1994.
- ⁴ N. Van Hightower, J. Gorton, and C.L DeMoss, “Predictive Models of Domestic Violence and Fear of Intimate Partners Among Migrant and Seasonal Farm Worker Women”, *Journal of Family Violence*, June 2000.
- ⁵ *Domestic Violence: A Guide for Health Care Providers*. The Colorado Domestic Violence Coalition and the Colorado Department of Public Health, Colorado, 1992.
- ⁶ R.J. Gelles and M.A. Strauss, *Intimate Violence: the Causes and Consequences of Abuse in the American Family*. New York: Simon and Schuster, 1988.
- ⁷ U.S. Department of Justice, Office of Justice Programs. “Violence between Intimates”, Bureau of Justice Statistics, Selected Findings. November 1994, NCJ-149259.
- ⁸ P. Klaus and M. Rand, “Family Violence.” Bureau of Justice Statistics of Special Reports, U.S. Department of Justice, Washington, D.C.: Government Printing Office, April 19, 1984.
- ⁹ *Domestic Violence: A Guide for Health Care Providers*. The Colorado Domestic Violence Coalition and the Colorado Department of Public Health, Colorado, 1992.
- ¹⁰ Migrant Clinicians Network, *Training Manual on Domestic Violence*, 1998
- ¹¹ Ibid.
- ¹² Carole Warshaw, MD and A.L. Ganley, “Improving the Health Care System’s Response to Domestic Violence: A Resource Manual for Health Care Providers,” produced by the Family Violence Prevention Fund in collaboration with the Pennsylvania Coalition Against Domestic Violence.
- ¹³ It should be noted that there are many men who grow up in abusive homes, but never become abusive themselves.
- ¹⁴ This material was adapted from the publication entitled, “Working with Battered Immigrant Women: A Handbook to Make Services Accessible,” produced by the Family Violence Prevention Fund, written by Leti Vopp and edited by Leni Marin.

SCREENING FOR DOMESTIC VIOLENCE¹

“Doctors—and other health care professionals—need to know the signs of abuse, what questions to ask, and how to screen women from all cultures and ethnic groups who may have suffered domestic abuse. They need to know that if they suspect child abuse, they also need to screen the parents... In a managed care environment, a woman doesn’t generally have one doctor—a Marcus Welby or Ben Casey taking care of her throughout her life. So it’s particularly important that every doctor, nurse, physician’s assistant, and midwife is learning about domestic abuse right along with anatomy and physiology.”²

It is important for clinics to establish a policy on domestic violence screening. Examples of policies include: screening all female patients and/or screening all female patients fourteen and older.³ Once a policy is in place it gives clinicians a justification for asking direct questions to their patient about domestic violence.

Part of the clinic screening policy can include a policy requiring the training of clinicians on domestic violence issues as well as cultural competency. This can improve the quality of care clinicians offer their clients. They will gain a better understanding of the migrant community after learning their traditions.

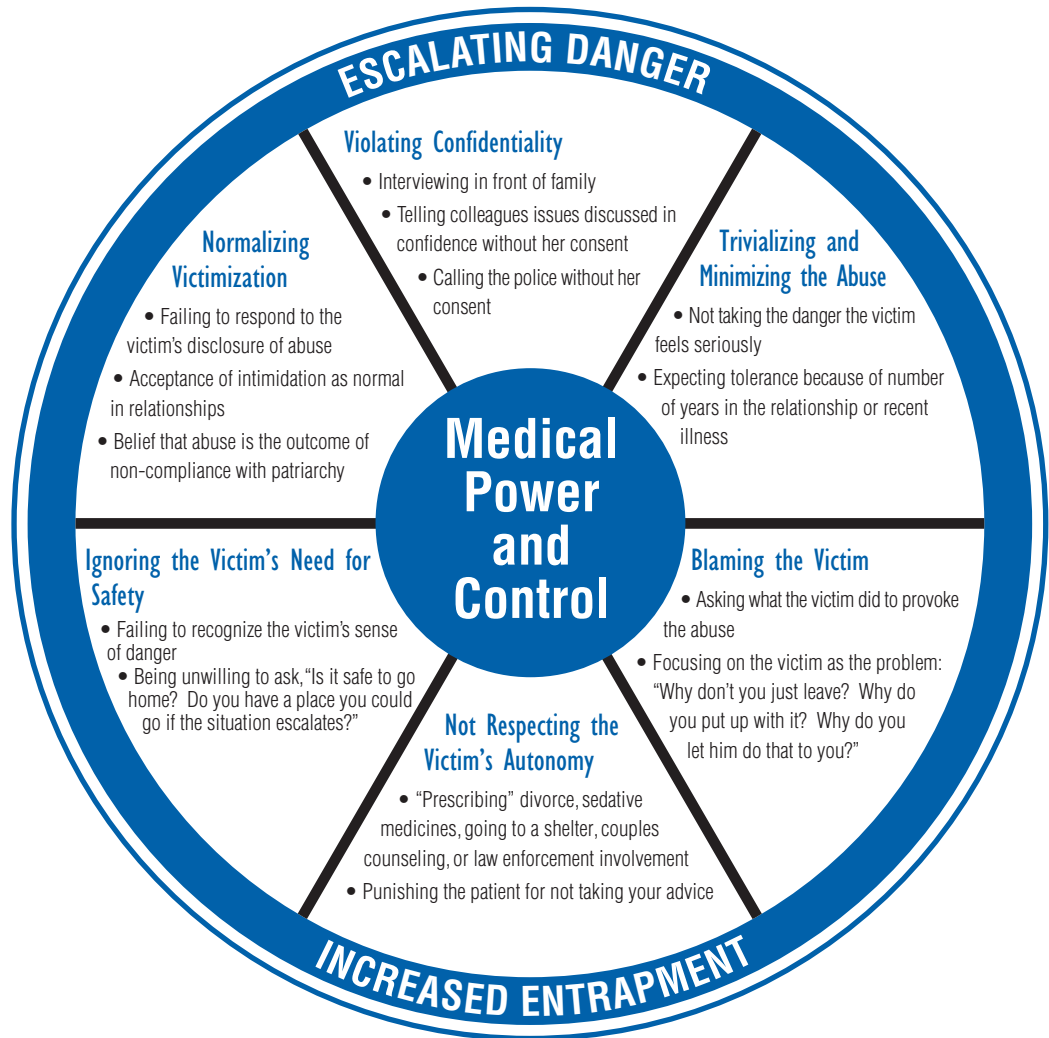
Surveys indicate that the majority of survivors disclose an abusive relationship to their health care provider before *anyone* else, including family, friends and clergy. Women of all races, ages, income levels, educational backgrounds, and sexual preferences are vulnerable to domestic violence. Screening for domestic violence only among particular “types” of women will miss crucial identification opportunities.

Comprehensive screening of all women entering the health care setting is a response that acknowledges the possible consequences of violence on health and safety. Medical visits are one of the most important opportunities for identification of domestic violence. Battered women tend to present themselves frequently for medical visits related to trauma, as well as for other types of medical visits. In fact, 20% of battered women have 11 or more physician visits because of trauma alone, and at least 30% of women seen in emergency rooms are abused.⁴

It is important for clinics to establish a policy on domestic violence screening.

Medical Power and Control Wheel

Many [providers'] concerns can be addressed through training sessions on how to identify and respond to cases of domestic violence.



Adapted by Pathways of Courage

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from the Power and Control Wheel developed by the Domestic Abuse Prevention Project

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The above wheel demonstrates the power and control model in reference to the medical profession. All patients can be affected by the wheel, but for immigrant battered women the language barrier can accentuate all the phases of the wheel.

Barriers to Screening

Many providers are hesitant to ask patients whether they are experiencing violence in their homes or from their partners. It is common for providers to feel unsure how to raise the issue, feel ill-equipped to respond if the patient is being abused, feel powerless to help, or feel concerned that they will be "opening a can of worms" for the patient and for themselves. Many of these concerns can be addressed through training sessions on how to identify and respond to cases of domestic violence. Feelings of powerlessness

are probably misguided. Providers have had great success in counseling patients about smoking cessation, weight loss, and other behavior changes. As for “opening a can of worms,” providers do not have to be trained to successfully intervene in domestic violence cases. If you noticed cardiac symptoms in a patient, you would not hesitate to ask the patient about it and refer that patient to a cardiac specialist.

► **Do you feel that your patient visits are too rushed as it is?**

► **Are you worried that you won't be able to find time to screen your patients for domestic violence?**

Most clinicians feel that screening for domestic violence is a good idea, but don't believe they have time to fit these screenings into already rushed patient visits. However, even though they often face pressures to keep patient visits brief, many providers still find time to ask about seat belt use, smoking, and drug and alcohol use. If you take the time to ask about other safety issues, then why not briefly ask your patients about partner abuse?

In addition, if we look at how we currently take a health history, there are clearly some questions that provide us with little information to help our patients. For example, why are we conducting cranial nerve assessments and reflexes on a 22-year-old female who has no chief complaint? Why do we ask about bowel habits and not safety in relationships? Does it make sense to include these types of questions, while neglecting to ask patients about the leading cause of injury to women? We suggest sitting down with your clinical teams, examining the changes that can and should be implemented, and making the time (on an individual and institutional level) to screen for domestic violence.

Many health care workers do not easily make changes in their practice styles. We were trained to conduct patient visits a certain way and even though that way may not be applicable or make as much sense as when we were trained, we continue to cling to established ways of doing things. Ask yourself, does the review of systems and the associated physical exam that you routinely conduct make sense *for this particular patient*? Challenge yourself to become a better provider. What changes are you willing to make to find the time to screen for domestic violence?

Fears: Have you considered what your fears might be in working with victims of violence? Are you afraid of the feelings it might stir up in you? Are you afraid that your questions about violence will offend your patients?

Frustrations: How can you do this work and feel less frustrated? How do you currently deal with your frustrations around caring for challenging patients? How do you currently deal with patients who have difficulty making changes?

Failures: Are you concerned about your skill or training to deal with issues of domestic violence? Are you uncomfortable discussing domestic violence? Do you feel powerless to help your patients escape from violence?

It is common for providers to feel unsure how to raise the issue, to feel ill-equipped to respond if the patient is being abused, to feel powerless to help, or to feel concerned they will be “opening a can of worms” for the patient and for themselves.

Challenge yourself to become a better provider. What changes are you willing to make to find the time to screen for domestic violence?

Women of all races, ages, income levels, educational backgrounds, and sexual orientations are vulnerable to domestic violence.

Who Should be Screened for Domestic Violence?

Ideally, everyone. Screening for domestic violence should occur in the context of routine primary care, as well as in care for injuries (including emergency room care), obstetric and gynecological care, and during pediatric visits. Clinicians must be able to recognize the “red flag” medical symptoms that appear in each of these settings and also must incorporate domestic violence screening into routine care for all women.

Women of all races, ages, income levels, educational backgrounds, and sexual orientations are vulnerable to domestic violence. Looking for a certain “type” of woman will miss crucial identification opportunities. The physical signs of abuse go beyond obvious trauma to vague complaints of chronic symptoms.

Screening during physicals, episodic care, and routine follow-up (such as dispensing birth control or monitoring medication levels) communicates to patients that you are willing to assist women who are being victimized by someone close to them.

Warning Signs of Abuse

The medical model of domestic violence looks at the physical pain and injury resulting from battering as an acute flare-up of an underlying, continuous experience of physical and psychological degradation. While it may be easier to detect the abuse when a woman is still showing physical signs of abuse, there are also underlying signs of which providers should be aware. Always, always, always...review the medical record! Many of these symptoms are patterns that are only visible over time. For some of these symptoms, it is not clear why they are common among abused women, but providers should be particularly sensitive to patients who make repeated office visits with vague symptoms, with particular attention to patients with the circumstances and conditions listed below:

General Warning Signs for Women

- Vague complaints
- Acute pain when no external injuries are visible
- Irritable bowel syndrome
- UTIs
- Chronic pain
- Fatigue

Life Circumstances (high-risk populations)

- Women whose partners are jealous, possessive and controlling (“*Do you find Your Partner is...*”)
- Women who are single, separated or divorced (“*What led to your separation/divorce?*”)
- Women who have obtained a restraining order (“*Have you ever obtained a restraining order?*”)
- Women who have been homeless (“*What led to your homelessness?*”)
- Women who do not have custody of their children (“*How many times have you been pregnant? How many living children do you have? Are your children living with you?*”)

Medical Visits

- Women who frequently miss appointments, clock watchers
- Women with multiple somatic complaints with no etiology
- Women whose accompanying partner is overly protective, agitated, or aggressive

Injuries

- Contusions, abrasions, burns, lacerations, gun and puncture wounds
- Injuries to face, neck, or throat
- Injuries to chest, breasts, abdomen or genitals
- Rib fractures, missing teeth, broken jaw, perforated ear drum, hematuria
- Injuries sustained during pregnancy, commonly to breasts or abdomen
- Multiple injuries in different stages of healing
- Injury inconsistent with patient's explanation
- Evidence of sexual assault
- Multiple sites of injuries
- Delay between injury and treatment

Effective Screening Strategies for Domestic Violence

Research has shown that screening is most effective when:

- patients are asked about abuse directly by their providers, rather than asked indirectly via a written survey;
- when a provider asks multiple questions about abuse during an interview;
- when a provider uses a structured list of questions to ask each patient about abuse; and
- when a provider asks in a non-judgmental and genuinely concerned manner.

In one study of pregnant women, only 8% of patients said on a written survey they were abused, but when asked by their prenatal provider, the same group of patients revealed that 29% had experienced domestic abuse.⁵

Thus:

- Providers should routinely ask *all women patients* about abuse.
- Patients should be asked about abuse at various times by all types of providers.

Confiding in a provider about abuse often depends upon a patient's intuition and interpersonal relationship with that provider. Some patients may be more comfortable discussing abuse with a nurse rather than a physician, and some may feel more comfortable confiding in their physician only. Therefore, the more chances that the patient is given to disclose the abuse, the better.

The Interview

- Give a reason for your questions (e.g. “Because domestic violence is so common, I ask all my woman patients about it.”)
- Assure the patient that the interview is confidential and will not be shared or reported without her permission.
- If you *do* notice that a patient exhibits warning signs, be extra thorough in your questioning and physical examination.
- Use active listening; sit down and focus on your patient. (Do not be writing in the medical record.)
- Project confidence, concern, and respect.
- Avoid stigmatizing terms like “battering,” “abuse,” or “violence.”
- Use gender neutral language (use “partner,” not “husband or boyfriend”).
- Ask about physical, emotional, and sexual abuse.

Strategies for Conducting Interviews with Non-English Speaking Women

- Using an interpreter can be very effective in communicating with the patient in her native language. The important issue is to have someone available to the client that can build a positive relationship through communication that will be effective.
- *Never* use a family member as an interpreter. A patient is less likely to disclose abuse to a provider when a family member is present (particularly if the interpreter is the abuser). In addition, a patient who discloses abuse in the presence of a translating family member may be put in even more danger if that family member decides to tell the abuser about the discussion.
- All interpreters and clinic staff should have training about domestic violence.
- Education of the staff and interpreters on the patient’s culture can benefit the relationship built between the clinic and the patient. Cultural awareness provides knowledge of the patient’s philosophy on health and domestic violence.
- Stress confidentiality to the interpreter around disclosures that are made.
- Build a list of organizations and resources that provide services appropriate to your patients’ cultures.

Safety Issues in Screening

- Reassure your patient that you will not share with her batterer any information she discloses.
- If you sense that your patient does not feel safe or comfortable disclosing any information during the session, encourage her to contact you or another health care provider at the center whenever she is ready.
- If batterers are present at the center, and there are concerns about staff or patient safety, call security or the response team to discuss plans for their assistance and availability. Never become defensive or argumentative with batterers; it’s always best to “smother them with kindness.”

- Never attempt to mediate a domestic violence case. You and your patient may be seriously injured.
- Remember: while some batterers will maintain the appearance of being very nice and personable, others will not care who you are and may become violent if they feel provoked or threatened.
- Be proactive in protecting your own safety. (*“I ask all of my survivors not to share my name with their batterer because I too need to feel safe.”*)

Suggested Screening Questions To Ask

Below is a list of questions and statements that you may want to utilize with your patients. We have included a long list here so that you may choose the questions you feel most comfortable asking and begin to incorporate them into your standard practice. Asking three or four standard screening questions during a patient session is both realistic and appropriate. We have included some general questions that could be asked routinely of all patients as well as some more specific questions to use in cases where you suspect abuse.

When asking these questions, do not assume your patient’s partner is a man. Start out asking these questions in a gender-neutral way (“your partner”). Once your patient has referred to her partner as her boyfriend, husband, or girlfriend, follow her lead and refer to her partner the same way throughout the rest of the interview.

General Screening Questions:

- I see many women in my practice who are experiencing abuse from someone they love. Is this happening to you?
- I ask all of my women patients if they are in a relationship, if their partner ever makes them feel afraid or scared.
- Do you know where you could get help if a partner was hurting you or someone you know?
- Periodically I check in with all my patients. Do you feel safe at home? Has your partner ever hit or hurt you? Does your partner ever force you to do sexual things you don’t want to?

When a Patient Discloses Abuse

Before asking your patients whether they are experiencing domestic violence, it is crucial to make sure that you are ready to respond if a patient discloses abuse. On an institutional level, it is important that a health center has adequate structures in place to provide referrals and immediate advocacy and support for the patient. On an individual level, providers should have referrals on hand, literature to give to patients about domestic violence, and should be sensitive and supportive. When a patient discloses abuse to you, you should take the following steps

1. Assess the current situation and level of risk.
2. Clearly document her history, symptoms, and any physical findings in her medical chart.

3. If your patient is thinking of pressing charges against her batterer now or in the future, collect forensic evidence, and photograph injuries with a Polaroid camera.
4. Reassure her that you are concerned for her safety and leave the door open for future discussions.
5. Encourage her to consider all of her resources and options and to consider what she would do to assure her safety if she made the decision to leave.
6. Develop a safety plan together. The safety plan will vary, depending on whether she plans to stay or to leave the relationship.
7. Educate your patient about domestic violence. Verbally explain the cycle of violence and then tie in her feelings and symptoms as they relate to being abused; offer her printed education materials to take with her.
8. Though she may not be immediately ready to accept or utilize other resources, let her know what kind of assistance is available; give her important phone numbers, such as hotlines and other emergency numbers.
9. Make a follow-up plan with your patient that includes booking her next appointment (if it is to be with you), answering questions, and determining how to safely contact her, etc.

What to Expect

A Woman Who Is Battered

- Requires validation of her feelings and fears
- Feels responsible for the abuse and may need to be reassured that the batterer is responsible for his behavior
- May be afraid for her life. Trust her instincts, she knows the batterer best. Specifically, she may have immediate safety concerns, and fears of intensified violence should the abusive partner find out that she has disclosed the abuse
- Fears losing her children
- Has concerns that seeking mental health care will jeopardize custody battles
- May not be aware of her legal options and rights *or* may have specific concerns about legal issues (obtaining restraining orders, violations of restraining orders, child custody, etc.)
- May have concerns about economic status (jobs, housing, paying the bills, etc.)
- Is a survivor, but needs assistance in identifying her strengths, options, and resources. Providers do not need to be equipped to respond to all these concerns, but should provide support and referrals. Providers should also be aware that, like any behavioral change, the patient may not be ready to take action immediately. Don't give up!

How to Respond

Make validating statements

- No one deserves to be beaten.
- I believe you.
- It is unlikely that this violence will stop.
- I'm afraid for your safety and the safety of your children.
- I'm here for you when you are ready.
- There is help for you when you are ready.
- I'm so sorry this is happening to you.

Tell her:

"I want you to know that I think you are a strong, courageous woman. I wish you well and I want you to live without violence or fear."

Exploring Her Options

As a provider, your role is to provide support to your patient, to help her explore her options, and to make referrals. *Do not, under any circumstances, make decisions for her or tell her what you think is best for her.*

To help the abused woman consider her options and to help her create a larger support network, ask her several of the questions below:

- Do you know anyone who has been in a similar situation? Would you feel comfortable talking to them about your situation?
- Who in your support network can you go to for help?
- Who listens to you? Who do you trust? Who can you confide in?
- Who do you think would support your actions and feelings in this difficult situation?
- When you are in distress and need someone to talk to, whom can you call on the telephone at any hour?
- What relatives and friends are available to you now, both in this area and outside of this area?
- Who might be able and willing to provide you with temporary safe housing, lend you some money, help you with transportation, food, childcare, etc.?
- Is there anyone you can ask to go to the police or the courts with you?

Refrain from the Following

AVOID...

Asking questions that will illicit a “Yes” or “No” response

Making assumptions of any kind

Violating the victim’s privacy and confidentiality

Discussions with a victim in front of children, partners, others

Asking a victim “Why” –

“Why didn’t you tell someone?” “Why didn’t you leave?” “Why do you put up with this?”

Asking what she did to ‘cause’ this ...

Telling her what is best for her

Using the word “should” –

“You *should* have left, “ “You *should* have called the police,” etc ... (*Instead, say: “Here are some of your options, you need to do what you think is best for you and your children”*)

Making promises –

“I know s/he will get arrested,” “A restraining order will keep you safe,” “If you leave, you’ll be safer/happier.”

Implementing or making referrals for services without the consent of the victim

¹ This material was excerpted and adapted from the publication entitled “Family Violence Resource Manual – A Primary Health Care Provider’s Guide” produced by Neighborhood Health Plan, written and compiled by Annie Lewis O’Conner, MSN, MPH with assistance from Kathleen Bennett, MD, Trudy Brown-Ripin, MPH, Katy Kehoe and Lisa Taich-Daly.

² Donna Shalala, *Domestic Violence and Health Care: Initiatives for the New Millennium*, Remarks to the Family Violence Prevention Fund National Conference, Washington, D.C., November 3, 1997.

³ *Preventing Domestic Violence: Clinical Guidelines on Routine Screening* produced by the Family Violence Prevention Fund, October 1999.

⁴ Bay and Jones Chambliss, “Domestic Violence: An Educational Imperative?” *Am J Obstet Gynecol*, 1994.

⁵ N.L. Norton, et al. “Battering in Pregnancy: An Assessment of Two Screening Methods.” *Obstetrics and Gynecology*. 85(1995): 321-325.

Once you have asked some basic questions to encourage a battered woman to start thinking about her options, you should help her make a *specific* plan to ensure her safety. The plan may involve not taking any action right now, but creating an escape plan in case she needs to leave suddenly or at a later time. If you are unable to help her develop a safety plan, find someone else who is qualified and available to help her.

There is no one-safety plan that applies to all battered women. Plans need to be *individualized* and take into consideration each woman's particular circumstances at that time. In general, the key to developing a safety plan is to work with the woman to identify what resources she has available. Where obstacles exist (there are always some), work with her to find alternatives. Below we have listed some considerations in safety planning.

Safety Plan Guidelines

Financial Issues

- Advise her to keep some money available. Talk about where she can keep the money hidden so that she has access to it.
- If there is a bank account involved, help her plan how to get access to the money in ways that do not arouse suspicion (e.g. withdrawing large amounts of money at once) and do not reveal her whereabouts once she leaves (some bank statements list where money was withdrawn).
- If a woman receives AFDC or other government assistance, this may be an important aspect of deciding when, where and how to leave. Plan around the dates that she receives the checks. She may want to make arrangements to have the check mailed to another address or post office box if she can afford it (although checks cannot go to post office boxes, unless specific authorization is granted).
- Advise her to consider direct deposit if available and advisable in her situation.

Transportation Issues

- If there is a car, advise her to keep an extra set of keys accessible.
- Discuss whether taking the car is the best alternative for her, or whether it could reveal her whereabouts. Is he likely to drive around looking for the car and/or report it stolen?
- If your facility has transportation options, such as vouchers, help her to obtain access to these.
- If public transportation is the only option, help her plan how to get to it. Help her identify what obstacles might be present, such as coordinating schedules, children, or clothes.

Plans need to be *individualized* and take into consideration each woman's particular circumstances at that time.

Documents and Other Needed Materials

- Help her identify documents that may be important for her to have, e.g. birth certificates, health information, legal documents, and social security cards.
- Identify which documents are absolutely essential and which she does not need immediately; consider how she can obtain these without compromising her safety.
- While these documents make the transition smoother once a woman decides to leave and to relocate, *it is not absolutely necessary that these documents be obtained before she can leave. The first priority is her safety.*
- Documents and other items she wants to bring with her should be maintained in a safe place. This may be a room, closet, an area of the home where the batterer does not usually go, or may be in the home of a friend or family member.

Plan an Escape Route

- Plan where she could go and who could help her.
- Plan a way to get there, as well as alternative ways to get there in case she needs to take a route with which the batterer is not familiar.

Support System

- Identify helpful people in her social and family network (including her church and community).
- Identify people who would *not* be helpful or who, out of fear, might compromise her safety. It is important that she think about this carefully to avoid giving information to people who might inadvertently let something slip to the batterer.
- While she is still in the home, have her consider finding someone to call for help if needed, and to check in with her on a regular schedule to make sure she is safe.

Children

- Help her think about what to tell the children before and during the time they are relocating.
- The plan may include leaving the children with someone else.
- Trust the woman's ability to ascertain what is and what is not safe for the children.

Personal Safety Plan

Following is a sample safety plan for use with patients who disclose abuse. The safety plan should be modified to meet the needs of your patient.

Safety During an Explosive Incident

- Try to avoid arguing. If an argument occurs try to have it in a room or area that has an accessible exit. Avoid having the argument in the bathroom, kitchen, or anywhere near weapons.
- Practice how to get out of your home safely. Identify which doors, windows, elevator, or stairs are the easiest and safest escape routes.

- Keep a packed bag ready and keep it at a friend's or relative's house in order to leave quickly.
- Identify a friend or neighbor you feel you can tell about the violence. Ask that they call the police if they hear a disturbance coming from your home.
- Devise a code word to use with your children, family, friends, and neighbors when you need the police.
- Plan for where you will go if you have to leave home (even if you don't think you will need to).
- Use your own judgements and instincts to keep yourself safe, if the situation is very dangerous. Call the police as soon as it is safe to do so. (You have the ability to obtain a restraining order at your local court during business hours and through local police during the nights and weekends.)
- Always remember: *you have the right not to be abused in your relationship – physically, emotionally, or sexually.*

Safety When Preparing to Leave

- Determine who would let you stay with them or lend you some money.
- Try to take your children with you or make arrangements to leave them with someone safe.
- Leave money, an extra set of keys, copies of important documents, and extra clothes with someone you trust.
- Open a savings account in your own name, start to establish or increase your independence. Think of other ways in which you can increase your independence.
- Keep shelter phone numbers close at hand and keep change or a calling card with you at all times.
- Review your safety plan with a domestic violence advocate in order to plan the safest way to leave your batterer. *Remember – leaving your batterer is when you are in the greatest physical danger.*

Safety in Your Home

- Inform neighbors and the landlord that your partner no longer lives with you and that they should call the police if they see your abuser near your home.
- Rehearse a safety plan with your children for when you are not with them.
- Inform your children's school or day care about who has permission to pick up your children (give them a copy of your protection order).
- Change or add locks on your doors and windows as soon as possible. Add a peephole and increase outdoor lighting if possible. Try to borrow a portable or cellular phone.
- Change your home and/or cellular telephone number.

Safety with a Protection Order

- Keep your protection order with you at all times.
- Call the police if your partner breaks the protection order.

- Think of alternative ways to keep safe if the police do not respond right away.
- Inform family, friends, and neighbors that you have a restraining order in effect.
- Try to avoid places in the community where your batterer may frequent.

Safety on the Job and in Public

- Decide on someone at work whom you can inform of your situation. This should include office or building security (provide a picture of your batterer if possible).
- Arrange to have someone screen your telephone calls if possible.
- Devise a safety plan for when you leave work. Have someone escort you to your car, bus or train. Use a variety of routes to go home if possible. Think about what you would do if something happened while going home.

Your Safety and Emotional Health

- Discuss an alternative plan with someone you trust, if you are thinking about returning to a potentially abusive situation.
- Determine the safest way to communicate with your partner, should you have to do this.
- Think positively about yourself and be assertive with others about your needs.
- Plan to attend a support group for at least two weeks to gain support from others and to learn more about yourself and the relationship.
- Decide whom you can call freely and openly to give you the support you need.
- Read books, articles, and poetry that make you feel stronger.

If You Are a Teen in a Violent Dating Relationship

- Talk about your relationship with someone you trust, if things in your relationship don't seem right to you.
- Decide which friend, teacher, relative, or police officer you can go to in an emergency.
- Contact a domestic violence advocate in the district attorney's office or the police to learn how to obtain a protection order and make a safety plan.
- Remember – you should never have to feel afraid in your relationship.
- Remind yourself – *no means no!!*

Checklist: What You Need to Take When You Leave

IDENTIFICATION

- Driver's license; car title, insurance and registration
- Children's birth certificates
- Your birth and marriage certificates
- Social Security card
- Welfare identification

FINANCIAL

- Money
- Bank books
- Checkbooks

LEGAL PAPERS

- *Your protection order*
- Lease, rental agreement, or house deed
- Car registration & insurance papers
- Custody papers
- Divorce papers
- Health and life insurance papers
- Medical records for all family members
- Work permits
- Green card/immigration papers
- Passport

OTHER

- House and car keys
- Medications
- Small objects you can sell
- Address book
- Photos of you, your children, and your abuser
- School records
- Jewelry
- Children's small toys
- Pets (if you can)
- Changes of clothing for you and your kids
- Phone card

¹ This material was excerpted and adapted from the publication entitled “Family Violence Resource Manual – A Primary Health Care Provider’s Guide” produced by Neighborhood Health Plan, written and compiled by Annie Lewis O’Conner, MSN, MPH with assistance from Kathleen Bennett, MD, Trudy Brown-Ripin, MPH, Katy Kehoe and Lisa Taich-Daly.

DOCUMENTING EVIDENCE¹

This manual encourages the documentation of all domestic violence cases. Documentation can be valuable evidence in a court of law, which can protect the victim from the batterer. The education of health care providers is the best means of sensitivity toward the victim's needs. Building trust through confidentiality is an important role the health care provider plays with documentation.

Originally, the principles of forensic science were used primarily to conduct physical examinations of murder victims. Today, forensic science is also used to conduct physical examinations of patients that have been injured by violence. Forensic medicine, also called legal medicine or medical jurisprudence, deals with the interaction between medical science and the law. Medical science can often assist the administration of justice in both civil and criminal matters.²

Accurate, careful, and thorough chart documentation, photographs of injuries, and collection of physical evidence may serve as the basis for legal prosecution of batterers. In a legal case against a batterer, these types of documentation often become legal documents that are submitted into evidence. Careful collection and preservation of forensic evidence can help bring perpetrators to justice and break the cycle of abuse in your patients' lives.

Policy

It is a good health center policy to screen *all* female patients for family violence. It should also be the policy of the health center to intervene on behalf of all identified victims of violence by providing medical treatment, referrals, resources, and follow-up. For non-English speaking women, providers are encouraged to seek consultation with an interpreter who is not a family member or friend of the patient.

Screening/Documentation Tool

The Migrant Clinicians Network Evaluation for Physical Abuse form, developed by Judith McFarlane, was designed for domestic violence screening. The form asks the patient about her physical abuse experience as well as its frequency. It refers to her partner's experience with drug and alcohol and asks her if she is afraid of her partner. The form is an excellent tool for screening the patient and documenting her information, and includes body maps. See the appendix for a sample of the form. The form may be copied to use in your clinic.

Chart Documentation Guidelines

Some patients may volunteer that they are experiencing abuse; others may disclose abuse during the screening. Even though you notice and ask about injuries or other warning signs of abuse, during the examination/interview some patients will still deny abuse.

Accurate, careful, and thorough chart documentation, photographs of injuries, and collection of physical evidence may serve as the basis for legal prosecution of batterers.

Whether or not your patient admits or denies abuse, you should precisely and thoroughly document all of your observations in her medical record.

Whether or not your patient admits or denies abuse, you should precisely and thoroughly document all of your observations in her medical record. In particular, you should carefully document your patient's injuries and perceptions of danger or fear. Documentation provides concrete evidence of abuse and violence and may be used in a court of law.

Many of the things you should document will come up as a result of your asking screening questions and conducting a lethality assessment. Listening carefully to your patient is very important.

Document the chief complaint in the patient's own words. Sometimes a patient's chief complaint is vague and may only refer to abuse indirectly: "patient complains of frequent headaches and feelings of hopelessness." Other times, a patient's chief complaint directly describes an abusive incident: "Patient reports she was hit by her husband's fist 3 times at 9:00 p.m. this evening. She states she was hit at least three times in the face, then kicked in the abdomen and the back."

Do not use phrases like "patient alleges." This implies that you may not believe her. Instead use phrases such as, "patient reports," or "patient states."

Gather specific details of the incident, including:

- date, time, and location where abuse occurred
- specific assault/injuries (twisted my arm, bit my shoulder, kicked my back)
- any weapons used (furniture, cords, threats with a knife)
- any threats
- patient's fears
- any witnesses

Remember that gun shot wounds, stabbing and extensive burns (greater than 5%) must be reported to the police. It is important to take into account local police culture and attitudes toward domestic violence in migrant and immigrant populations. Some law enforcement agencies may not be aware of the rights of an undocumented resident under the Violence Against Woman Act (VAWA). This act will be discussed in detail in Chapter Six.

Record your assessment of how well the patient's explanation fits with her injuries: (For example "Injuries are consistent with the history given by the patient" or "Injuries are not consistent with the history given by the patient").

Use body maps to document the location and size of injuries.

Offer to photograph your patient's injuries in order to obtain complete and thorough documentation.

Photography Guidelines: One Picture is Worth a Thousand Words

Documentation provides concrete evidence of abuse and violence and may be used in a court of law. Photographs complement chart documentation and add a good deal of credibility to a survivor's statement. In addition, taking high quality photographs of a survivor's injuries reduces the likelihood that a provider will be required to testify in court should the survivor decide to press charges against the batterer.

The provider should inform the patient that having pictures taken is her choice and it is *always* her decision. If the patient chooses to be photographed, review the consent form

with her before you ask her to sign it. It can also be beneficial to take pictures 2-3 days after the visit, depending on when the injury occurred and the degree of injury. A patient may not want to have pictures taken on the day you see her, but may consider returning for pictures a day or two later when injuries may still be visible.

Inform the patient of the value of the pictures, particularly if the case is likely to involve litigation.

When possible, and especially if the patient requests, the photographer should be the same sex as the survivor.

When possible, photograph injuries before they are treated.

Use an instant camera such as the Spectra by Polaroid to take high quality photographs of your patient's injuries. If you would like some training on how to effectively photograph injuries, the Polaroid Company provides free training sessions on photographing injuries as well as offering significant discounts to health care providers on cameras and film. Staff can practice taking pictures on each other to become familiar with the camera. The following are some guidelines to follow:

Use the Rule of Three

1. **Full-body pictures** should be taken showing the survivor's face and visible injuries, anteriorly, posteriorly, and laterally. Position the survivor two feet from the corner of the room, using a wall as the background. When photographing the survivor's back, have the patient turn her face towards her back so those facial features can be identified in the picture.
2. **Medium range pictures** should be taken of each and every separate injury. When photographing legs, have the survivor sit in a chair, exposing the legs and face together (for example, the survivor puts her knees below her chin).
3. **Close up pictures** should be taken of a wound and its relationship to another part of the body. For example, don't just photograph a wound on a patient's knee. Instead, photograph the patient's whole leg so that it is clear where the wound is on the body.

Other suggestions

- Do not use an external light source around an injured eye; secondary retinal damage may occur due to repeated flashing of the strobe, and it is also uncomfortable for the survivor.
- Establish a standard sense of scale: Use a ruler or a coin so that a standard of size can be established. Lay the object on the body or have the survivor hold it while you photograph her.
- When possible, shield areas not being photographed.
- Work efficiently and thoroughly. Start photographing the survivor's injuries from her head to her feet or from her left side to her right side.
- Although it may be necessary to get close to the survivor to take an effective photograph, be sensitive to the fact that the closer you are to the survivor, the more uncomfortable she may feel.
- Provide emotional support and respect your patient's feelings. Throughout the process, ask the survivor how she is doing and let her know that she can stop at any time. Try to progress at the pace with which the survivor feels comfortable.

Provide emotional support and respect your patient's feelings.

- Label each photo with an adhesive label, which includes the following: the name of the survivor, the survivor’s medical record number, time and date taken, and the name of the photographer. *Do not* write on the back of a photograph as it may destroy or distort the picture.
- Take two pictures of each injury, one with the scale and one without.

Each health center will have its own policy, but usually one copy of the photographs is given to the patient and one copy is placed in the medical record (in a sealed envelope, with the photographer’s signature over the seal, along with the date, time, and patient’s name). Depending on the patient’s preference, both copies can go in her medical record, or the patient may have a friend or relative hold the other copies.

As a health care provider your role goes beyond documenting the evidence, but the need to report the abuse. Every state is different on what you must report by law.

Mandatory Reporting

The scope of mandatory reporting of domestic violence within state statutes can vary a great deal. Most states require the reporting of injuries caused by deadly weapons (gun, knife, firearms, or other deadly weapons), yet few states require the reporting of incidents related to domestic violence that do not involve the use of deadly weapons.³

It is important to find out the most up-to-date laws relating to mandatory reporting within your state because these laws vary from state to state, and can change with time. Some advocates feel that mandatory reporting puts the victim at greater risk for danger. Over five hundred California physicians were surveyed on mandatory reporting in the mid 90’s, and the consensus of the respondents was that reporting the injuries of domestic violence clients may not be in the best interest of the client and could interfere with their patient-physician relationship.⁴ The victim’s safety should be the health care provider’s primary concern.

¹ This material was excerpted and adapted from the publication entitled “Family Violence Resource Manual – A Primary Health Care Provider’s Guide” produced by Neighborhood Health Plan, written and compiled by Annie Lewis O’Conner, MSN, MPH with assistance from Kathleen Bennett, MD, Trudy Brown-Ripin, MPH, Katy Kehoe and Lisa Taich-Daly.

² B. Knight, *Simpson’s Forensic Medicine*. 11th Edition. Oxford: Oxford University Press, 1997.

³ Arielia Hyman, “Mandatory Reporting of Domestic Violence by Health Care Providers: A Policy Paper” for the Family Violence Prevention Fund, funded by the U.S. Department of Health and Human Services & the Conrad N. Hilton Foundation, November 3, 1997.

⁴ Ibid.

It is important to find out the most up-to-date laws relating to mandatory reporting within your state because these laws vary from state to state, and can change with time.

LEGAL REMEDIES FOR DOMESTIC VIOLENCE¹

It is important for clinicians to gain an understanding about some of the basic legal issues surrounding domestic violence. Immigration law is very complicated and clinicians are encouraged to advise patients to seek advice from an agency that specializes in legal assistance for immigrants. Agencies can be located in the Resources section of this manual. The following information is provided as a general resource to clinicians.

Basic Human Rights

Everyone has a right to be free from violence in their home.

A battered woman should never be afraid to report abuse, regardless of her immigration status.

In fact, it is important to report the abuse to law enforcement because:²

- The woman's personal safety is an issue.
- Documentation that the abuse exists will be established.
- The battered woman is not required to inform the police about her immigration status.

Protective Orders

Basics

A protective order is an order by the court that, if violated, can have both civil and criminal consequences.³ The purpose of the protective order is to prevent further domestic violence. In different jurisdictions, protective orders may be called by different names (e.g., orders of protection, stayaway orders, restraining orders). Relief and eligibility requirements vary by state and tribe, but often include no contact, no abuse, custody, visitation, property, child support, use of the home, relinquishment of weapons, and police assistance provisions.

The National Domestic Violence Hotline at 1-800-799-7233 is available 24 hours a day. Interpretation services are available for over 100 languages other than English. The hotline will connect you with the nearest resource available to file a protective order.

Preserving Evidence

A court will examine evidence of abuse to determine whether a protection order or another type of court order should be granted. Admissible evidence may include police reports, medical reports, witness testimony, and physical evidence. Clinicians can assist victims in gathering this evidence.

Immigration law is very complicated and clinicians are encouraged to advise patients to seek advice from an agency that specializes in legal assistance for immi-

For a woman married to a U.S. citizen or lawful permanent resident, VAWA relief is an important tool.

The Violence Against Women Act

In 1994, Congress passed the Violence Against Women Act (VAWA), which included immigration provisions that allow battered immigrants and their children to obtain lawful permanent residence without the cooperation of their U.S. citizen or lawful permanent resident spouse or parent. VAWA was reauthorized in 2000. VAWA created two forms of relief for battered immigrants: VAWA self-petitions and VAWA cancellation of removal. For a woman married to a U.S. citizen or lawful permanent resident, VAWA relief is an important tool.⁴ Common law marriage is considered a marriage for the purposes of VAWA relief. This remedy, unfortunately, is not available to battered immigrants married to persons who have never been lawful permanent residents or U.S. citizens or to battered immigrants who have never been married to their abusers. Recognizing this, Congress passed legislation creating a U-Visa, which may be available to certain battered immigrants who are ineligible for other remedies.

Self-petitioning

A battered immigrant woman who is currently, or was, within the two years prior to filing, married to a lawful permanent resident or U.S. citizen is eligible to self-petition for lawful permanent resident status.

The following groups of individuals may self petition for immigrant classification:

- Abused spouses married to U.S. citizens or lawful permanent residents; these persons may apply for themselves and for their abused or unabused children even if the children are not related to the U.S. citizen or lawful permanent resident
- Abused children of U.S. citizens or lawful permanent residents
- Unabused spouses who are parents of children who are abused by the immigrant parent's U.S. citizen or lawful permanent resident spouse

A person who falls into one of the above categories will be allowed to file on her own under VAWA, without the sponsorship of the abusive spouse, if she meets *all* of the following requirements:

- Her spouse or parent is a U.S. citizen or lawful permanent resident, or has lost status within the two years prior to the filing of the application for reasons related to an incident of domestic violence;
- She has resided with the citizen or lawful permanent resident spouse or parent;
- She was battered or subjected to extreme cruelty during the marriage;
- She is a person of good moral character; and
- She married her spouse in good faith.

A battered immigrant who has divorced her abuser also may file an application if she does so within two years of a final divorce and she can demonstrate a connection between the divorce and battering or extreme cruelty by her spouse. A battered immigrant whose spouse (or parent) has died within the past two years also may apply.

VAWA reauthorization in 2000 deleted for certain petitioners the requirements that a person live in the United States and that the petitioner prove extreme hardship to her or her child if she were deported. As mentioned above, immigration law is complex and constantly changing, and clinicians should refer clients to agencies specializing in legal services for immigrants for assistance in completing self-petition applications. Evidence

is crucial when applying for a VAWA self-petition, and legal advocates can help applicants complete this application process.

Cancellation of Removal

A second VAWA remedy for battered immigrants is called cancellation of removal. This remedy is a defense against deportation. If cancellation of removal is granted, the judge will cancel the deportation and the applicant will be granted lawful permanent residency status. This remedy is available *only* to immigrants in deportation proceedings. Women who qualify for both self-petitioning and cancellation should self-petition because, if the self-petition is granted, she may be able to obtain her green card without being subjected to removal proceedings.

The following groups of individuals are eligible for VAWA cancellation of removal:

- Abused spouses or past spouses of U.S. citizens or lawful permanent residents
- Abused children of U.S. citizen or lawful permanent resident parents
- The parent of a child who has been abused by the child's other parent, who is a U.S. citizen or lawful permanent resident

Unlike self-petitioning, this provision is available to parents of abused children, regardless of whether the immigrant parent is married to the U.S. citizen or lawful permanent resident parent who abused the child and whether or not the parent has also been abused.

An immigrant woman in any of the above categories is eligible for cancellation of removal if she proves *all* of the following:

- She has lived in the United States continuously for 3 years immediately preceding filing the application for cancellation of removal; time accrued after being placed in immigration proceedings can be counted toward this three-year requirement. Any absence that exceeds 90 days or any series of absences that exceed 180 days will not result in a denial of cancellation of removal if the applicant can show that the absences were connected to abuse.
- She or her child was subjected to battering or extreme cruelty by her spouse while in the United States;
- She is determined to have "good moral character";
- She or her child (or, in the case of a child petitioner, her parent) would suffer extreme hardship if deported. In the experience of practitioners, the INS will rely heavily on the petitioner's affidavit in considering whether a case meets this requirement;
- She is currently deportable. She will not be eligible for cancellation if she is deportable for marriage fraud, certain criminal convictions or because she is a threat to U.S. national security.

The documentation necessary to prove a cancellation of removal case is similar to the documentation required for a self-petitioning case. Cancellation of removal cases are extremely complicated. No one should try to file for this without the assistance of an immigration attorney or an agency specializing in legal services to immigrants.

If cancellation of removal is granted, the judge will cancel the deportation and the applicant will be granted lawful permanent residency status.

Battered Spouse Waiver

Conditional residents are required to file a joint petition, with their citizen or permanent resident spouses, to remove the conditions on residency and to attend an interview with their spouses and an INS official after two years of marriage to prove that their marriage was not entered into for the sole purpose of obtaining immigration status. A battered spouse waiver allows conditional residents to petition for the removal of the conditional basis of their permanent resident status without the cooperation of the abusive spouse. After the battered spouse waiver is approved, the immigrant can apply for lawful permanent residency.

U-Visa

VAWA reauthorization in 2000 created a new, non-immigrant classification that is available for crime victims. This remedy is available to certain immigrant crime victims regardless of their immigration status, or the immigration status of their abusers. This visa is available to victims who have suffered substantial physical or mental abuse as a result of being subjected to specific crimes committed against them. In order to qualify for a U-Visa, a law enforcement officer, prosecutor, judge, or other local authority investigating certain criminal activity will have to certify that the victim has been helpful, is being helpful, or is likely to be helpful in the investigation or prosecution of the crime.

Full Faith and Credit

VAWA requires enforcement of valid protection orders issued by other states and Indian tribes as if the orders had been issued by the enforcing state or tribe. The new state must enforce the protective order from the other state even if that order would not have been issued in the new state. Temporary, final, civil and criminal protective orders are entitled to full faith and credit. Mutual consent orders are *not* entitled to full faith and credit. The holder of a protective order should contact law enforcement or the local domestic violence program in the new state for assistance in enforcing the protection order.⁵

Battered Immigrants and Public Benefits

In 1996, Congress passed the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA). The immigration provisions in this new welfare law, and its subsequent amendments, are extremely complex. In general, battered immigrants qualify for certain public benefits under PRWORA if they meet the following requirements.

A battered immigrant may qualify for public benefits if she:

- has an *approved* VAWA self-petition or family-based petition;
- has been granted VAWA cancellation of removal or suspension of deportation; or,
- has been notified by the INS or an immigration judge that her pending VAWA self-petition or family-based petition sets forth a *prima facie* case (this means that the application appears to meet all the requirements for a self-petition, but the application has not yet been approved).

[U-Visa] is available to certain immigrant crime victims regardless of their immigration status, or the immigration status of their abusers.

She will be eligible for public benefits if she can also prove that she meets all the standard eligibility criteria (i.e. income) for benefits and all of the following:

- ▶ She or her child has been battered or subject to extreme cruelty in the United States by her U.S. citizen or lawful permanent resident spouse or by her child's U.S. citizen or lawful permanent resident father. In the alternative, she may show that she was battered by a member of the spouse's or parent's family residing in the same household with her, but only if the spouse or parent consents to or acquiesces in such battering or cruelty. In the case of an alien who has a battered child, the alien must show she did not actively participate in the battery or cruelty. An approved self-petition, notice of a *prima facie* determination, or a protective order should fulfill this requirement;
- ▶ There is a "substantial connection" between the need for public benefits and the violence; and,
- ▶ She no longer lives in the same household with the abuser.

Access to benefits is limited. Some benefits require a minimum length of residency in the United States. To determine whether a particular individual qualifies for benefits and the specific benefits that person is eligible for, contact an organization that provides services for battered immigrants.

¹ Excerpted and adapted with permission from:
Jennifer Corrigan, *Passport to Independence: Assisting Battered Immigrant Women*.
2nd Edition. Austin: Texas Council on Family Violence, 2001

² Migrant Clinicians Network, *Training Manual on Domestic Violence*. 1998

³ Migrant Clinicians Network, *Training Manual on Domestic Violence*. 1998

⁴ Although the word "woman" is used throughout this chapter, it is important to remember that VAWA immigration relief is gender neutral.

⁵ Texas Council on Family Violence, "Traveling Safely: Enforcing Protective Orders Throughout the United States" [Brochure] 2000

Resources

Domestic Violence Resources

- Battered Women's Justice Project (800) 903-0111
- Health Resource Center on Domestic Violence (800) 313-1310
- National Domestic Violence Hotline (800) 799-7233
- National Resource Center on Domestic Violence (800) 537-2238
- Family Violence Prevention Fund (415) 252-8900

Other Resources

- Focus on Recovery Helpline (800) 234-0420
- National STD & AIDS Hotline (800) 342-2437
- National STD & AIDS Hotline Spanish Service (800) 344-7432
- National Mental Health Resource Center (800) 969-6642
- Resource Center on Domestic Violence Child Protection & Custody (800) 527-3223
- Advocates Against Battering & Abuse (970) 879-8888

Legal Resources

- Ayuda, Inc. (202) 387-0434
- American Bar Association Commission on Domestic Violence (202) 662-1737
- National Immigration Law Center (213) 487-2531

Web Links

- Advocates Against Battering and Abuse <http://www.cmn.net/~dimoore/>
- Family Violence Prevention Fund <http://www.fvpf.org>
- Welfare & Politics <http://epn.org/idea/welfare.html>

Legal Web Links

- American Bar Association
Commission on Domestic Violence <http://www.abanet.org/domviol/home.html>

Appendix

MIGRANT CLINICIANS NETWORK Evaluation for Physical Abuse

Date of Birth: _____ Place of Birth: _____

Marital Status: S M D W Sep Migrant or Permanent: _____

Cohabiting: _____ Pregnant: Yes ___ No ___

Ethnic Origin: _____ Number of months in pregnancy: _____

1. Does your husband/boyfriend/companion use alcohol or drugs? Yes ___ No ___

If the answer is yes, does your husband/boyfriend/companion abuse you when he is drunk or using drugs? Yes ___ No ___

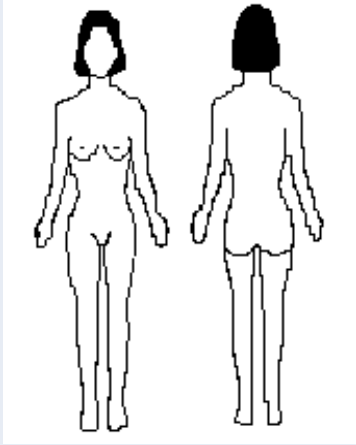
2. During the last year, have you been physically abused (hit, kicked, pushed) by another person? Yes ___ No ___

If the answer is Yes, the person who abused you was:

Husband Boyfriend Companion Ex-Husband Relative Other

Total number of occasions: _____ When was the last time you were hurt? _____

Mark on the drawing the areas injured. Next to each injury mark the appropriate scale:



1=threats, including threats with weapons
2=slaps, pushes, bruises or injuries with prolonged color, pulling the hair
3=punching, kicking, bruises or injuries with prolonged color, attempted strangulation
4=hitting, severe bruises, burns, broken bones
5=head injuries, internal injuries, broken bones
6=injuries caused by the use of weapons

3. Have you been forced to have sexual relations in the last year? Yes ___ No ___

If the answer is yes, with whom?

Husband Boyfriend Companion Ex-Husband Relative Other

Total number of occasions: _____ When was the last time you were forced? _____

4. Are you afraid of your husband/boyfriend/companion/relative, or other person threatening you? Yes ___ No ___

If yes, do you need help? Yes ___ No ___

This form was developed by Judith McFarlane, College of Nursing, Texas Woman's University, Houston, Texas. It was adapted by the Migrant Clinicians Network for use in a migrant health center setting and used with permission. This form may be duplicated if needed. For more information, please contact MCN at PO Box 164285, Austin, Texas 78716, (512)327-2017, fax(512)327-0719.

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