PREVENTION OF GENDER-BASED VIOLENCE IN AND THROUGH HEALTH SETTINGS

Teaching resources

# Acknowledgements

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## Acknowledgement of Country

Our Watch acknowledges the traditional owners of the land across Australia on which we work and live. We pay our respects to Aboriginal and Torres Strait Islander peoples past and present.

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# INTRODUCTION

These materials have been prepared to assist academic teaching of primary prevention of gender-based violence content through undergraduate programs in the field of health sciences.

While health professionals often come into contact with people who have experienced gender-based violence, they also need to maintain a focus on how they can contribute to the primary prevention of violence – that is, stopping it before it begins. Evidence tells us that to prevent violence against women we need action across Australia to:

1. Challenge the condoning of violence against women.
2. Promote women’s independence and decision-making in public life and relationships.
3. Build new social norms that foster personal identities not constrained by rigid gender stereotypes.
4. Support men and boys in developing healthy masculinities and positive, supportive male peer relationships.
5. Promote and normalise gender equality in public and private life.
6. Address the intersections between gender inequality and other forms of systemic and structural oppression and discrimination, and promote broader social justice.
7. Build safe, fair and equitable organisations and institutions by focusing on policy and systems change.
8. Strengthen positive, equal and respectful relations between and among women and men, girls and boys, in public and private spheres.

## How to use this resource

This resource includes discipline-specific teaching resources, including hypothetical scenarios and video interviews that have been developed by Our Watch in collaboration with teaching academics.

The teaching resources can be used in tutorials as group exercises or modified to form assessments. While they are designed with specific student groups in mind, they can also be tailored to meet the requirements of your teaching and learning needs. Further advice on using and tailoring the resources can be found in the [*Educators’ guide to upskilling preservice professionals to support the prevention of gender-based violence*](https://handbook.ourwatch.org.au/leadership-resource/educators-guide-to-upskilling-pre-service-professionals-to-support-the-prevention-of-gender-based-violence/?utm_source=PDF5&utm_medium=PDF+5%3A+Teaching+resources+prevention+of+gender+based+violence+in+and+through+health+settings), which provides general advice to teaching academics about integrating prevention of gender-based violence concepts into teaching content and practice.

It is necessary to spend some time developing understanding around the threshold concepts that students need in order to approach material related to gender equality and the prevention of gender-based violence, so that it informs their way of thinking and knowing.

These threshold concepts include:

* the social construction of gender
* privilege, oppression and intersectionality
* the socio-ecology of gender norms, practices and structures
* the gendered drivers of violence against women.

For additional information about teaching the threshold concepts that underpin these materials, please refer to [*Facilitation guidance – Prevention of gender-based violence in and through health settings*](https://handbook.ourwatch.org.au/leadership-resource/facilitation-guidance-prevention-of-gender-based-violence-in-and-through-health-settings/?utm_source=PDF5&utm_medium=PDF+5%3A+Teaching+resources+prevention+of+gender+based+violence+in+and+through+health+settings).

## Safety and support for students

Many of the stories and experiences represented in this resource explore different types of violence and non-physical forms of abuse, which raises the question of how to appropriately respond if someone discloses that they’ve experienced or perpetrated violence themselves. It is important for students to know their professional or personal role, and not attempt to provide specialist care or counselling unless they are qualified to do so.

The key steps to safely and effectively responding to disclosures include:

1. **Recognise** the signs of gendered violence.
2. **Respond** with appropriate care.
3. **Act** in accordance with relevant university family violence response and prevention policies and procedures.
4. **Refer** to support services.

1800RESPECT provides information and resources for professionals supporting people impacted by sexual assault and domestic and family violence, including online or telephone secondary consultation and support for work-related stress and trauma. Call 1800 737 732, or use their online resources for professionals.

For further information refer to Our Watch’s [*A victim/survivor-centred approach to responding to violence*](https://media-cdn.ourwatch.org.au/wp-content/uploads/sites/2/2021/03/19124201/1.4-Victim-centred-approach-1.pdf).

# Responding to a disclosure of gender-based violence in a health setting

This short guide is written to support students who are training to be healthcare professionals. It aims to develop their understanding of appropriate responses to disclosures of gender-based violence. Gender-based violence can impact anyone, and can include family violence, elder abuse, sexual violence and harassment, violent online abuse, dating violence, stalking and human trafficking.

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| **What is a disclosure?**  A disclosure is when someone reveals they have directly experienced violence as a survivor or a perpetrator. This may be a service user, a family member of a service user, or a colleague, and the disclosure might be about them or someone close to them. The violence may be ongoing, may have happened recently or may have occurred in the past. Sometimes the disclosure is about violence experienced by a close family member or friend, rather than someone disclosing that they have experienced violence themselves. A disclosure can occur in many different contexts and it is important that those working in a healthcare setting are able to identify and respond appropriately and effectively. |

## Important things to understand before you respond to a disclosure

In your professional role it is important that you do not provide specialist care or counselling unless you are specifically qualified to do so. If a victim-survivor discloses an experience of gender-based violence or domestic family violence (DFV) to you it is important to be able to respond in a way that combines warmth and care with clarity about the victim-survivor’s rights and options, and your professional responsibilities and limitations.

### Reflecting on your practice

Responding appropriately and effectively in diverse contexts involves becoming aware of your own values and attitudes. This means committing to ongoing learning and critically reflecting on your own practice. Healthcare professionals should not make assumptions based on people’s identity, but sometimes we may do so without realising, due to our own unconscious bias. Unconscious bias can be influenced by our upbringing, beliefs or media messaging.

As a health professional, you are in a position of power and authority, which can inspire in service users a high degree of trust, deference and respect. Some may also feel fear and mistrust, depending on their past experiences. This can influence what victim-survivors tell you and impact on their decision to disclose.

### Awareness of systemic barriers

Victim-survivors may have experienced, or may be experiencing, intersecting barriers and marginalisation that compound their experience of family violence and make it difficult to access and sustain support. They may be:

* Aboriginal and Torres Strait Islander
* a person with a disability
* LGBTIQ+
* from a refugee or migrant background
* not fluent in English.

Often systems work best for the people who they were created by. One example of a systemic barrier is the vast majority of buildings that do not cater to people who use wheelchairs. Another might be information about health or support services almost always being provided in English only.

Because of systemic and everyday oppressions such as racism, sexism, ableism, heterosexism, ageism and the ongoing impacts of colonialism in Australia, not everyone has the same access to information, services and legal protections. These barriers can make it more difficult for some people to seek support.

To avoid unconscious bias, it is important to be aware of the possible barriers people face, due to not being in the majority population group.

### Other barriers to making disclosures

There are many complex emotions connected to being a victim-survivor of violence. Frequently, people feel guilt and shame, fear and distress. They may love the perpetrator and be worried about what will happen if they disclose their experience of violence. When the perpetrator is their spouse, they may also believe that marriage should be for life, or that their success and acceptance in society is dependent on making a relationship work. For refugee and migrant women, for example, there can also often be fear (founded on threats from the perpetrator) that they will be forced to leave the country.

For this reason, it is important not to make judgements or assumptions about why or how a person should disclose, and to support them to make their own decisions as much as possible.

Make yourself aware of organisational policies and procedures and seek consultation or advice from experts if immediate safety concerns are apparent.

### Roles and responsibilities

Unless you’re a specialist in family or sexual violence, you should not provide advice or engage in counselling the victim-survivor. Your role is to listen without judgement, establish the level of risk and make a referral to a specialist.

You can refer to professionals who have expertise such as specialist DFV services, and consult with colleagues who are trained to undertake risk assessments and therapeutic intervention.

You are likely to have a responsibility to report reasonable suspicions of child abuse and neglect to child protection authorities, in line with mandatory reporting requirements.

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| **Mandatory reporting**  Mandatory reporters are required by law to report suspected abuse and neglect to government authorities. This mainly relates to children, but can also relate to adults if the person involved is living in a residential service, such as a psychiatric care or aged care facility. **Legally, if a child is a witness to, or affected by, family violence, they are a victim-survivor of family violence.**  The laws around who is required to report and in what circumstances are different in each state and territory.  For more information about your mandatory reporting requirements, call 1800RESPECT or visit 1800RESPECT, [Mandatory reporting.](https://www.1800respect.org.au/resources-and-tools/reporting-and-protection/mandatory-reporting) |

### Workplace policies and supports

Most health settings will have policies and processes for managing risks to immediate safety, or for child protection notifications. This should include comprehensive referral systems and, where relevant, pathways to organisations in the community that can provide specialist support and services.

Confidentiality and privacy are also important to consider, as, depending on your legal requirements, you may be legally obliged to breach the person’s confidentiality because you are a mandatory reporter. These rules and regulations will also be outlined in your workplace policies.

## Responding appropriately to a disclosure

Your role as a health professional is to:

* Recognise when a disclosure is taking place.
* Facilitate a private discussion in a sensitive manner and in an environment where the person feels safe.
* Provide specialist service options to the victim-survivor and refer the person as appropriate or required.

If you are a mandatory reporter, there are additional things you need to do, including telling the victim-survivor that you are a mandatory reporter and what your obligations are. You should refer to the guidelines in your state or territory. Regardless, everyone can take the following steps to increase the safety and support for victim-survivors as early as possible.

### Recognise a disclosure

Gender-based violence includes a wide range of controlling and abusive behaviours that may have been occurring over a long period of time. People often do not recognise what they are experiencing as violence. This is because of an ingrained belief among many people that gendered and family violence refers only to physical violence.

A victim-survivor may not explicitly say they have experienced violence, but you may see, observe or hear something that may indicate someone is experiencing violence. Indicators of violence include bruises, injury to parts of the body hidden from view, rape and sexual assault, miscarriages and other pregnancy complications, mental illness, depression, panic attacks, anxiety and suicidal thoughts.

Asking a direct question in a sensitive way may help the victim-survivor overcome barriers to disclosing. Open questions can be effective in respectfully opening up the discussion without probing or pressuring the person in an intrusive way.

#### Things you could say

* ‘Is there something in particular that is making you feel upset or stressed?’
* ‘You don’t seem yourself lately – is everything OK at home?’
* ‘How does your partner behave towards you?’

A person-centred approach means acknowledging the victim-survivor as the expert on their experience. There are many barriers to disclosing violence and they still may choose not to disclose. You need to respect this. Let the victim-survivor guide the process as they know what they need to remain safe and feel supported.

### Respond sensitively

The most important things you can do are to listen to the person, show you believe them, and take the disclosure seriously. Even when undertaking mandatory reporting it is possible to maintain this approach.

You may be the first person, or at the least the first in a professional role, that the victim-survivor has spoken to about their situation. It is therefore extremely important that you’re receptive and responsive to what they’re telling you. This involves listening without interruption and then responding respectfully, by:

* Validating their feelings about their situation, and being sure not to blame the victim or justify the violence in any way.
* Naming what they are experiencing as violence.
* Ensuring that you emphasise that the violence is not the victim-survivor’s fault and was not caused by anything they did, or did not do. Perpetrators of violence choose to be violent and are responsible for this choice.
* Explaining that this is a societal problem which occurs across all age groups and cultural and socioeconomic backgrounds, and that there is support available.

#### Things you could say

* ‘Thanks for sharing your experience with me.’
* ‘That sounds like a terrible experience.’
* ‘I imagine it has taken a lot of courage for you to share your story with me.’
* ‘No one should have to experience what you’ve been through.’

### Establish risk and the victim-survivor’s willingness to act

Your responses to victim-survivors, and your actions, will depend on their level of risk, whether they have children, and whether they’re willing to receive further support.

In some instances of low risk, it may be enough to simply acknowledge that the victim-survivor has shared their experience with you. Remember that your response should be guided by the victim-survivor, and all actions taken with their consent, unless there is an immediate threat to safety.

If you are concerned for someone’s current safety then it is important to make them aware of your concern and what the options are, as well as your responsibility in the situation.

#### Things you could say

* ‘Will you feel safe when you leave here today?’
* ‘Do you have any immediate concerns about the safety of your children or someone else in your family?’

Only DFV specialists can undertake comprehensive risk assessments, but it is important to establish whether the person is in immediate danger and at risk of serious injury or death. High-level risk indicators include:

* escalating physical violence
* stalking
* harming or killing family pets
* threats to kill
* suicide threats
* attempts to choke or strangle the victim-survivor (choking and strangulation require immediate medical attention).

If a victim-survivor discloses that these things have occurred, you should refer them to a specialist immediately.

Each state and territory may also have their own risk assessment tools which may be used by non-specialist services. If these relate to your role, it is important to be familiar with them, and to utilise them as appropriate.

If the victim-survivor has children and does not want to act, you should refer to your workplace policies and procedures. Regardless of whether you are a mandatory reporter, if you have reason to believe that a child is being sexually abused or is in danger, you have a responsibility to notify the appropriate authorities. If you are unsure, you should always consult with a senior staff member.

Aim to be as transparent and collaborative as possible by giving the victim-survivor a clear explanation of each step of the process, and their position within this.

### Plan for safety

Regardless of whether a victim-survivor decides to stay or leave, it’s important to explore some safety options with them and encourage them to make a safety plan, in the event that the violence escalates. This involves thinking about things they can do to be safer when living with violence and abuse.

Safety plans are usually best made with the help of a specialist service, but there is often a gap between you making the referral and the service establishing contact with the victim-survivor. Or it may be that the victim-survivor does not want a referral at the present time.

You should work with the victim-survivor to make a plan that suits their needs. A basic safety plan may involve having an escape bag with some clothes, money and copies of important documents kept at a trusted friend’s house. You can ask if they have an emergency support person, and ensure they have the emergency number for police and contact details for a specialist violence support service. Your state or territory or local family violence support service may also have safety plan templates available.

While being sensitive and supportive, you also need to set a professional boundary around your role and avoid being the victim-survivor’s main support person, as there are professionals trained to do this. If you have trouble managing this boundary, you should speak to a supervisor.

### Refer to a specialist service

Ensure you know about the appropriate support services in the victim-survivor’s geographic area – for example, specialist family violence and gender-based violence services, including services for people from Aboriginal and Torres Strait Islander, LGBTQI+, immigrant and refugee communities, as well as support regarding elder abuse and for people with a disability. Referrals are far more likely to be successful if the person who is being referred knows what to expect in terms of process and wait time.

1800RESPECT is a national telephone and online counselling service for issues of sexual assault and domestic family violence. It operates 24 hours a day, seven days a week, and provides professional advice to victims and perpetrators, as well as to third parties for secondary consultation. Their website includes a range of useful information about violence, abuse and healthy relationships, as well as a directory that covers a wide range of local, state and national specialist services.

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| **Further information**  1800RESPECT 1800 737 732 <http://www.1800respect.org.au/>  <University to insert contact details of local support services> |

### Responding appropriately to a disclosure of gender-based violence in a health setting

[Text-equivalent description of decision tree](#_Text-equivalent_description_of_1)

**If you are a mandatory reporter,** follow workplace polices and consult your supervisor.

**If you see signs or indicators that gender-based violence is present:**

**Make a sensitive inquiry.**

**Ask: You seem stressed – is everything OK?**

**Yes, everything is OK, not experiencing violence.**

Respect their answer and let them know where to seek support if they ever need it.

If you still have serious concerns about the person, consult your supervisor.

**No, things are not OK.**

Let them know that you are there to support them. Let them know the limits of your confidentiality, particularly with regards to children’s safety. Listen to the person closely with empathy and without judging.

**Ask** the following questions to identify whether gender-based violence is occurring:

* **Has anyone in your family done something to make you or your children feel unsafe or afraid?**
* **Have they controlled your day-to-day activities (e.g. who you see, where you go) or put you down?**
* **Have they threatened to hurt you in any way?**
* **Have they hit, slapped, kicked or otherwise physically hurt you?**

**Yes, violence is occurring.**

Establish immediate risk.

**Ask: Do you have immediate concerns about your own safety or someone else in your family?**

**No, not in immediate danger.**

While it is indicated there is no immediate threat, there may still be a serious risk.

**Ask: Can I refer you to a specialist?**

**No, they do not want to seek assistance.**

Consider child wellbeing and safety and consult your manager to share information if needed.

You can call a violence service with de-identified information for advice as well.

Provide them with information about the help and support that is available, including emergency numbers. Let them know that they can get help if things change.

**Yes, they are willing to receive assistance.**

If it is safe to do so and they are in immediate danger, call the police, or encourage them to call the police.

Provide them with the numbers and details of specialist violence services to assist with safety planning and support.

Consult with your manager, DFV specialist and/or a specialist violence service.

**Yes, in immediate danger.**

Establish their willingness to act.

**Ask: Can I offer you further assistance? Would you like me to call the police?**

# Scenarios

These scenarios aim to represent a diversity of situations that demonstrate the intersections of the drivers of gender-based violence and others forms of inequality and oppression. They can be tailored to meet the learning objectives of your unit or used as they are. If you plan to adjust any details of the scenarios, refer to the guidance in the [*Educators’ guide to upskilling preservice professionals to support the prevention of gender-based violence*](https://handbook.ourwatch.org.au/leadership-resource/educators-guide-to-upskilling-pre-service-professionals-to-support-the-prevention-of-gender-based-violence/?utm_source=PDF5&utm_medium=PDF+5%3A+Teaching+resources+prevention+of+gender+based+violence+in+and+through+health+settings).

## Scenario 1 – Ivy’s iPad

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| Audience/level | Purpose | Key concepts |
| First-year health students | * To explore gender, gender construction, gender myths, assumptions and stereotypes. * To provide students with the chance to explore less explicit forms of abuse and how gendered power and control can present itself in social settings while professionally working with groups of people. * To support students to critically reflect on how they can plan for and respond to sexism and gender-based stereotypes in group work. | Aged care setting, placement context, violence against women, power and control, critical reflection, planning for and responding to dynamics of sexism and gender power imbalances. |

You are on placement at Cottage Homes, a hostel aged-care facility for people over 60 who have low-care needs, but who require support with independent living.

You have been asked to consult residents about activity ideas in order to co-design and facilitate a group program.

Around seven residents are interested in joining the ‘Group Activities Committee’, and you gather them together. There are five women and two men, all aged between 65 and 75.

Ivy is a standout personality. She comes to the gathering with a notebook and pen, and an iPad. She uses a walking frame, but her posture is straight and she has strong overall muscle control. She is the oldest resident in the committee group.

You ask Ivy if she has any thoughts regarding what activities they could organise. She says, ‘Yes, well, I’ve been talking to pretty much everyone and there are three main ideas that have come out. Men and women would like to have some training on how to use modern technology, like this iPad. The women especially would like to know how to use online banking—’

Before Ivy can finish, one of the men interjects gruffly, saying, ‘Why would women want to worry themselves about banking? I don’t even care about that stuff anymore. I let my son sort it all out. The last thing I want to do is worry about that.’

Another woman agrees. ‘That’s true, Reg. It’s a hassle, isn’t it? My husband took care of it and I let my son-in-law look after all that now. I mean, it’s probably a pointless skill to have now anyway.’

Ivy looks surprised and says, ‘Jessi, you’re only 66 – nine years younger than me, and fitter too. You have a lot more years ahead of managing your finances. Anyhow, another idea people have shared – and that includes men too, Reg – is that they want to stay agile, with their hands. I was thinking instead of typical activities like knitting and craft – I hate knitting – I mean, that’s what my grandmother did. I bought my jumpers from Myer’s. We aren’t ancient! Anyhow, I was thinking we could do something mechanical – you know, like fix lawnmowers or even motorbikes, or mobility scooters or something.’

You’re a bit surprised by these suggestions, especially from an older woman, and feel a little put out, as you’d planned to run an art class and had lots of fine motor activities planned. You’re not sure how you’d go about actioning Ivy’s ideas.

Reg is becoming agitated and interjects aggressively with, ‘Oh, for goodness sake, woman, these ideas are ridiculous.’ He turns to the other women in the group, asking, ‘Ladies, do you really want to do this or is this radical lesbian just revving you up and causing trouble?’

The women in the group are quiet. Many don’t look at Ivy or Reg and seem uncomfortable.

The other man in the group, Oliver, who’s sitting next to Ivy, pats her hand and says, ‘Don’t get upset, Ivy. There are some good ideas and I like the banking one. Perhaps that one’s something that’s better suited to us all. The men can also help the ladies. In fact, Reg, your son works at a bank. Perhaps he could lead the activity. It would be nice to get our children involved, don’t you think, ladies?’

There’s a murmur of agreement from the other women, who all have children. Ivy does not.

The men go on to lead the conversation from there and some of the other women join in, although they seem to agree with the men rather than contributing alternative ideas. Ivy is quiet and takes notes in her notebook and looks up items on her iPad when other residents ask her to.

One idea that seems to be getting traction is a resident’s garden – something that Reg is very keen on. He tells the group that he was one of the main gardeners at the Botanical Gardens before he retired. He comments to Ivy that gardening is also a good activity for the hands, in what sounds like a patronising tone.

At the end of the meeting, you feel a bit uncomfortable, so you reach out to meet with your site supervisor and talk to them about what happened and the dynamics of the meeting. The supervisor tells you that Ivy was one of the first female mechanical engineers in the country and how, with her late husband, who was a structural engineer, she travelled to developing countries, responding to natural disasters. The supervisor also says, ‘Reg is always grumpy. Don’t mind him. He can be a bit of a bully, but it’s more of a generational thing. And Oliver is one of those traditional gentlemen, a “knight in shining armour” type. I’m sure he didn’t mean to take over that way.’

### Additional resources

* Our Watch, [*Doing Nothing Does Harm*](https://www.doingnothingdoesharm.org.au/)

### Sample discussion questions and answers

1. **What are some examples of the drivers of gender-based violence present in this story?**

Rigid gender stereotyping:

* Women, especially older women, aren’t expected to have financial or digital literacy.
* Older women’s interests are limited to knitting, arts and crafts.
* Women who do men’s jobs/activities/roles must be lesbian because they don’t fit the mould of traditional gender roles.
* Being a lesbian is a bad thing.
* All women become mothers.

Rigid gender roles:

* Women taking on the role of consulting others for community benefit.
* Men dominating discussion in a mixed group.

Condoning of violence:

* Trivialising Reg’s behaviour as him being ‘always grumpy’.
* Excusing his behaviour because of his age.

Men’s control of decision-making:

* Reg and Oliver take over the discussion when they disagree with Ivy’s ideas.
* Preference being given to Reg’s idea, which aligns with his interests, whereas Ivy’s ideas, which align with her interests, are dismissed.

1. **Who has or takes the power in this group meeting? Who is disempowered and silenced in this encounter?**

* The two men take the power when Reg reject’s Ivy’s contributions, and Oliver aims to pacify Ivy to resolve the conflict rather than challenging Reg. Ivy in particular becomes disempowered by Reg’s behaviour.
* This then works to enforce a passive and agreeable role on the rest of the women in the group.

1. **How is Ivy challenging gender stereotypes and norms in this scenario? Consider other elements as well, such as ageing and sexuality.**

She is challenging gender, age and sexuality stereotypes by:

* Being interested in learning how to use digital technology and engaged with her own personal finances, in contrast with the stereotype of older people being too old to learn or less capable and needing to refer banking tasks to younger (usually male) relatives.
* Being active and mobile, despite her age and gender.
* Being interested in non-traditional activities like building and mechanics, as an older heterosexual woman – challenging the notion that her gender identity and sexuality have to be aligned. That is, just because she has non-traditional interests as a woman doesn’t mean she cannot conform to dominant forms of sexual orientation and be heterosexual.

1. **Is Reg’s behaviour just ‘a generational thing’ or is it abusive? List the behaviours that he exhibits towards the members in the group and discuss any patterns you observe in relation to power and decision-making.**

Reg’s problematic behaviours include:

* Interrupting Ivy when she talks and shutting down her ideas, calling them ‘ridiculous’.
* Confronting the women in the group, and getting them to rally against Ivy.
* Referring to Ivy as a ‘radical lesbian’.
* Speaking to Ivy in a condescending manner.

By taking over the conversation and shutting down ideas from other people in the group, Reg manipulates the discussion and decision-making around which group activity to implement. This is typical within patriarchal societies that award men the position of power to lead conversations and oversee important decisions. As a result, decisions made don’t reflect the diverse interests of the wider group but rather those of the person or people with the most power.

1. **What actions could you take after this scenario that could contribute to stronger gender equity and prevention of gender-based violence in group activities?**

Students should identify actions that link to one or more of the drivers of gender-based violence:

* Talk to Ivy privately and ask if she is OK. Reassure her that her ideas are important and can be considered.
* With the support of colleagues, and if safe to do so, speak to Reg privately to explain that respectful behaviour and language is expected if he’s to continue participating in the group.
* Facilitate the next meeting to ensure that everyone gets the same time and space to contribute, e.g. establish some group agreements around respectful discussion and actively facilitate if discussion is dominated by someone or comments are inappropriate.
* Openly support Ivy and anyone else who is challenging gender stereotypes, e.g. point these instances out to the group and commend their efforts.

## Scenario 2 – ‘It wasn’t an accident’

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| Audience/level | Purpose | Key concepts |
| First-year health students | * To introduce myths, assumptions and stereotypes regarding gender-based violence and understanding referral pathways. * To provide students with the opportunity to reflect and identify their own ideas/values and possible assumptions regarding gender and where this could, or how it might, impact their professional practice. | Gender, gender construction, myths and assumptions, gender-based violence, family violence, disclosures of violence in a health team setting, physical injury and rehabilitation, rural setting, family violence risk, referral, specialised support. |

You are located at a regional hospital within a new multidisciplinary health team that specifically supports women to recover from post-traumatic injury due to an accident. The key focus of the program is to support individuals in their rehabilitation and recovery.

This holistic and targeted approach of specifically working with women as a group is new for the hospital and is influenced by recent government funding designed to provide support to women in regional areas. There has been some resistance from some staff over the focus on women, given that men have high rates of injury in the area too.

You are part of a care team meeting that is discussing a new referral. The referral is for a 34-year-old woman named Chelsea who has two children aged under five years. She is a qualified accountant but currently not employed, due to caring responsibilities and assisting on the family farm. She has a partner of six years who’s connected to one of the town’s most influential and affluent farming families.

Two weeks ago, Chelsea was admitted to the hospital emergency department and reported it to the nursing staff as a farming injury. Her left hand had been caught and semi-crushed in a gate when helping with the moving of sheep.

The project’s intake worker presents Chelsea’s initial assessment information to the team and says that in their conversation Chelsea disclosed that it wasn’t an accident and that her partner had rammed the gate closed on her hand on purpose. The intake worker says that Chelsea disclosed many past and current acts of violence that have been occurring in the relationship over the last six years.

The speech pathologist responds, ‘She’s a city girl, right? Moved up here from her desk job – what was it? Receptionist or something? Do you think she has an underlying mental health issue? I can’t imagine anyone from the Fraser family hurting their wife on purpose. Could she be overreacting to what was an honest accident?’

The mental health nurse replies, ‘At this time there is no history of mental health issues and I think we need to believe her reports of family violence, even though you might think it’s not that common around here.’

The trauma counsellor says, ‘Yeah, it’s been a tough couple of years for men, with the drought. Lots of families are pushed to the brink. Even the best of guys are not acting themselves – drinking more, lashing out. Men carry the burden of financial worries for the farms – we know this. Anyhow, I’m assuming we need to get her well and fit to care for the kids, so is the rehabilitation focus on daily care tasks and supporting of dependents?’

The speech pathologist speaks up again. ‘Well, if there’s domestic abuse, why has she stayed? I mean, seriously, if someone crushed my hand I wouldn’t be going back. Why do women stay? She’s probably a bit depressed, missing the city life. They’re both stressed and have had a one-off horrible fight that’s gotten a bit nasty, and now we’re all having to expose their dirty laundry.’

### Additional resources

* Family Violence Law Help, [*Domestic and family violence: Myths and misunderstandings*](https://familyviolencelaw.gov.au/domestic-family-violence/myths-and-misunderstandings/)
* United Nations Human Rights Office of the High Commissioner, [*Gender stereotyping*](https://www.ohchr.org/en/issues/women/wrgs/pages/genderstereotypes.aspx)
* Our Watch, [Responding to a disclosure of gender-based violence in a health setting](#_Responding__to) (above)

### Sample discussion questions and answers

1. **Discuss how gender stereotypes have impacted your life. Reflect on how they may have impacted your experience with the healthcare system, e.g. How you have been treated by healthcare professionals in your life?**

Students should be encouraged to reflect on their own experiences of gender. If they are new to this content or knowledge they may need to be introduced to gender stereotypes as a concept and discuss briefly what typical gender stereotypes exists in Australia generally, as well as in their own community. Some students may find this step uncomfortable or confronting to their notions of identity. Encourage them to sit with the discomfort and share your own experiences of gender stereotypes if you feel comfortable to do so.

1. **What are the family violence myths presented in the scenario?**

* Family violence is less of a problem in rural or regional Australia.
* Family violence only happens in low socioeconomic families.
* Victims provoke family violence.
* Family violence is a private matter.
* If victims don’t like the abuse, they could leave.
* Women often make false or exaggerated claims of family violence.

1. **Where can you see the condoning of violence occurring in this scenario?**

* Victim-blaming – the suggestion that Chelsea is mentally ill, and has made up or exaggerated about the violence’, and ‘Why do women stay?’
* Trivialising the violence – ‘Is she overreacting?’
* Justifying – good men are pushed to the brink when they commit violence, so it’s not their fault; stress causes violence.

1. **Discuss and identify the gender roles and stereotypes presented in this scenario.**

* There is no need for women-focused health services.
* People from the city can’t really handle rural life.
* Women in corporate settings are usually receptionists (not professionals).
* Women often overexaggerate the seriousness of violence.
* Women who are mothers are primarily concerned with tasks/occupations related to housework and childcare.
* Women are expected to give up work to be the primary carer.
* The husband is the provider, the head of the household, and in charge of financial decision-making.

1. **When responding to an incident of violence, we can sometimes reinforce the very gender stereotypes and norms that drive gender-based violence.What could you do to avoid reinforcing the drivers of violence? Does this strategy consider how violence might impact all groups of women, men and gender diverse people?**

Students should be able to describe at least one example of challenging the drivers of violence against women, e.g. believing a person when they make a disclosure; avoiding making assumptions about the person’s situation based on their gender, class, race, age etc.; supporting women’s independence and ability to make their own decisions.

1. **Chelsea has described experiencing violence and has a significant injury and rehabilitation process which would be increasing her risk. Using the internet, search for services (in your area) you could use as a professional to seek secondary consultation for a female client experiencing family violence.**

Provide time for this activity in class, or set it as a homework activity. Students should be able to identify one or more services locally or nationally that supports health workers to respond appropriately to disclosures or suspicions of family violence.

## Scenario 3 – Riaan and his mother

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| Audience/level | Purpose | Key concepts |
| Second- or third-year health students (before a placement) | * To provide students with the opportunity to reflect and identify their own ideas/values, assumptions and bias relating to cultural diversity, gender and family violence, including impacts for children. * To explore the drivers of gender-based violence and for students to identify risk, and discuss referral pathways for potential cases of gender-based violence. | Gender, gender-based violence, family violence, school location, children and families, impacts of violence on children, trauma responses in children, CALD communities and racism/racial bias, identifying risk and professional judgement, safety planning, appropriate referral and services. |

You are a sessional OT in an inner-city primary school. Your key role is to support children who are presenting as challenging in the class environment and to support the team to assess for possible learning difficulties, ADHD and/or ASD.

Seven-year-old Riaan Shah has been referred to you for being disruptive in class, constantly talking and interrupting other students at work, not engaging in assigned classroom activities, being aggressive when asked to follow instructions, and preferring to go off and read alone in the book corner. It is reported that he also startles easily and seems afraid of loud noises and has been seen rocking to soothe himself if particularly upset. It’s also been observed in the playground that he finds it difficult to engage with other children and tends to play on his own on the jungle gym.

The classroom teacher states that they’ve attempted to speak to his mother when she’s dropping Riaan off, but ‘her English isn’t good’ and it’s reported that the mother is pregnant and there is also another sibling around three years old. A letter was sent home about the concerns regarding Riaan’s behaviour, but the family has not been in touch. The classroom teacher comments to you, ‘It’s probably because his parents are refugees, which has impacted their parenting or something.’

From Riaan’s school file you know that his father was born in Australia and is university educated. There’s nothing on file about Riaan’s mother. You note from the file that the other language spoken at home is Hindi.

After spending some time with Riaan and talking more with teachers who previously taught him in grade one, you believe that he may be exhibiting trauma responses rather than having a learning difficulty or disability. You connect with the school welfare officer, who also happens to speak Hindi, and they agree to call Mrs Shah to make a time to meet. When they call the number, the phone is answered by Mr Shah who says that his wife does not have a mobile. The welfare officer asks if the family can visit the school to discuss supports for Riaan in class. Mr Shah is friendly but says he will tell his wife to speak to the teacher, saying that he is very busy and cannot talk right now as he is at work.

Over the next couple of weeks, it is difficult to locate Mrs Shah at the school pick-up and it is noted that she has now parked the car further down the street and that Riaan is walking to reach her. You and the welfare officer walk Riaan to his mother and have a brief conversation. From what the welfare officer translates for you, it seems that Mrs Shah was told by her husband to change how she dropped Riaan off and picked him up, and that although she wants to do what her husband says, she too is worried about Riaan. She says that Riaan is always nervous and has been having nightmares.

You suggest to Mrs Shah that she could attend the end-of-term party next week and that you and she could chat then. Mrs Shah agrees to this and seems positive, but does not turn up on the day.

Riaan continues to attend school but often arrives late and although he does not disrupt classes as much as he did, he’s becoming more withdrawn and has had two toileting accidents in the last fortnight. In a recent session you had with Riaan, he stated that ‘Mummy is stupid. She doesn’t speak English as good as me and Daddy.’

### Additional resources

* 1800RESPECT, [Domestic and family violence and children](https://www.1800respect.org.au/violence-and-abuse/children-and-young-people/children-and-violence/impacts)
* Raising Children Network (Australia), [Family violence: Effects on parents, children and families](https://raisingchildren.net.au/guides/first-1000-days/safety-and-security/family-violence-effects)
* Multicultural Centre for Women’s Health, [Challenging myths about culture and violence in migrant and refugee communities](https://www.mcwh.com.au/challenging-myths-about-culture-and-violence-in-migrant-and-refugee-communities/)

### Sample discussion questions and answers

1. **Reflect on what we know from the scenario about Mrs Shah, as a non-English speaking woman in Australia (a foreign country for her), pregnant, with two young children and no access to a mobile phone. How much control, decision-making and independence might she have over her own life?**

* Mrs Shah’s decision-making over her own life, including that related to her children and marriage, would be limited if she doesn’t speak English and doesn’t have her own communication device.
* Mobile phones provide a plethora of information that supports people to navigate their day as well as additional information and supports, and can even overcome language and communication barriers.
* Mrs Shah’s pregnancy and responsibility for a younger child would limit her mobility to some degree and make it hard for her to go some places, e.g. recreationally and socially.

1. **How might this situation make it easier for someone to choose to use violence against Mrs Shah?**

* Mr Shah is able to control the information that Mrs Shah receives and can influence her parenting practices, e.g. instructing her on how to pick up Riaan and interact with the school staff.
* As a migrant to Australia, Mrs Shah may have limited social and family supports in her community, therefore increasing her isolation and vulnerability.
* These factors can affect Mrs Shah’s ability to seek help, including information about support systems and how she can best ensure the safety of herself and her children.

1. **What are some of the assumptions being made about each member of the Shah family? What barriers might be occurring for them?**

Mrs Shah:

* The teacher assumes that both Riaan’s parents are refugees when in fact there is nothing to indicate that Mrs Shah is a refugee – just that she doesn’t speak English.
* The assumption that in coming from a different culture Mrs Shah’s parenting style may be different and potentially the cause of Riaan’s behavioural issues. The attitude and practice of attributing particular behaviours to culture puts victim-survivors and their children at further risk, as their real needs may be overlooked, and can be a barrier to reporting if they think any reports of violence may not be taken seriously.
* When a parent is experiencing abuse it can make it hard to manage daily activities and meet a child’s needs.
* Even though the school welfare officer speaks Hindi, there may still be language or interpretation barriers that occur in the exchanges they have with Mrs Shah. Unconscious bias affects us all and can influence our thinking if it is not explored, examined and interrupted.
* Mrs Shah may be fearful of race-based discrimination or assumptions about her culture, which may make it difficult to speak honestly with the interpreter about what she’s experiencing at home.

Riaan:

* When children exhibit behavioural problems such as acting out, withdrawing and toilet accidents at school, it can be interpreted as a disorder or learning difficulty. However, these can also be indicators of trauma induced by experiencing or witnessing family violence.

Mr Shah:

* The teacher assumes that both Riaan’s parents are refugees when in fact Mr Shah was born and educated in Australia.
* Non-Anglo-Celtic men often face racial discrimination and assumptions about the influence of culture and religion on their daily practices. This can lead to feelings of shame, oppression and disempowerment.
* If Mr Shah is experiencing negative emotions or personal challenges, e.g. in his work or marriage, he may face barriers to help-seeking as a result of fear of racism or misunderstanding from mainstream services, or an absence of men’s formal and informal supports within his community.

1. **Reflecting on Riaan’s last comment, in which he puts down his mother’s English skills, discuss what this might reveal about what is possibly happening at home.**

It is likely that Riaan has picked up this attitude from his father, who speaks English and is able to use his proficiency in English as a way to exert power over Mrs Shah and separate her from her own son. This is a common tactic used by perpetrators of intimate partner violence against migrant women.

1. **Choose the suggestion that you think would be the best course of action to respond to this family’s situation, and explain your choice:** 
   1. **There isn’t much you can do because it’s not really clear if violence is occurring. It could be cultural factors or a misunderstanding with English. Continue to talk to the teachers and continue sessions with Riaan, asking questions when you can, to get more information and see if you can confirm there is violence occurring at home.**
   2. **Go to Riaan’s house to talk to Mrs Shah and collect more evidence to support your suspicions that violence is occurring. Then contact child protection and report your concerns.**
   3. **Work with senior school staff to create a clear care and safety plan for Riaan. Connect with a local culturally and linguistically diverse (CALD) family violence service and seek secondary consultation regarding how you could engage with the mother and any possible risks to be aware of. Continue sessions with Riaan, assuming that home might not be a safe place, and keep activities focused on classroom-related behaviour and sensory experiences.**
2. There is something everyone can do. Gender-based violence is a social problem and will only be eliminated when everyone plays their role. However, it is inappropriate to talk about the issue with anyone other than senior staff and those qualified to support risk assessments and safety planning for Riaan and his mother. It is also inappropriate to try to solicit information from Riaan about his home situation, as it can risk retraumatising him.
3. It would be dangerous to approach Mr Shah directly, especially without the consent of Mrs Shah, as this could cause suspicion on his part and potentially aggravate the situation at home. Likewise, a report to Child Protection without getting Mrs Shah and Riaan to safety could potentially worsen the situation if Mr Shah becomes aware of the report.
4. This would be the best course of action. Working with qualified staff and specialists will ensure you follow all the necessary legal and ethical protocols. CALD services will be best placed to understand the specific types of barriers that Mrs Shah is facing, and how to keep her and Riaan safe. They would also understand the most effective way to approach the issue with Mr Shah, understanding some of the constraints or barriers he may face when seeking help and support.

## Scenario 4 – Something doesn’t feel right

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| Audience/level | Purpose | Key concepts |
| Third- or fourth-year health students | * To explore the construction of gender from an intersectional perspective and the role this plays in determining risk factors including gender-based violence. * To explore a response that a practitioner could take when supporting a client. | Community health setting, social determinants of health, disability, intersectionality, supporting independence, home visiting, violence against women, intimate partner violence, risk assessment, risk management, planning a response and specialised referral. |

You’re working for a very busy community health service located in the city centre and the team you’re assigned to is delivering an NDIS- and state government–funded pilot program. The program aims to work with corporate agencies and local business to support people living with a disability to secure and or maintain their employment.

Hong (Rose) has self-referred to your service and her case is assigned to you. When you first meet, she tells you that Rose is her English name, but that she’d prefer you to call her by her Vietnamese name.

Hong is a 37-year-old woman with cerebral palsy diplegia. She has the use of a customised wheelchair that supports her day-to-day mobility and she lives in a one-bedroom rental flat that has been slightly modified for her needs through her NDIS plan. The flat is located on the same street where her older brother lives with his wife and two children. Her parents are both aged in their late sixties.

Hong identifies as Australian-Vietnamese. Both she and her brother were born in Darwin, her parents having met there as teenagers in 1977, when they first came to Australia as refugees following the Vietnam War.

Hong’s father is a retired primary school teacher, and her mother works part-time as a cleaner at the local hospital and has always been the primary carer for the family.

When Hong was diagnosed with cerebral palsy in childhood, her parents experienced discrimination from strangers and from people in the Vietnamese community in Darwin. Hong’s mother once told her that a woman from the community had said ‘your father and I must have done something terrible in a past life to deserve a daughter like you.’

Because of this discrimination her parents moved to Sydney, as they believed that, living in a bigger city, it would be easier for Hong to not ‘stand out’ and to find other people ‘like her’. Her father, who had difficulty finding permanent work in Darwin, was able to find a job teaching in a local school.

Hong’s parents have always supported her study and her educational and social interests, like chess club. Hong’s mother especially has encouraged her to become ‘smart and successful’. But both her parents have discouraged her from having boyfriends, and Hong has never introduced them to the few men she’s dated.

Her brother describes their parents as having ‘some traditional views on people with a disability’. He has always been Hong’s ‘secret’ ally and when she was in her twenties, he supported her in having nights out and what he describes as a more ‘normal social life’.

Hong’s verbal capacity is slightly impacted by the cerebral palsy, but she is understood by others. She is an administration manager for a small law firm that is located next door to the health service. She has worked there for the last three years. Recently, she has started to have difficulty with a number of self-care tasks, such as showering and dressing herself. She is also having difficulty with some fine motor tasks such as using a phone charger. She knows that this is a symptom of cerebral palsy, and that in future she’s likely to need increased support to live and work independently.

Hong does not have a car, but gets about by public transport or wheelchair-friendly taxis.

As you begin to assess Hong’s self-care and work needs you learn that in the last two months she’s reconnected with an old boyfriend from her university days, Richard, who’s just moved into the flat with Hong. Hong describes it to you as a ‘whirlwind romance’.

You ask if Hong would like Richard to be included in any of the self-care supports, or present for the upcoming home visit to complete a shower assessment. Hong says, ‘He’s very busy and I’ll take a personal leave day for you to come to the house during office hours.’

At first this does not cause you any concern, as showering can be a very private activity and not all clients want to involve their romantic partner. But the next week Hong presents at reception seeming stressed. She asks if the centre has facilities for battery charging and if she could borrow a fully charged mobility battery. She says her spare battery has somehow gone missing and the one in use is very low and would not get her through a full day of work. You know that Hong is very independent and organised and this seems out of character for her.

When you’re saying goodbye to Hong at reception after an exercise appointment, a man walks up and says, ‘Rose, is everything alright?’. Hong seems shocked and flustered. She introduces Richard to you and tells him that she’s just having an annual health check. Richard speaks directly to you, saying, ‘I thought I’d be romantic and surprise Rose with dinner after work and her office said she was here, next door.’ He seems genuine and friendly, but you notice that Hong seems unusually quiet and uncomfortable. You’re also surprised that he uses the English translation of her name and not Hong, which she always uses herself and says she prefers.

When you attend the house for the shower assessment, you’re surprised to see Richard is present. He’s friendly again and says, ‘Rose is going to let me help her more, so she doesn’t have to have strangers care for her. That’s the last thing we want, if we can help it.’

You feel uncertain about the situation. When you and Hong planned the assessment, she was very clear about her wants and the day and time of the visit. You ask if this time still suits Hong and she nods her head and agrees verbally and presents as smiling, but you notice the same slight strain and quietness that occurred when Richard surprised her at the health service.

Throughout the home visit Richard is attentive and caring to Hong and very interested in the processes you discuss, asking lots of questions, and Hong seems to get more quiet and less involved. There are so many things that just don’t feel right on this visit, and weighing them up you decide not to complete all aspects of the assessment. You tell Hong you’ll be in touch to discuss the next stage once you’ve had a chance to check the health service appointment calendar.

### Additional resources

* Women with Disabilities Victoria, [*Resources to accompany ‘Prevention of violence against women with disabilities: Workforce resources for action’*](https://www.wdv.org.au/resources-to-accompany-prevention-of-violence-against-women-with-disabilities-workforce-resources-for-action/)

### Sample discussion questions and answers

1. **Reflecting on the social determinants of health, what role does gender play in Hong’s health outcomes? What other determinants are influencing Hong’s experience of health? (Note: Health is more than just the absence of illness.)**

* Gender – as a woman with a disability, Hong’s parents have discouraged her from having intimate relationships, likely based on stereotypes about women with disabilities. This silencing and denial of Hong’s right to be in a relationship makes her more likely to be targeted with violence, as it limits her access to information about how to navigate difficult relationships. In addition, it puts her sexual and reproductive health at risk if and when she becomes sexually active.
* Disability – living in an ableist society means that Hong may face discrimination from people who do not accept or understand the nature of her life or her disability, e.g. the community in Darwin, whose discrimination led to a change in location. While her wheelchair gives her a greater level of freedom to move around independently, it relies on her being able to keep the battery charged. Some buildings may not be wheelchair accessible, which can limit some of her movement and choices also.
* Ethnicity – Hong’s parents are migrants and are likely to have had to sacrifice family and community in order to provide new opportunities for their children in Australia. This may influence their treatment of Hong in terms of defining success around employment and education at the expense of social and romantic relationships, which may be less valued.
* Geographic location – living in an urban setting gives Hong more social and employment options, which can contribute to her independence and overall wellbeing.
* Employment – Hong’s employment status in the law firm helps her to stay mentally and physically active and contributes to her sense of confidence and autonomy in her life, providing an income to support her choices as an adult and seek the supports and services that allow her to have a full life.

1. **Besides gender inequality, how else does power and oppression shape Hong’s experience? (That is, does racism, homophobia, ableism or ageism impact her experience too?) How might these contribute to the possible risk of Hong experiencing gender-based violence?**

* Hong’s power would come from being Australian-born and educated and resident in a capital city where she might have better access to education, employment and disability services than if she was living in regional Australia. The infrastructure and culture of the city may be more accommodating for a person who uses a wheelchair.
* On the other hand, Hong’s gender as a woman and her disability make her more likely to be a target of violence. Her parents don’t acknowledge the validity of her relationships, and this may create barriers to seeking support as well as feelings of guilt or shame if she’s been taught it’s not normal or acceptable for people like her to be in relationships.
* There is a distinct power imbalance in her relationship with Richard, based on gender, disability and race. He is Anglo-Celtic and able-bodied, and there is the potential for him to exploit this power through controlling behaviours and limiting her decision-making and independence, which can drive violence.

1. **Can you identify evidence to indicate that Hong might be currently experiencing controlling behaviour from Richard?**

* Her nervousness when he surprises her at the clinic might indicate that it makes her uncomfortable when he’s able to track down her location.
* Her inability to find her spare battery and her other battery being undercharged when she’s usually quite organised suggest that Richard has intentionally hidden her battery.
* Calling her by her English name instead of her Vietnamese name might be a sign Richard doesn’t value her Vietnamese heritage and/or respect her choices to be called by the name she prefers. This is a form of microaggression which belittles Hong’s Vietnamese roots.
* Appearing at the assessment meeting when Hong had indicated she preferred to do it in private, and went to the effort of using her personal leave to achieve that, suggests that Richard is not respecting Hong’s boundaries around her privacy and independence.

1. **Why do you think the health professional chose to discreetly leave the assessment incomplete and attempt to engage directly with Hong at another time? What could you, as the OT, ask when you next speak with Hong?**

* The practitioner senses that something is not quite right and is looking for an opportunity to have a one-on-one interaction with Hong, to facilitate a conversation where she might feel comfortable to open up about what’s happening in her relationship, e.g. why she appears stressed whenever Richard is around.
* Health practitioners can also experience violence in the workplace, so this strategy also takes their own safety into consideration, aiming to avoid aggravating or triggering Richard and risking the situation escalating.

1. **Using the internet, find two family violence or women’s support services you could refer Hong to.**

Provide time for this activity in class, or set it as a homework activity. Students should be able to identify one or more services locally that support women with disabilities who are experiencing gender-based violence.

## Scenario 5 – Being Trina

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| Audience/level | Purpose | Key concepts |
| Fourth-year health students | * To support students to explore a young trans woman’s experience of gender, gender stereotypes, gender norms, gender identity discrimination, trauma, homelessness, and structural and social impacts on mental health and identity. | Community health setting, social determinants of health, intersectionality, LGBTQIA+/Queer experiences, gender identity, trauma, homelessness, violence against women, historical sexual assault, mental health, critical reflection, protecting future practice from enforcing gender norms. |

You work in a housing support service that runs a day program for people experiencing homelessness or who live in unstable accommodation and identify as being part of the LGBTQIA+ community.

Trina has been attending your mental health support program for the last two months. She is a 23-year-old trans woman who, in Trina’s words, was ‘kicked out’ of home as a 15-year-old when she began to dress in women’s clothes and talk about herself as a girl. Trina said, ‘They wouldn’t give up Caleb for Trina. He was more important to them, so for Trina to live, there was no choice. I had to go.’

While Trina’s parents and siblings were unsupportive of her new gender identity, Trina’s aunt openly supported her. She lived with ‘Aunty D’, who assisted Trina to begin the transition from being male to female. This included helping and encouraging Trina to dress and move about in public spaces as a girl and to consult with Aunty D’s general practitioner. Aunty D enrolled Trina in a progressive public school, whose staff and students supported Trina’s transition. Trina was pleased when she got into uni and had just begun studying an arts degree when Aunty D died suddenly of a heart attack. Trina was 21 years old.

At the time, Trina had a casual fast food job and was able to find accommodation in a share house. But six months after moving in she was sexually assaulted by one of the male housemates and his friend, when they discovered that ‘I wasn’t a real chick and they wanted to teach me what it was like to be a woman.’ Trina did not report the assault to police because she didn’t think she’d be taken seriously.

Trina began to drink heavily after this event and had difficulty finding stable and safe accommodation. She was also finding it increasingly difficult to trust people.

Trina has been living in her car for the last 18 months and this has significantly impacted her physical health, emotional wellbeing and connection to others. She’s been unable to access women-only homelessness services because of their service criteria which require, for the safety of everyone, that clients identify as biological women. In addition, due to the assault perpetrated by her previous housemate, Trina is fearful of seeking accommodation in a generalist homelessness service or rooming house.

Trina was accepted for medium-term case management support at your service and has applied for priority public housing, but there’s a long waiting period. Trina was recently told by her housing worker, ‘Perhaps you should just give up the woman act for a bit so you can get housing. Then, once you’re stable, you can be who you want.’

Trina wants to get information about taking hormone therapy to support her full transition, but due to her unstable accommodation situation it’s been difficult for her to find a regular and supportive GP who can advise her. Also, due to her lack of money, regular drinking, and limited access to regular food and other resources, there are a number of other challenges.

Trina has expressed to you that she wants to complete her transition more than she wants to find stable accommodation. But you worry for her because you know that medication and surgery can be prohibitively expensive.

In yesterday’s support group the women were sharing stories of how they’re treated by the community and things that people say to them. Trina said, ‘I feel like whenever I try to ask for help everyone treats me like I’m crazy. When my aunt died, I lost it a bit, you know. Like, not sleeping much, and drinking. I was just so sad. I went to a GP who just wanted to give me pills. They asked if I wanted to do an assessment for a personality disorder – maybe I was bipolar. All this medical stuff. I was grieving! Now I’m homeless, broke and sleeping in my car and everyone assumes I’m crazy. Just on my way here, some guy bumped into me in the street, hard, and didn’t even acknowledge it, and I was like ‘Excuse me!’. I said it really loud and he called me a crazy bitch. No one even looked or cared. Then I got really angry at him and yelled a bit, and he kept walking, then some shopkeeper dude came out and was like ‘Settle down. Do you want me to call the police on you?’. I mean, a guy can smash into me and verbally abuse me, but if I react and try and stand up for myself, *I’m* the problem? It makes me so frustrated.’

### Additional resources

* Rainbow Health Victoria, [*Pride in Prevention: A guide to primary prevention of family violence experienced*](https://www.rainbowhealthvic.org.au/news/launch-pride-in-prevention-evidence-guide)

### Sample discussion questions and answers

1. **What events or statements are examples of others trying to police or enforce socially acceptable gender norms or behaviours on Trina?**

* Being told by her housing worker that her transition is an ‘act’, rather than a response to her feelings of gender dysphoria.
* Her parents kicking her out of home.
* The male housemate and his friend saying she wasn’t a real chick and they wanted to teach her what it was like to be a woman.
* The GP who just wanted to give her pills, asked if she wanted to do an assessment for a personality disorder, said maybe she was bipolar.
* The man who bumped into her calling her a ‘crazy bitch’ and and the shopkeeper saying, ‘Settle down. Do you want me to call the police on you?’ when she tried to hold the man in the street to account.
* Trina not going to the police about the assault, fearing that she wouldn’t be believed.

1. **Where has violence, oppression and discrimination occurred to Trina, based on her gender identity?**

* Being abandoned by her parents because they couldn’t accept her gender identity as being different to the one she was assigned at birth.
* The sexual assault by her roommate.
* The housing worker not validating the complexity of Trina’s situation, or her right to affirm her own gender identity, implying that it was attention seeking behaviour that she could turn on and off.
* Exclusion from safe housing and accommodation options.
* Verbal abuse from the man in the street who bumped into her and the shopkeeper who blamed her for causing the incident.

1. **Which of these examples reflect individual attitudes and behaviours? Which examples are the product of organisational or systemic conditions?**

Individual:

* Trina’s family’s rigid attitudes towards gender identity.
* The roommate and his friend choosing to sexually assault her.
* The attitudes of the GPs who don’t support Trina’s specific needs, related to transition, grief, trauma, etc.
* The housing worker’s comment about the ‘woman act’.
* The actions of the men in the street.

Systemic:

* The social and medical practice of assigning of gender at birth based on biological sex establishes a framework for cisnormativity that continues throughout life and creates multiple barriers for the people who later discover that they don’t identify with the gender they’ve been assigned. This is reinforced by the individual attitudes and behaviours of all the characters who exhibit violence or discrimination, or try to police Trina’s gender.
* The belief that the police will not provide respectful and supportive services to a transgender woman reporting a sexual assault is evidence of a culture of victim-blaming in that institution, and society more broadly.
* The housing system does not accommodate the specific needs of gender diverse people, who are at especially high risk of experiencing homelessness, social isolation and violence and are in need of safe housing.
* The high cost of a medical/surgical transition means only very wealthy/privileged people can complete their gender transition in this way.

1. **Reflect on and write down common responses to women when they express their anger or other emotions. Are there similar common responses to men, when they express their anger? If not, why do you think that is the case?**

* Examples might include ‘Calm down!’, ‘No need to get aggro!’, ‘She’s mad/crazy!’, ‘Crazy bitch!’, ‘No need to be so emotional!’, ‘Why are you so easily upset?’, ‘Don’t be so over the top!’, ‘You’re so irrational’, ‘Don’t be hysterical’, etc.
* Anger, aggression and similar negative emotions are associated with masculinity and condoned within the social framework of rigid gender norms and stereotypes. When women express similar emotions they are often policed, because it doesn’t conform with gender norms of femininity, which dictate that women should be gentle, caring, communicative, placid, and even passive.

1. **How can you ensure your future practice doesn’t reinforce gender norms or behaviours on your clients or co-workers? Reflect on actions at the individual, interpersonal and organisational level.**

Examples might include:

* Identifying and challenging your own biases and assumptions around gender; avoiding using gendered language; committing to learn more about the impacts of gender-based discrimination on people different to yourself.
* Asking people their preferred pronouns; having conversations with colleagues about gender equity and how to prevent violence; being an active bystander when you witness discrimination.
* Promoting the implementation of policies and procedures in the workplace that promote equity, inclusion and non-discrimination.

# Interviews with health practitioners

These videos have been produced to support teaching about the ways in which professionals working in health settings understand and aim to address the issue of gender-based violence in their work.

These are examples of some workers and their views and do not represent the wide variety of workplace experiences in this field.

The individuals and cohorts represented here might spend a lot of their time either dealing directly with victims and perpetrators of violence or supporting those who do. In this regard, the scope of their work might primarily be categorised as tertiary prevention (response). However, they are able to describe some of the ways in which their day-to-day work can address the drivers of gender-based violence and contribute to a primary prevention approach.

Each of the interviews is representing an institution, organisation or sector as well as their individual roles. Their views do not necessarily represent the views of Our Watch and the evidence base that guides Our Watch’s primary prevention work.

A critical lens is essential to viewing these videos, and students should be encouraged to discuss and analyse the content to identify key themes and practices that relate to the primary prevention of gender-based violence. To support an intersectional analysis, encourage them to consider the subtext of power and privilege in each video.

## How to use these videos

These videos can be shown to students in class or as part of tutorial previewing. They should be contextualised with background material about primary prevention work, the drivers of gender-based violence and an intersectional approach. They should also be followed up with a facilitated discussion to unpack and analyse their content. You may choose to use them in conjunction with one of more of the scenarios included in this resource.

The videos do not represent an exhaustive list of practitioner experiences, or of roles in which people have the opportunity to support the prevention of gender-based violence. Refer to the [*Educators’ guide to upskilling preservice professionals to support the prevention of gender-based violence*](https://handbook.ourwatch.org.au/leadership-resource/educators-guide-to-upskilling-pre-service-professionals-to-support-the-prevention-of-gender-based-violence/?utm_source=PDF5&utm_medium=PDF+5%3A+Teaching+resources+prevention+of+gender+based+violence+in+and+through+health+settings) for guidance on developing your own teaching resources.

## Stacey Swindon – Occupational therapist

|  |  |  |  |
| --- | --- | --- | --- |
| Audience/level | Purpose | Key concepts | Duration |
| Occupational therapy students | * To explore the role occupational therapists can play in the prevention of gender-based violence, drawing on prevention frameworks and best practice. | Drivers of gender-based violence, family violence, health setting, gender stereotypes, client disclosures of violence. | 9′48″ |

### Screenshot from video of Stacey Swindon, occupational therapist

### Watch video

* Original version – YouTube, [*Prevention of gendered violence and occupational therapy, Stacey Swindon*](https://www.youtube.com/watch?v=ojHnzAcEfIU)
* Audio described version – YouTube, [*Prevention of gendered violence and occupational therapy, Stacey Swindon, audio description*](https://youtu.be/0r8LL_kPDEA)

### Summary

Stacey Swindon is an experienced occupational therapist. In this Q&A she describes the way in which gender plays out in her professional practice and identifies some of the ways in which she tries to address the drivers of gender-based violence in her role as a therapist and as a colleague.

| Time | Topic |
| --- | --- |
| 0′27″ | Introduction |
| 1′00″ | Why does gender matter in relation to your work as an occupational therapist? |
| 1′41″ | Where do you see gender stereotypes come up in your work? |
| 2′49″ | Where do you see gender-based violence in your work? |
| 3′54″ | What do you do when clients disclose experiences of violence? |
| 4′47″ | What do you do to help prevent violence? |
| 5′49″ | What makes your work more effective in relation to promoting gender equity and preventing violence? |
| 6′52″ | What are the challenges? |
| 8′18″ | What advice would you give to other OTs going into the workplace? |

### Discussion

1. What is your reaction to the interview? What surprised you about the interviewee’s responses?
2. What do you understand about the difference between a health practitioner’s work in tertiary response and primary prevention?
3. What kind of gender stereotypes might Stacey be referring to in relation to people’s relationships, in the home, in the workplace and in friendships? Where do you see an opportunity as a practitioner to challenge some of these stereotypes?
4. Why is it important to create safe and non-judgmental spaces for clients who choose to disclose an experience of violence? How does this help to prevent gender-based violence from happening in the first place?
5. Where do you think gender bias might come up in professional practice? What other biases might affect the way you treat and interact with clients and colleagues? What can you do as a professional to challenge or interrupt your biases?

### Discussion points

* Occupational therapists often come into contact with people who have experienced gender-based violence. Occupational therapists have a professional responsibility to recognise the signs of gender-based violence, respond appropriately and respectfully when a client discloses an experience of gender-based violence, and to refer them on to specialised support or counselling services. In some states and territories occupational therapists are mandatory reporters of family violence and have a legal obligation to report suspected or known abuse or neglect.
* Occupational therapists also need to maintain a focus on how they can contribute to the primary prevention of gender-based violence – that is, stopping it before it begins. This is achieved by addressing the drivers of gender-based violence, such as rigid gender stereotyping and the condoning of violence against women.
* Gender stereotypes are seen in the profession when engaging with people’s perceptions of their own occupations, in relationships, in the home, in the workplace, in the community, etc. This might relate to the domestic roles and activities they undertake, or the types of work they do, both paid and unpaid. It can also show up in the OT profession in the way that other health practitioners regard and interact with occupational therapists, a highly female-dominant occupation. Stereotypes may also be prevalent about groups of women that OTs work with as colleagues or clients, such as women with disabilities, First Nations women or migrant women.
* Occupational therapists have an opportunity to help clients understand that there’s no limit to the occupations they can engage in. They can do this through providing education in supportive and tailored ways to help clients engage with potentially new ideas about gender that will help them better understand their rights and responsibilities – for example, that they deserve to be treated and spoken to respectfully by their family members, who may try to exercise power over them.
* Condoning of violence against women occurs when victim-survivors are either blamed for the violence they experience, or perpetrators of violence are excused from taking full responsibility because the violence is seen to be trivial, provoked or ‘out of character’. This helps to drive gender-based violence because it fails to make perpetrators accountable for their actions, and it can shame or traumatise victims into believing they are somehow responsible, or deserved the abuse. Low levels of accountability of perpetrators can lead to low levels of help-seeking on the part of victims because they don’t feel supported or validated., This makes it easier for anyone to choose to use violence, either for the first time or in an ongoing way.
* By ensuring that people who experience violence don’t feel judged, are believed, and feel that there is a benefit to disclosing their experience (either to ensure their own safety or to report the violence and seek justice), the focus shifts from what the victim-survivor is doing to what the perpetrator is doing. Framing the issue of violence as a problem of perpetration in every instance will support new attitudes and behaviours, and contribute to new systems and processes, that challenge the condoning of violence against women.
* Everyone has a bias of some sort, based on gender or other factors. These can be positive or negative and often operate unconsciously to influence automated behaviours in relation to our perceptions, beliefs, communication styles, body language and values. Sometimes they are conscious and lead to an open acknowledgement of prejudice. Biases of health practitioners need to be acknowledged, explored and examined so that they don’t lead to some clients or colleagues being treated more or less favourably.

### Additional resources

* Liedberg, G.M., Björk, M., & Gunnel Hensing. (2010). [*Occupational therapists’ perceptions of gender – a focus group study*](https://pubmed.ncbi.nlm.nih.gov/20868422/)*.*

## Abbey Newman – Family violence specialist in a forensic care setting

|  |  |  |  |
| --- | --- | --- | --- |
| Audience/level | Purpose | Key concepts | Duration |
| Social work, mental health students | * To explore the role mental health specialists can play in the prevention of gender-based violence, drawing on prevention frameworks and best practice. | Drivers of gender-based violence, family violence, mental health setting, justice setting, victim-blaming, rigid gender stereotypes, privilege, intersectionality. | 11′03″ |

### Screenshot of video of Abbey Newman, family violence specialist in a forensic care setting

### Watch video

* Original version – YouTube, [*Prevention of gendered violence and forensic health – Abbey Newman*](https://www.youtube.com/watch?v=E5WaIvy-9Z0)
* Audio described version – YouTube, [*Prevention of gendered violence and forensic health – Abbey Newman, audio descri*](https://www.youtube.com/watch?v=vTfr47QLFaE)*ption*

### Summary

Abbey Newman is a qualified social worker who has nearly two decades’ experience working in the family violence sector in mental health, justice and tertiary education settings. In this Q&A she describes the way she supports workers in the mental health and justice sectors to bring a gender and prevention lens to their work; how she supports colleagues to address the drivers of gender-based violence; and some of the things that make her prevention work more successful.

| Time | Topic |
| --- | --- |
| 0′17″ | Introduction |
| 0’42” | How does your work bring family violence, justice and mental health together? |
| 1’42” | How do you apply a family violence lens in these settings? |
| 2’32” | Where do you see the drivers of gender-based violence come up in your work? |
| 5’04” | What does the condoning of gender-based violence look like? |
| 6’50” | What tools do you use to support others to incorporate primary prevention into their work? |
| 7’44” | What makes your prevention work more successful? |
| 9’42” | What advice do you have for other workers in mental health and justice settings? |

### Discussion

1. What is your reaction to the interview? What surprised you about the interviewee’s responses?
2. What do you understand about the difference between tertiary response and primary prevention?
3. Why do you think there might be tension between the medical model of diagnosis and a family violence framework for understanding and treating some mental health conditions that are impacted by family violence? Why is it important to use both?
4. Can you recognise examples of victim-blaming in your placement experience, or your personal life? Reflecting on intersectionality, what assumptions do you think are often made about people who experience gender-based violence?
5. Why is it important to understand a person’s privilege in the context of them using or experiencing gender-based violence? How does this understanding contribute to the prevention of gender-based violence?

### Discussion points

* First responders to incidents of gender-based violence need to treat victim-survivors with sensitivity and respect, and be attuned to the subtle indicators of family violence. Abbey’s work in forensic hospitals and in courts often deals directly with people who use and/or experience gender-based violence. However, the drivers of gender-based violence such as the condoning of violence against women and rigid gender stereotypes show up in many contexts, including in health settings.
* A whole-of-community approach to primary prevention means every organisation, institution and person plays a role in addressing the drivers of gender-based violence and promoting gender equality. Abbey works with mental health professionals who bring a medical and diagnostic approach to health issues such as family violence, but who also have the opportunity to identify and challenge the drivers of gender-based violence in their professional practice.
* International and Australian research demonstrates that gender-based violence and family violence is driven by gender inequality, gender stereotypes and gendered assumptions. Gender inequality manifests as norms, practice and structures that operate at both the individual and systemic level. A medical model focuses on the individual only, and as a result may not be able to identify how certain types of attitudes and behaviours are not unique to an individual’s case but rather part of a pattern of gender bias, discrimination and inequity across society.
* Taking into consideration a person’s environmental factors and how this may influence how they use violence or experience violence reduces the likelihood of condoning violence through excusing a perpetrator’s behaviour or blaming the victim. Addressing the condoning of violence contributes to the prevention of gender-based violence across society.
* There are many ways in which victim-blaming occurs, shifting some or all of the blame from the perpetrator to the victim. Common types of victim-blaming can disproportionately impact women with intersecting identities who are experiencing gender-based violence, and can make it harder for them to seek help. For example, an Aboriginal woman might be blamed for not reporting family violence to the police when in fact they may distrust government agencies due to the history and ongoing impacts of colonisation. Blaming the ‘culture’ of a migrant woman for the violence she is experiencing is a way of absolving perpetrators of responsibility for their actions and might make the survivor feel that she will not be taken seriously, and hence reluctant to report and seek help.
* Privilege is about power that is granted to someone without merit. Gender-based violence is more likely to occur when there is a power imbalance between women and men. Men who use violence often do so to reassert their male privilege in a context where their rigid notions of masculinity are being challenged, undermined or threatened. In order to address violence at its core we need to challenge the rigid gender roles and dominant forms of masculinity that men who choose to use violence are often trying to protect or defend. Challenging harmful forms of masculinity helps to support men and boys to develop healthy masculinities and positive, supportive male peer relationships, which are actions to address the drivers of gender-based violence.

### Additional resources

* Australia’s National Research Organisation for Women’s Safety. (2020). [*Violence against women and mental health*](https://www.anrows.org.au/publication/violence-against-women-and-mental-health/). (ANROWS Insights, 04/2020).
* Our Watch. (2019). [*Men in focus: unpacking masculinities and engaging men in the prevention of violence against women*](https://www.ourwatch.org.au/resource/men-in-focus-unpacking-masculinities-and-engaging-men-in-the-prevention-of-violence-against-women)

# Text-equivalent description of decision tree

This decision tree describes how to respond appropriately to a disclosure of gender-based violence in a health setting.

## If you see signs of indicators that gender-based violence is present.

* If you are a mandatory reporter, follow workplace polices and consult your supervisor.
* Make a sensitive inquiry. Ask: You seem stressed – is everything OK?

## If the answer is yes, everything is OK, not experiencing violence.

* Respect their answer and let them know where to seek support if they ever need it. If you still have serious concerns about the person, consult your supervisor.

## If the answer is no, things are not OK.

* Let them know that you are there to support them. Let them know the limits of your confidentiality, particularly with regards to children’s safety. Listen to the person closely with empathy and without judging.
* Ask the following questions to identify whether gender-based violence is occurring:
  + Has anyone in your family done something to make you or your children feel unsafe or afraid?
  + Have they controlled your day-to-day activities (e.g. who you see, where you go) or put you down?
  + Have they threatened to hurt you in any way?
  + Have they hit, slapped, kicked or otherwise physically hurt you?

## If the answer is no, not in immediate danger.

* While it is indicated there is no immediate threat, there may still be a serious risk.
* Ask: Can I refer you to a specialist?

## If the answer is yes, violence is occurring. Establish immediate risk.

* Ask: Do you have immediate concerns about your own safety or someone else in your family?

## If the answer is yes, in immediate danger.

* Establish their willingness to act.
* Ask: Can I offer you further assistance? Would you like me to call the police?

## If the answer is no, they do not want to seek assistance.

* Consider child wellbeing and safety and consult your manager to share information if needed.
* You can call a violence service with de-identified information for advice as well.
* Provide them with information about the help and support that is available, including emergency numbers. Let them know that they can get help if things change.

## If the answer is yes, they are willing to receive assistance.

* If it is safe to do so and they are in immediate danger, call the police, or encourage them to call the police.
* Provide them with the numbers and details of specialist violence services to assist with safety planning and support.
* Consult with your manager, DFV specialist and/or a specialist violence service.

[Return to text following decision tree](#_Scenarios).