Addressing domestic violence: improving the health care response

A training toolkit

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List of Acronyms

DV: Domestic violence
ECP: Emergency contraceptive pill
GBV: Gender based violence
HIV: Human immunodeficiency virus
IPV: Interpersonal violence
IUD : Intrauterine device
PEP: Post exposure prophylaxis
STI: Sexually transmitted infections
VAW: Violence against women

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Foreword

Domestic violence is an attack on human rights with a devastating impact on public health. Historically it has been seen as a private matter within the family with no role for health care professionals other than dealing with its medical consequences including lacerations, fractures, gynaecological problems, chronic pain depression, anxiety and post-traumatic stress disorder. There is now a growing recognition internationally, as reflected in the WHO guidelines on intimate partner violence and sexual violence against women and girls[1], that health care services need to respond compassionately and effectively to patients experiencing abuse.To practice medicine competently we need to understand the aetiological role of abuse in many conditions, recognize the indicators of abuse, ask patients about their experiences, and respond appropriately and safely, helping access the support they need. Although building on the skills that doctors learn as part of our medical training, there is specific knowledge about abuse and competencies in identifying victims/survivors and provision of appropriate support that we also need to learn

A key recommendation of the WHO guidelines is training of health care professionals, a pre-requisite to addressing the needs of patients experiencing abuse. This toolkit, built around a series of training videos, focuses on the consultation between doctor and patient. Through the text and the videos it gives a comprehensive framework for training clinicians in asking about and responding to abuse. It includes sensitivity to the patient's situation, such as family structure and values or legal aspects like refugee status. Most impressive is the detailed guidance on how to ask and how to respond to disclosure (or non-disclosure) of abuse. This toolkit is a substantial contribution to domestic violence training materials for doctors. It is a valuable contribution to training of doctors not only in Lebanon, but throughout the Eastern Mediterranean, with the potential to inform clinician training internationally.

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I- INTRODUCTION

Interpersonal violence (IPV) exists in all societies and among all socioeconomic classes to variable degrees. In Lebanon, despite the lack of population based surveys to assess the prevalence of the problem, the results of the few available studies suggest that it is quite prevalent. Exposure to violence is also an important factor affecting individual and population health, and should be a central concern for healthcare providers.

In 2002, a study supported by the United Nations Populations Fund (UNFPA) office in Lebanon revealed that 35% of women presenting to primary health care centers in Lebanon admitted being exposed to at least one form of domestic violence. They had significantly more symptoms and complained of poorer health when compared to women not exposed to violence (Usta, 2007). A school-based health survey revealed that almost 4 in 10 students (37.0%) were physically attacked by an adult family member one or more times during the month preceding the survey while almost 2 in 10 students (17.3%) reported being subject to sexual harassment (WHO, 2005). Similarly, in another study, 16.1% of children admitted experiencing at least one form of sexual abuse (Kafa, 2008), 65% reported at least one incident of psychological abuse at home in the year preceding the survey, 54% reported at least one incident of physical abuse at home and 30% witnessed violence at home (Usta, 2013). Children exposed to violence had more psychological symptoms when compared to those not abused. Moreover, wars and armed conflicts seem to increase the rates of DV; in a study conducted by UNFPA in 2012 to assess the reproductive health and GBV needs for Syrian women displaced to Lebanon, the Syrian women refugee situations reported high levels of domestic violence from which they are suffering in silence; some resorted to beating their children as a coping mechanism (Usta, 2012)

The above data suggest that IPV is strikingly prevalent in Lebanese society. Although women would prefer for the health system to actively address Domestic Violence (DV) and considered this to be a "socially accepted way to break the silence" (Usta 2012), physicians rarely broach the topic with their patients. This can be attributed to several reasons, one of which is lack of knowledge and skills in properly addressing this concerning issue. Moreover, improper choice of words and body language or inattentiveness to cues provided by the patient may potentiate the survivor's feelings of isolation and helplessness, thus reinforcing feelings of guilt and depression.

This toolkit was developed to enhance the capacity of the health care provider to address DV survivors, which goes in line with the recommendations of the UNFPA's situational analysis conducted from 2009-2011 (UNFPA, 2011). It is based on series of filmed interviews drawn from real life encounters. The first 5 interviews are supposed to enhance the skills of the health care provider to communicate with and care for IPV survivors: how to create a safe environment in which the patient can feel comfortable confiding experiences of domestic violence, gathering relevant information (history and physical) and appropriately documenting in the medical chart, ensuring safety and providing guidance, and referring to the various related services (soial, legal,shelter..) .

The other scenarios represent the application of these principles in specific situations: that of a child and of a sexual assault refugee survivor.

This toolkit contains also a manual in addition to the filmed scenarios. The manual has 4 major sections:

1. Background information about violence: definition, types, consequences and indicators. This section is meant to set the stage for a common understanding of violence among participants.
2. The basics of communication with violence survivors.
3. The role of the health care provider in the management of a survivor.
4. Transcripts of sample interviews with a violence survivor. Within these transcripts are boxes with guiding comments addressed to the facilitators of the training workshop for the points to be covered during the discussion. The first three present interviews with adult survivor, the 4th and 5th are improved versions of the first three. The 6th scenario introduces the special situation of a child survivor while the 7th is its improved version. The last 5 are interviews that address the specific case of a refugee who was subject to sexual abuse while the last is the improved version of the encounter with a refugee survivor of sexual assault.

This manual ends with VI annexes: the first provides examples for statements that can be used during the communication, the 2nd is the legislation related to DV that the physician should be aware of, the 3rd is a list of available resources to whom a DV survivor can be referred for help, the 4th is the treatment of survivors of sexual assault, the 5th is the workshop evaluation form and the 6th is the pre- and post test to be administered to participants.

Tips for using the toolkit

The duration of the training workshop is expected to be three days. It is advisable to start with a "go-around" the room, asking people to state their experience in caring for individuals who have been victims of violence and their goals for the session. This can be followed by a discussion (power point presentation or brainstorming) about violence (Definitions, types, impact and indicators) then proceed with projecting the scenarios. When the sign "Discussion" appears on the screen, the facilitator is encouraged to bring out the points mentioned in the boxes and then to ask two participants to replay the scenario as they consider it improved while the others comment on the role play, mentioning its positive and the negative aspects. At the end, the improved version of the scenario is projected.

In order for the training to proceed smoothly, facilitators are advised to avoid going through discussions relating religion to violence. It is important to keep reminding the participants that the focus of the workshop is the relation of violence to ill health and that the aim of the training is to show what the health care providers are supposed to do to improve the wellbeing of their patients.

Moreover, participants commonly raise concerns regarding the usefulness of their role, feeling helpless and unable to make drastic changes in the survivor's life. The

facilitator is advised to keep highlighting that the role of the provider can be summarised in recognizing survivors, listening to their complaints, helping them stay safe and guiding them through the services available to them; all of these tasks are to be done through proper communication not causing further hurt or harm to the survivor.

II- BACKGROUND INFORMATION:

II.1-Definitions of commonly used terms:

Violence
Defined by a WHO working group in 1996 as: "the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, mal development or deprivation." (WHO 1996). Violence can be either self-inflicted, inter-personal or collective— (Krug 2002). ***Self-inflicted violence*** includes self-inflicted injuries or suicide. ***Interpersonal violence*** includes community violence, occurring among acquaintances and strangers like violence in the workplace, school violence; and family/partner violence, perpetrated by family members including intimate partner, domestic or spouse violence. ***Collective violence*** includes violence condoned or perpetrated by the state including discriminatory laws and absence of family violence law

Sex
Refers to the biological and physiological characteristics that differentiate females and males and is limited to physical differences such as genetic makeup, reproductive organs, functions, and physiology. For example, members of the female sex typically have an XX genotype, possess a uterus and ovaries, and thus, can become pregnant and bear children. However, at times, reality is more complicated. Naturally occurring intersex exceptions challenge the male/female sexual binary, (e.g. an XX patient with congenital adrenal hyperplasia or an XY patient with androgen insensitivity syndrome). (See: http://www.isna.org/faq/what_is_intersex.) However, in most cases, sex is often male or female and does not change over time.

Gender
"Refers to the socially constructed roles, behaviours, activities, and attributes that a given society considers appropriate for men and women." (http://www.who.int/gender/whatisgender/en/). Gender indicates the social characteristics that are attributed to the sex of the individual, based on specific identities, social status, roles, responsibilities, and relationships. These characteristics vary among different cultures, as they are acquired by the individual through socialization. In other words, while people are born females or males (sex), they learn later how to become girls and boys, and then to be women and men (gender). Several factors affect the social characteristics of gender such as age, national origin, ethnicity, and socioeconomic background. For one example, in some cultures, it may be considered feminine to have long hair, whereas in other cultures, long hair may be gender-neutral (i.e., it may be

normal for either women or men to grow their hair long). Gender roles also change over time, depending on changes in the social, political, and cultural environment. To continue with the reproductive analogy, while sex might allow women to bear children, in many societies raising children is a task assigned to the feminine gender role. Although there is no specific biological or physiological reason which makes men incapable of caring for children, this is not a task typically assigned to the masculine gender role. A man who stays home to care for his children may be even considered less masculine or effeminate.

While gender is often thought of as only existing in a male/female binary, in reality gender is more of a continuum. Some people may demonstrate gender characteristics different from the idealized expression of gender ascribed to their sex. For example, while some women may identify with a conventional ultra-feminine gender role, always wearing makeup and high heels; other women may not feel this suits them and prefer to wear sneakers and never use makeup. At the other end of the continuum of gender norms are people who experience distress about their socially-prescribed gender (known as Gender Dysphoria) and may as a result undergo varying degrees of gender transitions, ranging from altering their way of dress, to using hormone therapy or even electing to have sex-reassignment surgery (sometimes referred to as sex confirmation surgery).

Gender-based violence

Gender-based violence (GBV) is the general term for violence that occurs as a result of the normative role expectations associated with each gender, along with the unequal power relationships between the two genders, within the context of a specific society. Any act of violence that results in, or is likely to result in, physical, sexual or psychological harm to a person because of his or her gender or gender role in a society or culture, including threats and intimidation, assault and battery of individuals who may or may not be in a relationship; sexual violence related to exploitation; rape; sexual harassment and intimidation inside or outside of the workplace, in school and elsewhere; human trafficking; sexual abuse and forced prostitution.

VAW/G (violence against women) constitutes a part of GBV. Violence against women is defined by the UN as "any act of gender-based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life." (Declaration on the Elimination of Violence Against Women, 1993). While both males and females can be subject to all these forms of violence, it is women and girls who suffer overwhelmingly, particularly from rape, forced prostitution and sexual slavery. In addition, forced impregnation, forced maternity and forced termination of pregnancy are violations specific to women and girls.

Men and boys can also be victims of GBV from their intimate partners, other family members and communal violence. Apart from in situations such as humanitarian emergencies or human trafficking, the greatest proportion of violence women experience is most likely to be perpetrated by a husband, intimate partner, or relative. This contrasts violence enacted against men, which is far more likely to be perpetrated by a stranger or

acquaintance. Furthermore, gender-based violence against men manifests when men deviate from socially ascribed masculine gender roles. For example, men with feminine gender expression and men who have sex with men express behavior that is considered an aberration from the expectations of how men should behave and experience everything from discrimination in the health and legal sectors to physical attacks in the community.

Intimate Partner, Family and Domestic Violence

These three types of violence encompass all kinds of physical, sexual or psychological harm, and "acts of omission or commission resulting in physical abuse, sexual abuse, emotional abuse and neglect or all other forms of maltreatment that hamper individuals' healthy development" (Levesque, 2001). It frequently includes controlling behaviours such as isolation, over-surveillance and restricting access to resources. This type of violence can occur among heterosexual or same-sex couples, does not require sexual intimacy and can be perpetrated by people of all genders. (Saltzman 2002). Victims of violence can involve family members (partners, children, elders), in-laws and domestic workers. They are differentiated by scope. ***Intimate Partner Violence (IPV)*** specifically related to violence perpetrated by a partner or spouse (may include marital rape). ***Domestic Violence (DV)*** describes harm done by any member of the household or domestic unit (Convention on preventing and combating violence against women and domestic violence, 2011, http://conventions.coe.int/Treaty /EN/ Treaties/Html/210.htm), and ***Family Violence (FV)*** extends the scope to harm done by any family member regardless of shared residence.

Refugee

Is "any person who, owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of his nationality, and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country or return there because there is a fear of persecution...". On the other hand, those who are persecuted on the basis of race, religion, nationality, status, or political opinion and remain within their own country without crossing an international border are "internally displaced persons".

Cycle of violence

Is the cycle that goes between two individuals in a violent relationship. Knowing the cycle helps understanding the survivor (emotional lability, depression, anxiety..). It includes:

- *Tension building phase* The abuser experiences increasing stress (job, bills..) that makes him/her feel powerless ; the survivor minimizes the problem, the abuser chooses to act out by name calling, accusations, threats; the survivor withdraws, tries to calm the abuser by trying to anticipate his/every need; the abuser increases control, the survivor feels like "walking on eggshells".
- *Abusive incident:* The abuser becomes more violent, the survivor is traumatised. It may happen only once or may get repeated.
- *Honeymoon phase* the abuser loving, attentive and apologetical, but uses defence mechanisms like blaming the survivor for precipitating the violent incident; the survivor feels guilty and blames self, reconsiders reconciliation and minimises abuse.

Once the rationalisation sets in place, both partners try to make the relationship continue by pretending everything is normal; if the problems in the relation are not addressed, the cycle of abuse gets repeated with increase in violence severity and shorter honeymoon phase.

II.2 Types of violence

According to the World Health Organization, acts of violence can be physical, sexual, psychological, and economical or can involve neglect or deprivation (Krug et al., 2002).

Physical violence is the intentional use of physical force with the potential for causing death, disability, injury, or harm. Physical violence includes, but is not limited to: scratching, pushing, shoving, throwing, grabbing, biting, choking, shaking, poking, hair pulling, slapping, punching, hitting, burning, use of a weapon (gun, knife, or other object), and use of restraints or one's body, size, or strength against another person, coercing other people to commit acts of physical violence (Saltzman et al., 1999), the use of chemical restraints such as intentional overmedication or administration of tranquilizers (Hustey & Glauser, 2011).

Sexual violence is the non-consensual sexual contact of any kind, ranging from unwanted touching and indecent exposure to rape (Hustey & Glauser, 2011). Sexual violence involves all acts whereby an adult uses another adult or a child for his or her sexual gratification (Krug et al., 2002). Such acts include: "sexual activity without consent, causing pain during sex, assaulting genitals, coercive sex without protection against pregnancy or sexually-transmitted diseases, forcing the survivor to perform sexual acts unwillingly, criticizing, or using sexually-degrading insults" (NSW Department of Premier and Cabinet, 2010).

Psychological or emotional violence: The United States Centers for Disease Control and Prevention (CDC) defines psychological or emotional abuse as "trauma to the victim caused by acts, threats of acts, or coercive tactics". It includes verbal abuse and social abuse and can be manifested by (Saltzman et al., 1999):

- Humiliating the other
- Controlling what the other can or cannot do
- Withholding information from the other
- Getting annoyed if the other disagrees
- Deliberately doing something to make the other feel diminished or embarrassed (e.g., saying you are not smart, not attractive…)
- Spending the other's money (also considered as economic abuse)
- Taking advantage of the other
- Disregarding what the other wants
- Isolating the other from friends or family, forbidding from meeting others (also referred to as social abuse)
- Putting down capacity as parent or spouse (also referred to as social abuse)
- Prohibiting access to transportation or telephone (also referred to as social abuse)
- Coercing the other to engage in illegal activities

- Using children to control the other's behaviour
- Threatening loss of custody of children
- Threatening separation or divorce
- Smashing objects or destroying property
- Denying access to money or other basic resources (also considered as economic abuse)
- Disclosing information that would tarnish the other's reputation
- Withdrawing all interest and engagement (e.g. weeks of silence)
- Blackmailing

In addition to the above, psychological violence against children includes (Kairys, Johnson, and the Committee on Child Abuse and Neglect, 2002):

- Belittling, degrading, shaming, or ridiculing a child
- Singling out a child to criticize or punish; and humiliating a child in public
- Rejecting the child (avoiding or pushing away)
- Denying the child emotional responsiveness
- Making a child feel unsafe
- Setting unrealistic expectations with threat of loss, harm, or danger if they are not met
- Threatening or perpetrating violence against a child or child's loved ones or objects
- Child witnessing violence at home
- Neglecting mental health, medical, and educational needs
- Unreliable or inconsistent parenting
- Restricting a child's movements (Krug et al., 2002)

Neglect or Deprivation: Neglect is defined as "the failure of a parent or caregiver to provide for the development of the child (or dependent) in one or more of the following areas: health, education, emotional development, nutrition, shelter and safe living conditions" (Krug et al., 2002). Abandonment or desertion of the dependent family member by the individual's custodian or care provider assuming responsibility may be classified along with neglect (Hustey & Glauser, 2011).

Neglect or deprivation is another form of family violence that generally involves children, elderly, family members with disabilities and special needs requiring the care of another family member or caregiver. The term neglect can be only correctly utilized in the absence of poverty; i.e. when reasonable resources are available to the family or caregiver (Krug et al., 2002).

Economical violence: Economic violence or abuse defined as the perpetrator's control of the survivor's access to resources, work to achieve income, education, or ability to find and keep a job (National coalition against domestic violence, 2011). It can be manifested via acts that include:

- Interfering with the survivor's work performance through harassing activities

- Denying the survivor's access to money or the means of obtaining it, to the point that he/she is entirely dependent on the abuser for food, clothing and shelter
- Prohibiting the survivor from working or attending school
- Intentionally withholding necessities such as food, clothing, shelter, personal hygiene products, or medication
- Stealing, exploiting, or destroying the survivor's money or assets
- Forbidding the survivor from maintaining a personal bank account

II.3 Health Consequences of Violence

The health consequences of violence go far beyond the direct and immediate physical injury to have long term effect on the individual and extend, in a ripple-like-effect, to affect the family and society (Krug et al, 2002).

The short term consequences associated with DV are easier to recognize by health care providers (Diaz-Olavarrieta 1999, Leserman 1998). These include acute injuries like fractures, bruises, burns, scalds, hematomas and internal hemorrhages, sometimes resulting in death or disability. However, the long-term effect of these injuries, in addition to the fear and the stress associated with living with an abusive individual, result in significant morbidity. A variety of somatic and stress related symptoms are associated with exposure to violence such as pains, fainting, gastrointestinal disorders and appetite loss, viral infections, and cardiac problems including hypertension and chest pain (McCauley 1995.Croholm 2011, Tjaden 2000, Tollstrup 1999, Wisner 1999, AAFP 2004, ACOG 2005), as well as menstrual irregularities, poor pregnancy outcomes, obstetrical complications and gynaecological problems (Rodriguez 1999). In addition, cancer, chronic lung disease, ischemic heart disease, liver disease, arthritis, chronic neck or back pain, migraine or other types of headache, and peptic ulcers were associated to exposure to violence.(Krug et al., 2002; Family Violence Prevention Fund, 2004).

Moreover, children exposed to violence are at risk for failure to thrive, poor hygiene, and exposure to dangers in the environment as well as drugs (Krug et al., 2002), developmental delay, school failure, violence against others (Nelson et al., 2004), asthma and bronchitis, in addition to speech and language delay, bed-wetting, and sleep and eating disturbances (Sharpen, 2009), as well as a higher risk for diseases during adulthood among which are obesity, heart disease, hepatitis, diabetes, depression, and suicide (United Nations, 2006; Family Violence Prevention Fund, 2004).

Such consequences translate into lower health status, lower quality of life, and higher hospitalization rates for all conditions, higher utilization of outpatient health services for illness and injury, and less preventive and well-adult care (Population reports 2009, Hamberger 1998, Hamberger 2007, UNFPA 2009). DV survivors are frequent users of health care services, including emergency rooms, primary care and community mental health centres (Boy, 2008).

In addition, children and adult survivors and witnesses of family violence are at risk of numerous long-term psychological, social and behavioural consequences that affect the way they interact with their environment. Awareness of these consequences may help healthcare providers recognize signs of violence, understand survivor behaviour, and communicate more effectively with survivors.

Chronic exposure to violence, abuse, or maltreatment destroys the sense of self and personal safety leading to poor self-esteem and self-confidence, negative emotional or life view, lack of trust and paranoid thinking, feelings of shame, guilt, helplessness, fear, and denial, self- harm, suicidal ideations or attempts, and even suicide or homicide (Kairys et al., 2002; Krug et al., 2002; Sharpen, 2009). Exposure to violence has also been associated with emotional instability, anger, anxiety, depression, hyperactivity, traumatic and posttraumatic stress disorder, borderline personality disorder, panic disorder, emotional unresponsiveness, impulse control problems, personality disorder, psychosis, eating disorders, sleep disorders and sexual dysfunction. (Kairys et al., 2002; Krug et al., 2002; Mace, 2011; Family Violence Prevention Fund, 2004).

Accordingly, violence survivors may display antisocial behaviours such as aggression or violence, delinquency and risk-taking violent or nonviolent criminal behaviours, disobedience, passive aggressiveness, smoking, alcohol or drug abuse, gang participation, abuse of children spouse or others. Alternatively, they may display self destructive behaviours manifested by non compliance and decreased engagement in preventive health care, or possess limited social competency reflected by poor relationships, and difficulty making friends, insecure or disorganized attachment, self-isolation and withdrawal from relationships, low sympathy & empathy for others, dependency and sexual maladjustment or unsafe sexual practices. (Kairys et al., 2002; Krug et al., 2002; Sharpen, 2009). Children may have educational difficulties: poor school performance, absenteeism from school, learning impairments, impaired moral reasoning, delayed or impaired cognitive or language development. They can also display noticeable changes in their behaviour such as irritability, sleep disturbances, heightened startle responses, increase in tantrums, delayed speech or skill development, and a regression to more childlike behaviours (Kairys et al., 2002; Krug et al., 2002; Sharpen, 2009). These consequences impact the way survivors interact with the health care team making them "difficult patients" by being angry, demanding, dependent, unsatisfied or non compliant…

II.4 Indicators of Violence in Clinical Settings

Violence often goes unrecognized by the health care professionals. There is no prototype image of a survivor and don't let a cheerful appearance of a patient misguide you into disregarding the presence of abuse. There appears to be a constellation of signs and symptoms or recurring patterns of healthcare utilization suggestive of violence, although they are not diagnostic. These include the following:

a. Medical Clues

- Injury
  - Multiple sites of injury or multiple injuries at different healing stages
  - Bruises having a form or pattern (usually the object used in physical abuse)
  - Repeated chronic injuries
  - Injuries during pregnancy
  - Injuries to face, arms, breast, abdomen, or genital area

    - History inconsistent with injury
- Vague or nonspecific symptoms
- Pains (Chronic pain, psychogenic pain)
- Chronic headaches
- Gastrointestinal complaints, palpitations, dyspnoea, atypical chest pain
- Frequent, unexplained gynaecologic complaints; pelvic pain
- Frequent vaginal and urinary tract infections
- History of spontaneous abortions, miscarriages, and premature labour
- Sleep and appetite disturbances, fatigue, decreased concentration, sexual dysfunction
- Somatisation disorder
- Signs and symptoms of Post Traumatic Stress Disorder (PTSD), depression, or anxiety disorders
- Feelings of isolation and an inability to cope
- Suicidal attempts or ideations
- Alcohol or drug abuse
- Patient directly or indirectly brings up the subject of abuse

b. Patterns of Healthcare Utilization

- Changes in appointment patterns; frequently missing or cancelling appointments
- Delay in seeking medical care for an injury or a serious medical condition
- Late or sporadic access to prenatal care during pregnancy
- Frequent clinic visits with vague complaints or symptoms without evidence of physiologic abnormality, suggestive of help seeking behaviour
- Multiple visits to the emergency department
- Frequent use of prescribed minor tranquilizers or pain medications
- Noncompliance with treatment regimens
- Overly protective spouse or family member: Perpetrator accompanies patient, insists on remaining in the exam room, and answers all questions directed to the patient
- Threatening spouse or family member: use of threatening words, gestures, or glares
- Patient's reluctance to speak or disagree in the presence of the perpetrator
- Intense irrational jealousy or possessiveness expressed by perpetrator or reported by patient
- Denial or minimization of violence by patient or by spouse or family member
- Have limited access to medical care or to medication
- Lack independent transportation, access to finances, or the ability to communicate by phone

c. Red Flags to the presence of violence

The presence of any of the following red flag sign(s), should alert the health care provider to initiate assessment for violence exposure

- ***Red Flags for Adults Survivors of Violence (WHO, 1997)***

  - Suicidal attempt or suicidal ideations
  - Injuries that are inconsistent with the explanation of how they were sustained
  - Physical injury during pregnancy
  - Several injuries, at different stages of healing
  - Chronic or vague complaints with no obvious physical cause
  - Delay in seeking medical care
  - Overly protective spouse or family member accompanying the patient, insisting on remaining in the exam room, and answering all questions directed at the patient.

- ***Red Flags for Children Survivors of Violence***

  - A child having injuries that are inconsistent with the explanation of how they were sustained
  - A child with several injuries, at different stages of healing
  - A child having recurrent, medically unexplainable somatic problems (e.g. failure to thrive, abdominal or genital pain or injuries, headaches, enuresis, encopresis, problems eating or sleeping)
  - A parent reluctant to speak in the presence of their spouse or family member
  - A parent (or adult family member) insisting on accompanying the other parent and child and answering all questions directed at them
  - A parent attempts to hide the child's injuries with clothing
  - Frequent clinic visits with vague complaints or symptoms without evidence of physiologic abnormality.
  - Multiple visits to the emergency department
  - Delay in seeking medical care

(Brown, 2002; Washington State Department of Health, 2008; City & County of San Francisco Department of Public Health Community Public Health Services, 1996; Mc.Calister et al., 2004; Smith & Jackson, 2011)

III- THE ROLE OF THE HEALTH CARE PROVIDER

The approach to survivors is usually a multidisciplinary one, involving physicians, social workers, psychologists, lawyers as well as community resources. The clinician's role is to identify cases of abuse, assess the patient and her family's level of safety while explaining the nature and course of DV, assess the level of readiness to make changes and facilitate the change when wanted by the survivor, educate about the range of available

support services and make the appropriate referrals, document the findings, ensure follow-up, continuity of care and non-judgemental support. Throughout this process, the physician-survivor interaction should be governed by three guiding principles: respect, safety, confidentiality.

Respect: conducting the interview in a private place, showing empathy and patience, not being judgemental or having stereotyped ideas, respecting life choices of the survivor.

Safety: providing a safe place when needed, setting a safety plan based on survivor's conditions, maintaining confidentiality.

Confidentiality: refusing to discuss the patient case with a family member or employee not related to case without getting patient approval first, storing all information and pictures related to the case in a restricted location (locked cabinet or drawer), obtaining the consent of the person when there is a need to exchange information or ask for consultation. Confidentiality is limited by concerns of patient inflicting harm to self or others.

Helping a violence survivor can best be achieved through adequate communication and properly conducted clinical session or interview that does not alienate or further victimize the survivor.

III.1 Special considerations for communication with violence survivors

Communication with violence survivors is very delicate and sensitive and has to be done tactfully. It is the cornerstone of intervening with and helping survivors. Asking about violence within a properly conducted interview encourages survivors to speak out, facilitates disclosure, decreases their guilt and shame feelings, decreases their isolation and helplessness, and can make them feel supported and empowered. The key elements are to provide a comfortable environment for the interview (discussed later under conducting the interview), demonstrate active listening, avoid blaming the survivor or being judgmental, and convey positive messages. The most important message that needs to be related is "***there are no justifications for violence and no one deserves to be abused***".

The communication skills that are mostly needed when interviewing violence survivors are as follows:

a. Listening skills: paying attention to non-verbal behaviour; showing empathy and validation of feelings; summarizing/paraphrasing

b. Asking skills: using open ended and then closed questions (funnelling); use of descriptive and analytic questions

c. Focusing skills: in order to help the survivor concentrate and follow through the complaint while coping with the effects of violence

a- Listening:

Adequate listening includes being attentive to non- verbal and verbal communication that will help to demonstrate empathy, and validate feelings; summarizing and paraphrasing convey adequate listening and encourage further discourse.

i- ***Nonverbal communication includes:***

- Conducting the interview in a private physical environment (alone, children are given the choice of a trusted adult to be present) with absent or minimal background noise, making arrangements to avoid unnecessary interruptions; providing comfortable non-confrontational seating (around the corners of the desk or sidewise, avoid opposing face to face when possible). The presence of visual materials (posters, flyers..) that highlight family or interpersonal violence is helpful.
- Conveying interest through body language: Assume a relaxed, calm and unhurried posture; avoid looking away from the survivor, and keep eye contact.
- Using survivor words whenever possible, can paraphrase to allow further communication or clarification.
- Avoiding inappropriate touching, better to ask permission first.
- Respecting patient autonomy and decisions: refrain from giving advice, better to counsel
- Treating patients of all ages and cultures with dignity, respect and compassion.

ii- ***Verbal communication:***

There are certain techniques or words that are better avoided, as they may deter survivors from disclosing abuse, while others are encouraged for they put the survivors more at ease, not making them feel judged or controlled.

The techniques that are better avoided are:

Technique	**Example**
Questioning	"*Why did you run away"; "how come you left home*?"
Falsely reassuring	"*I wouldn't worry about that*"; "*you'll do fine*"; "*I am sure your parents love you*"
Giving approval	"*I fully agree with what you are doing"; "I am glad that you...*"
Rejecting	"*I don't want to hear about you doing…*"
Disapproving	"*That's bad*"; "*I'd rather you wouldn't*"
Advising	" *I think it is better if you do..*"; "*why don't you?*"

Disagreeing	"*That is wrong*"; "*I definitely disagree*"
Challenging	"*Do you have the courage to say these words*";" *I don't think you will ever leave, you keep repeating this and never did something*"; "*that will be The Day when you confront*"
Testing	"*If you had a pregnancy test, what was the procedure*";
Interpreting	"*What you really mean is*"; "*unconsciously you are saying..*"
Lecturing	Giving speeches or telling stories

The techniques that are advised to be used are:

Technique	**Example/Explanation**
Invitation to talk	"*There seems to be something on your mind, would you like to talk about it*?" Or "*Maybe you could tell a bit about what happened*"
Broad openings	"*Family violence is widespread in our society. Has your spouse or other family member(s) ever tried to physically hurt you?";* instead of: "*have you been raped*"
Funnel Technique	Start with indirect or framing questions (example in annex I) and then move to direct questions (example in annex I)
Reflect feelings	"*Sounds like you feel angry*"
Show empathy	"*I understand that you feel/think this way, given your experience/situation?"*
Validation	"*I understand that you feel/think this way, it is only natural*";" *you have the right to do so, anybody would have felt that way*"
Seeking clarifications	"*I am not sure I understand. Could you please explain*?"
Restating/paraphrasing	Survivor: "*I can't sleep, I stay awake all night*"

	Provider: "*You have trouble sleeping?*"
Exploring	"*Could you tell me more about it?*"
Attempting to place in sequence	"*What seemed to lead up to this point is...*"
Offering self	"*I am concerned about what you are saying*"
Giving recognition/empowerment	"*It takes courage to tell me your story*"
Suggesting cooperation and/or collaboration	"*Together we can sort out the problems you are having*"
Summarizing	"*Let us see if I got this straight, you said that…*"

Source: Adapted from Communication Skills in Working with the Survivors of GBV Reproductive Health Response in Conflict Consortium, 2007.

b- Asking skills

Asking about violence starts with opening remarks and invitation to talk (mentioned above). Follow-up questions can be later used to serve either one of two major functions:

- *Describe*: by providing clarification: *Can you explain more about it? What do you mean*, or requesting elaboration of earlier statements: *How did it happen? Can you give some examples*?
- *Analyse*: by asking for ideas related to causes and effects, or consequences: *Why do you think this has happened? Why do you think you are feeling those pains, palpitaions?*

Again, it is better to avoid certain questions:

Blaming questions	"*You failed your exams, wouldn't you have avoided the beating if you didn't…..*"; "*what did you do so you were beaten?*"
Asking directive questions	"*Won't you consider leaving home?*", Better "*What would happen if you decided to leave?*"
Why questions	"*Why did this happen?*"; Better to ask "*What happened?*", "*How did it happen?*", "*When did it happen?*"…

Ridiculing/ minimizing questions	"*Oh this happens frequently, why should you be stressed about it?*"; "*Do you want to discipline your parents?*"
Insisting/confronting	"*How can I help you if you don't tell me what is going on?*". Better to say " *I respect your privacy and am willing to help you*"
Being judgmental	"*How can you live like this*?"; "*There should be a good reason for your parents to treat you this way*";
Using the word violence when asking	"*Are you in a violent relationship?".* Better to ask about specific behaviours "A*re you being hit, beaten*?"
Using loaded words	"beast", "animal", "violence", "rape"
Showing disbelief	"Are you sure this is what happened and you are not saying something you saw in a movie?";

(*Source*: City & County of San Francisco Department of Public Health Community Public Health Services, 1996; The Family Violence Prevention Fund, 2004)

c- Focusing skills

Many survivors get lost in details and need to be redirected to what is relevant. They may present several problems at one time and seem to be confused. For example: "*Well, I have a headache most of the time, but I also sleep badly and one of my fingers is infected and doesn't get better, and I feel weak in my legs".* Summarizing and setting a list would be helpful "*You mention headache, bad sleep, infected finger and weakness in the legs, shall we start with headache and talk about others later?"*

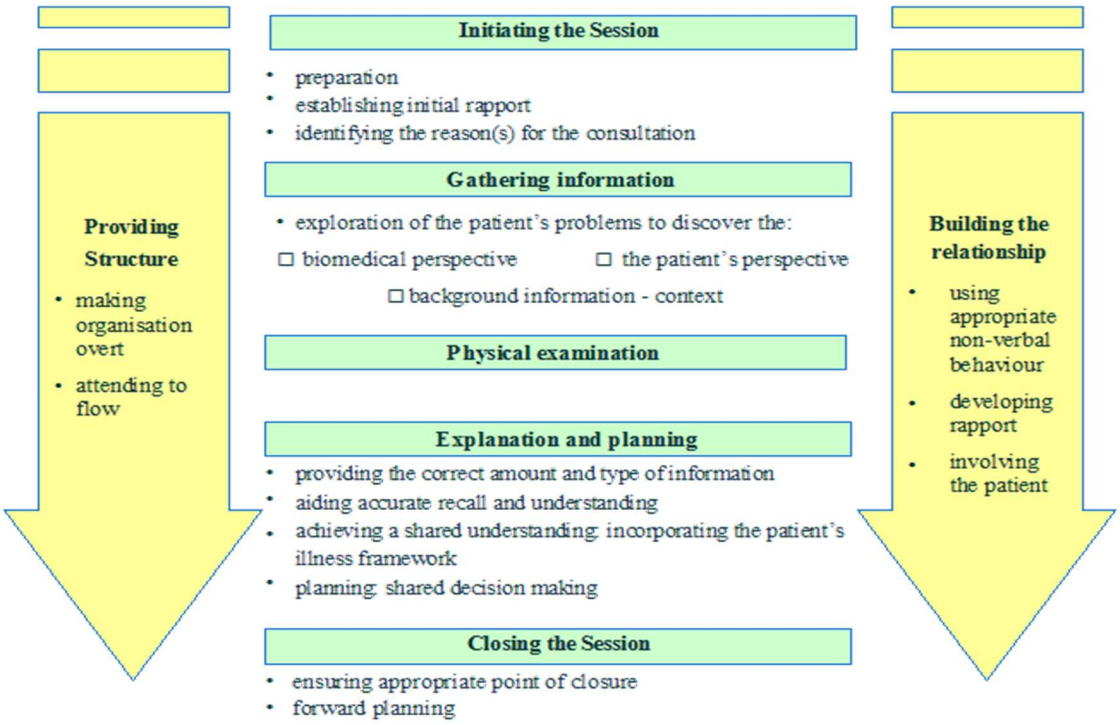
Quite often survivors use statements with double messages, sometimes contrasting like: "H*e beats me a lot,* but *he really loves me*", or "*it is nice to be a mother,* but *kids drive me crazy*". Using summary/question draws attention to the contradiction and determines the focus. Examples:

"*You mention a positive and a negative side. Can you give some examples of both?"* or *"You mention a positive and a negative side. Shall we discuss first the positive, then after that we can talk about the negative."*

III-2 Conducting the clinical encounter

Survivors of violence rarely present to health care to disclose violence but often seek assistance for medical complaints. The clinical setting should be prepared to accommodate an unexpected encounter with violence survivor. Based on the Cambridge-Calgary Model depicted in figure 1 (Silverman, 2013), the following is recommended to facilitate case finding of a violence survivor, conduct the interview and initiate the proper management and referral.

Figure1. The Cambridge-Calgary Model



a- Initiating the session

Having awareness leaflets, brochures or posters advocating against DV with a list of community resources and hotline numbers available in the patients' waiting room or inside patient restrooms are advisable as it prepares the stage for the interview and may sometimes encourage survivors to initiate discussion about violence.

In the presence of signs and symptoms or red flags (mentioned above) suggestive of violence exposure, the health care provider has to initiate asking about it. For some providers, it may be easier to integrate asking about violence within the routine health screening when asking about smoking or other health risk behaviours. This approach has additional advantages: It sends the message that violence is not a taboo or private issue

but rather a problem that poses risks to health; it opens the invitation to the patient to disclose exposure to violence and to feel cared for.

Regardless of whether performing general or targeted screening, asking about DV has to include both current and past relations, and must be done in a private and in a confidential manner. It is advisable not to discuss DV with children present or when the patient is accompanied by another person.

When inquiring about violence, it is advisable to maintain a caring posture (leaning slightly forward) with good eye contact, when culturally appropriate, and use a non-hurried tone. Observing the patient's non-verbal cues when answering questions can be helpful. Introductory statements can help to normalize the discussion. For example we ask all our patients these questions." "*Violence is so common around here, that we started asking everyone about it*" or " *I am going to ask you some personal questions, as I think they would help me understand your complaints more, is that ok?"*. A funnelling technique, that is moving from the broad less-threatening questions (example: "*Married couples may disagree; How do you resolve conflicts at home*') to asking about specific behaviours (example: Do your arguments ever become physical? " have you ever been threatened physically or hit?") is recommended.

In certain circumstances, it may be better or safer not to ask about family violence (The Family Violence Prevention Fund, 2004) :

- When the physician or interviewing healthcare provider cannot secure a private space to conduct the assessment.
- If there are concerns about the safety of the patient or of the healthcare provider.
- If the physician or interviewing healthcare provider is unable to secure an appropriate interpreter who would assist in conducting the screening in the patient's primary language.

Suggested Approach to Overcoming such Challenges

- Can ask about abuse while examining the patient (having the suspected abuser leave the room for the physical exam) or schedule another appointment when the interview can be arranged done in private.
- Have referral information readily available for the patient. Give the referral/ hotline information covertly.
- Never confront the abuser or attempt to mediate between the abuser and survivor.
- Your priority is to keep your patient and your office staff safe; Think of a safety plan in case the perpetrator does become difficult.

b- Gathering Information

Following the introductory statements, and after getting the approval of the patient to proceed with sensitive or personal questions, and assuring the confidentiality of the information collected, the provider can proceed to inquiring about the presence of violence. Questions need to be direct and specific inclusive of all types of violence (physical, psychological, sexual), inquired about separately like "A*re you being hit, kicked, pushed or beaten?*", "*Are you being insulted, screamed at, threatened physically or threatened to have your children taken from you?*" "Have you aver been forced or pressured to have sexual relation, "*with someone against your will?*". Avoid using "violence" or "abuse" as they may be emotionally distressing. In addition, individuals may be in a violent relationship without recognizing it as such, and therefore may deny it depending on the words a provider uses to inquire.

i- What to do when the patient doesn't disclose violence?

Most violence survivors do not disclose violence during the first encounter. It is better not to push them into a confession or confront them, but to:

- Respect the patient's response
- Offer supportive messages (examples in Annex I)
- Offer reassurance and willingness to help, in case violence happens
- Emphasize that privacy, confidentiality and safety are secured for patients whenever they would like to disclose any information about experiences of personal violence
- Encourage the patient to take a list of resources available to violence survivors
- End the interview with a positive statement.

Some of the statements that can be used when the survivor does not disclose abuse (Washington State Department of Health, 2008):

- "*If things ever change, I am here for you and am willing to listen*."
- "*If this becomes an issue for you in the future please know that I am open to talking with you. My job is not to tell people how to live their lives, but to talk about choices, safety, and resources for help*."
- "*I am glad you are not being hurt by your spouse or family member(s). I always tell my patients that it is safe to talk about their fears or any abuse they may have experienced; there are helpful resources*."
- "*I am glad to hear there is no abuse now. Should that ever change, this is a safe place to talk*."

ii- What to do when the patient discloses violence?

- Show empathy "*I am sorry this happened to you*"
- Acknowledge the courage it takes to disclose *"This must be hard for you to talk about"*

- Validate the survivor's experience and alleviate guilt *"No one deserves to be hit or treated badly"," It is not your fault"*
- Offer help and assurance of continuous assistance in the future "*you are not alone in this, We can help you take care of your health and support you while going through this problem*"; But don't give false hopes (e.g avoid: "*All your problems will be solved")*
- Use supportive statements or messages (examples in Annex I)
- Assure the survivor that the violence is not her/his fault, no one deserves to be abused and that there is no excuse for violence
- Acknowledge the patient's somatic complaints and validate "*I have seen patients having symptoms like yours and they have been be abused"*, "*This is how the body reacts sometimes to mental distress*"
- Gather more information on violence that will help to assess the severity of the situation and recognize if the survivor is in imminent danger: who is/are the perpetrator(s); severity, pattern and frequency over time; use of weapon or instruments, other family members affected by violence like children, help sought previously, family or social support system. Indicators of danger include history of threats of murder or suicide, attempts of suicide or homicide, increase in the severity or frequency of the perpetrator's fits of anger, use of weapons or tools in the assault or if there is an attempted strangulation, alcohol or substance abuse, or if the survivor acknowledges fear for life. Violence tends also to escalate during life changes like pregnancy, separation, divorce or unemployment.
- To facilitate "history taking", use listening skills and respect the patient's pauses of silence for they may reflect psychological upset or confusion.It is better to obtain a behavioural description of what has happened rather than an explanation of why it happened. Asking about the "why" has the subtle implication that violence can be justified in certain situations.
- Avoid being judgmental, blaming, pushing the patient to disclose information, or showing disbelief:
    - Don't be judgemental. Avoid asking *"What did you do so he started to hit you?"*
    - Don't blame, avoid statements like, *"Your kids are aggressive because you are letting them observe their father screaming and shouting."*
    - Avoid pushing the patient into more confession. Eg. avoid, *"How can I help you if you don't tell me everything?"*
    - Avoid showing disbelief even there is discordance, *"If he doesn't let you go out, then how come you are at the clinic today?"*
    - Avoid labelling the perpetrator. Don't use words like *"beast, animal, savage."*
- Assess for psychological problems: psychological illness, depression, suicidality, PTSD, drug addiction, alcoholism, risk taking behaviours, abuse of tranquillisers, analgesics.
- Recognize the coping and defence mechanisms that the survivor is using.

The abuser can be denying (for example, "*He is a nice man but he can be difficult sometimes when stressed."*) or minimizing abuse (for example, "*It is not that bad, he only hits me when he is angry.*"). Denial can create a barrier against further intervention.

- Assess the survivor's readiness to change. The process of change takes several stages:
    - **Pre-contemplation:** The survivor is not aware of the situation or is still justifying abuse. The survivor doesn't recognize the situation as a problem which can be changed.
    - **Contemplation:** The survivor is considering change but is not ready to take action yet.
    - **Determination:** A decision has been made by the survivor to make change.
    - **Action:** The survivor is actively taking steps to address the DV.

- Assure the survivor that you are concerned about and committed to her/his health
- Assure the survivor that you are available to help when she/he is ready
- Confirm to the survivor the confidentiality of information and explain documentation policies and reporting laws, if applicable
- Provide the survivor with appropriate referral information or support system, hotline number
- Do not get involved in couple counselling.

c- The physical exam

When abuse is suspected, a complete physical exam should be performed with inspection of all body parts as the survivor could hide bruises or other injuries by wearing long sleeves or large pieces of jewellery. If it were inappropriate to ask the survivor to fully undress, the physical exam may be done by uncovering certain parts of the body and covering the parts already examined. It is better to explain each step of the physical exam to reassure the survivor. The presence of chaperone is advisable whenever possible. The examination room should be warm and well lit to allow recognition of colour variation. The healthcare provider should maintain a neutral facial expression during the physical exam, regardless of findings, in order not to cause the patient emotional distress

When doing the physical exam, check for:

- Scalp: bumps, hair plucking, cuts
- Ears: ecchymoses on pinna, tympanic membrane perforation
- Eyes: sub-conjunctival hemorrhages
- Mouth: fractured teeth, petechiae or hematomas inside of cheeks or sublingual
- Face: bruises, finger-marks (slap), tenderness of nose
- Neck: strangulation marks, excoriations
- Chest: tenderness over rib cage, bruises, ecchymoses

- Abdomen: tenderness, bruises
- Extremities: tenderness over bones, bruises, ecchymoses, lacerations, check range of movement of all joints
- Skin: bruises of various colours (red means recent, then it turns to violet, blue and then yellow) or shapes, lacerations, scars, burns, burrows (scabies may reflect neglect)
- Genitalia: bruises, lacerations, bleeding, abnormal discharge. Laceration in a parous woman may reflect forced intercourse.
- Growth and neurodevelopment for children

d- Explanation and planning

Although most survivors encountered are not in imminent danger, the physician should, after gathering the information and performing the physical exam, assess the situation, negotiate a plan of further action with the survivor and devise a safety plan even when the survivor denies danger. Keep in mind that reporting is mandatory for children who are violence survivors, and will also be mandatory for women subject to domestic violence with the approval of family violence law.

While explaining the situation and negotiating a plan of action, the physician has to avoid advising the survivor and dictating a solution. It is better to provide alternatives and discuss them before reaching a workable plan. Discuss options "*If you decided to leave, where you could go*?" , "*What would be your children's or your parents' reactions if you requested divorce*?"

Respecting and supporting the survivor's choice, and not pressuring them to leave the relationship is of prime importance. The use of focusing techniques is quite helpful as survivors can be confused. Addressing the survivor according to the stage of change can help in shifting the survivor from one stage to the other. For example: if the survivor is justifying abuse (pre-contemplation), it may be useful to ask the survivor, "*Do you believe anyone who had a bad day is allowed to hit people*". Treating the psychological ailment is sometimes helpful. Antidepressants can be of use but benzodiazepines (and analgesics) are better avoided as they can potentially be abused.

When setting a safety plan, it is better to keep in mind that survivors are more experienced with their situation and know better what can work, so instead of telling the survivor what to do, discussing different safety plans and anticipating problems when implementing them is more helpful. The safety plan is to be revisited at each encounter and modified according to situation

Tips for safety planning

- Hide money, extra car keys, or a bag with extra clothes;
- Have important documents (IDs, passports, certificates, bank account numbers, driving license, insurance policy, marriage license) in a place outside the home in the event of an urgent escape;
- Agree on a safe place to escape to (shelters' hotlines should be provided when available);
- Agree with neighbours on signals to alert requesting their help
- Avoid rooms with weapons (such as the kitchen) or with hard surfaces (such as a bathroom) when the perpetrator is around

- Call 112 for the police: It is now an alternative as the internal security forces have received training in responding to family violence calls.

The care of the domestic survivor is usually multidisciplinary (social worker, psychologist, psychiatry..). The primary care provider should explain to the survivor that help may be needed at some point during the therapeutic relationship and a referral may be needed, and reassure the survivor that referral doesn't mean ending the clinical relation; show willingness to continue taking care of the survivor when this will happen "*you are not alone in this, I am here to help you, and will be with you"*; Provide information about legal tools and community resources (e.g. non- governmental organizations, women's shelters, support groups, legal advocacy- list available in Annex III..), but advise survivors to hide list from perpetrator.

e- Closing the interview

Summarise the action and safety plan and offer a follow-up appointment. Check for barriers to access and discuss solutions if present. Reassure the survivor again of your continuous support and willingness to help. End the interview on a positive note thanking the patients for their trust and acknowledging their courage to talk about violence.

f- Self care

Dealing with survivors of abuse or mistreatment represents an undeniable challenge, and it usually brings out various reactions in the care provider. When dealing with a person whose physical and emotional safety is continuously undermined, it is natural that these encounters stir feelings (love and hate, concern, anger, frustration, etc.) within the care provider that vary according to past experiences. It is important to differentiate between the feelings raised by the recipient and those resulting from recalling personal experiences or cases. Refrain from feeling angry at the patient for not taking action or for going back on decisions made; this should not be interpreted as failure as many factors could have prevented patients from doing so.

Physicians often underestimate their role. At the end of every clinical encounter with the survivor, the physician is advised to stop for a moment and recognise that they helped a person who was in need; Simply listening to disclosure of abuse was found to decrease somatic complaints and improve wellbeing. Considering the limited control that the physician has on the life, decisions, and special circumstances of the survivor, the provider needs to keep in mind that assisting abused patients does not mean saving the patients but assisting them in carrying out the changes themselves; and acknowledging that change is a long process and doesn't happen overnight.

g- Documentation

Although the survivor may not be willing at the time of the interview to report violence to authorities, the information provided during the encounter can be useful at a later stage,

in case legal channels are pursued; hence the importance of documenting the following information in the medical chart:

- Detailed description of the incident using the patient's own words, including the name of the alleged perpetrator and relationship to survivor
- Date, time and location of the violent incident
- Description of the injuries when present: type, position, colour, size, shape; can use body pictogram/map or even photographs but only after obtaining patient's approval.
- Document the assessment of the mental status, danger severity
- Write details of intervention and measures taken
- History of DV including previous and current complaint and injuries
- Document the follow up plans

III-3 Special considerations

a- Children

It is better to avoid discussing violence with a parent in the presence of a child, especially if the child is above 2 years of age. When meeting with abused children, the same ***guiding principles*** (respect, safety and confidentiality) that apply to adults hold. Begin the clinical encounter by building trust and creating a safe environment: Make the young person feel at ease by allowing a trusted adult accompany her/him or involve the child in a conversation about topics not related to abuse (cartoon, TV series, computer game, school, friends..). Talk to the young person respectfully and sit at his/her level while doing so. Use language he/she understands. Explain what you're doing and that your main concern is the child's best interest. Try to keep eye contact as much as possible and let the child move around if he/she wants to.

Begin the interview by asking open-ended questions, such as "*Why are you here today*?" or "*What were you told about coming here*?" or "*Would you like to tell me what happened?*" Allow the child to use his/her own words without correcting him/her as children may misuse words. Consider the child developmental milestones when listening to the child: a 3-5 year-old child is unlikely to have a logical or linear thought pattern and may be unable to give detailed information, 6-7 year-old children may be talkative, but may not have a clear understanding of the passage of time and can mistaken yesterday for tomorrow, or before for after, so the sequence of events they narrate may be haphazard or confusing.

When asking questions, it is better to use non-directive questions while avoiding assumptions. For example, it is better not to ask: "*Was it your father who hit you badly?*" Rather ask, "*Who did that to you?*" It is preferable not to say, "*You say your uncle doesn't let you sleep at night. Does he molest you*?" But rather, "*What does your uncle do so you can't sleep at night?*" It is also important to avoid showing disbelief to the child like

saying, "*Did this truly happen or it is something you saw on TV?*" It is also better not to repeat the same question several times to check for consistency; because children like to please, they may change their replies because they thought you didn't like the previous one. One should also avoid asking the child to repeat the story several times, which can be distressing and may reflect disbelief.

Abused children have difficulty expressing their emotions; it is important to allow the child to express his/her emotions and not to make assumptions about what they could be feeling. Don't push for information as the goal is to help and not investigate. Don't touch the child without taking permission. Sexually abused children dislike physical touching.

Confidentiality is also of prime importance when dealing with children, especially teenagers. Resist revealing to the parents the information confided to you by the child unless you think a major harm is imminent. Explain to the child that you are his/ her advocate and that your concern is his/her best interest. Keep in mind though that it is mandatory to report child abuse to legal authorities.

Provide the guardian and child with information about the ***examination*** you are about to perform. Obtain consent for each element of the history and physical exam, while reminding the child and guardian that even if consent is given, they can refuse to continue at any point. Better keep a support person or trained health worker whom the child trusts while doing the exam. Encourage the child to ask questions about anything he or she is concerned about or does not understand at any time during the examination.

Explain what will happen during the examination, using terms the child can understand. Never restrain or force a frightened, resistant child to complete an examination. Restraint and force are often part of sexual abuse and, if used by those attempting to help, will increase the child's fear and anxiety and worsen the psychological impact of the abuse. It is useful to have a doll on hand to demonstrate procedures and positions. Show the child the equipment and supplies, such as gloves, swabs, etc.; and allow the child to use these on the doll.

b- Sexual assault- the case of a refugee

For several reasons (shame, guilt, fear of stigma, safety concerns, psychological impact of the traumatic experience..) most survivors of sexual assault do not seek medical assistance in the immediate period following the assault and, when they do, they often present with a variety of other complaints. It may be even more difficult for refugees to seek help for they may have other concerns related to displacement and meeting basic needs for food and shelter, fear of being rejected by their own community, perceived cultural differences with the existing system and lack of awareness on where to go for help. It is important to provide abused refugees with compassionate, competent and confidential care.

Compassionate treatment means treating the abused refugee with kindness and respect; creating safe, private and supportive environment; being sensitive and respectful of cultural differences without discrimination. If a health care provider has any personal,

cultural or religious barriers to provide complete services to survivor, he/she is expected to delegate the care to another provider. Competence implies having the required skills and qualifications to provide appropriate care and avoid having survivors re-tell the abuse incident several times to different people which delays treatment and make them relive the experience of abuse. Confidentiality means avoiding discussing the case outside the clinic, and keeping the related information restricted to only those directly involved in the care of the survivor. Any other release of information requires the survivor's permission. Limits to confidentiality are to be stated: "*Anything you tell me will remain confidential. I am not going to share with anyone without your consent. However, if something poses a threat to your life, then I am bound to inform the authorities to make sure you will be safe*". Legally, all cases of non-marital rape are to be reported.

i-The interview

Sometimes the refugee survivor needs a translator. It is best to have a translator from the health facility or to let the survivor chose a translator from the community with whom she feels comfortable and who is able to maintain confidentiality. When gathering information, the patient may be confused and give a non-coherent history. Summarizing and requesting clarification can be used. Keep in mind that the purpose is NOT to decide if a rape has occurred, but to guide the examination and management. Do not ask unnecessary questions, nor pressure the survivor to talk. Active listening skills are very useful. Let the survivor proceed at her own pace, respecting episodes of silence or expression of emotions. Use comforting words and validate feelings, "*I know this is hard to talk about. Feel free to proceed when you are ready.*" Avoid blaming statements, like asking, "*Why you did not fight back?*" or "*Why did you go out at night?*" If the survivor expresses guilt or shame, explain gently that rape is always the fault of the perpetrator and never the fault of the survivor. Assure her that she did **not** deserve to be raped, that the incident was **not** her fault, and that it was **not** caused by her behaviour or manner of dressing. Do not make moral judgements of the survivor.

ii-The medical history

The medical information that needs to be collected from a sexual assault survivor include: past medical history including allergies, last menstrual period, current contraceptive methods, medications including alternative or herbal remedies, family or social support.

As for the sexual assault, gather information about when the assault occurred, whether it was it a single incident or repeated over days; whether physical force was used; if oral, vaginal or anal penetration occurred; number of assailants; whether the assailant was a stranger or an acquaintance; and whether the survivor lost consciousness during or after the assault.

The sexual assault survivor may consider suicide. Asking about suicide specifically is important: "*Are you feeling so bad that you are considering killing yourself?*" or "*Do you sometimes wish you could go to sleep and not wake up?*" Listen carefully to the response. When the reply is, "I don't know," or "No," without giving reasons to live for, then it may mean yes. This warrants further asking about plans being

considered to commit suicide. Let the survivor express emotions and extract a promise from the patient to contact you or a trusted person when she is considering harming herself.

iii-***The physical exam***

A complete physical exam is to be performed while preserving the patient's dignity: asking permission for touching (sexual assault survivors are sensitive to physical touching), explaining every step of the exam, encouraging questions, allowing the survivor to be in control of the exam stating your readiness to stop whenever the patient wishes to. Keep the patient covered, uncovering the part to be examined one at a time. Do not examine over a sheet as it may hide bruises. Allow a companion to be present during the exam if the patient wishes to.

A vaginal speculum exam is performed when there is heavy uncontrolled vaginal bleeding, or a foul smelling vaginal discharge and a foreign body inside the vagina is suspected. If a gynaecological exam needs to be done to collect forensic evidence, then the patient is better referred to a legal doctor. The vaginal speculum exam is contraindicated in a prepubescent child or if the survivor is in her second trimester and bleeding (better refer to a specialised obstetrician as there is possibility of placenta previa). The exam is not to be done if the patient refuses.

iv- Management of sexual assault

This includes: preventing unwanted pregnancy, sexually transmitted infections (STIs) and tetanus, and long term psychological effect of sexual abuse. The sooner a survivor of sexual abuse seeks care, the more preventive care can be provided. Refer to annex IV for general guidelines of the medical treatment of sexual assault survivors.

a- Preventing pregnancy

Emergency contraceptive pills (ECP) can prevent pregnancy if given within five days after intercourse and should be offered to all female patients within the reproductive age group if there has been vaginal intercourse. They reduce risk of pregnancy by 80-90% but cannot prevent pregnancy resulting from sexual acts that take place after the treatment. Oral levonorgestrel is given once in a single dose and has few side effects like breast pain, vomiting and irregular vaginal bleeding. A pregnancy test is not required before taking ECP, but it is preferred as a positive test within a week of rape indicates a pre-existing pregnancy. If a pregnant woman takes ECP, however, it will neither end the pregnancy nor harm the foetus. It should be noted that ECP is most effective when taken within 72 hours of unprotected intercourse, and that it may be less effective in women who weigh more than 70kg.

An intra-uterine device is effective in preventing pregnancy if inserted within 7 days of intercourse. However, it is preferable to have a negative pregnancy test before insertion. It can be removed at the next menstrual period or left in place for future contraception. It necessitates a trained provider.

b- Preventing HIV/STIs

Women may be concerned about the possibility of becoming infected with HIV as a result of rape. While the risk of acquiring HIV through a single sexual exposure is small, these concerns are well founded especially in settings where HIV and/or STIs prevalence are high. Compassionate and careful counselling around this issue is essential. The health care worker may also discuss the risk of transmission of HIV or STI to partners following a rape.

Appropriate antibiotics can prevent sexually transmitted infections if given soon after the assault, preferably within 72 hours. They are usually effective against gonorrhoea, syphilis and chlamydia infections but do not cover all STIs and they do not cover future sexual acts. The patient is to be instructed to return to clinic if she develops anal or vaginal discharge or pain later. Hepatitis B vaccine must be given within 14 days of exposure to all unvaccinated or inadequately vaccinated survivors of penile vaginal or anal penetration.

HIV post exposure prophylaxis (PEP) is offered to all patients who present within 72 hours of sexual penetration (vaginal or anal) or if they had their eyes, nose, mouth or open wounds exposed to the assailant blood or semen. A 2 drug regimen (ZDV-3TC) is usually given for 28 days and is well tolerated. Side effects include mild to moderate nausea, fatigue, weakness, headache or inability to sleep. The survivor should be instructed to complete the 28 days course.

Testing for HIV is voluntary and should be offered for everyone but is never a requirement for treatment. Treatment should be initiated as soon as possible. Women who are pregnant should receive prophylaxis for STIs and HIV. Antibiotic regimens for STI prevention will need to be modified to ensure they are compatible with pregnancy. Combivir, the most common form of PEP, is safe in pregnancy. The Hepatiis B and tetanus vaccine are safe and effective in pregnant women. HIV post exposure prophylaxis (PEP) is safe for pregnant women.

c- Mitigating psychological impact

Medical care for survivors of rape includes referral for psychological and social problems. Mental disorders, stigma and isolation, substance abuse, risk-taking behaviour, and family rejection are common sequelae of sexual assault. Even though trauma-related symptoms may not occur, or may disappear over time, all survivors should be offered a referral to the community focal point for sexual and gender-based violence, if one exists. Survivors are at increased risk of a range of psychological symptoms; it would be helpful to tell the survivor that she has experienced a serious physical and emotional event and to advise her about the psychological, emotional, social and physical problems that she may experience. Explain that it is common to experience strong negative emotions or numbness after rape. Encourage her to confide in someone she trusts and to ask for emotional support and to actively participate in family and community activities.

Involuntary orgasm can occur during rape, which often leaves the survivor feeling guilty. Reassure the survivor that, if this has occurred, it was a physiological reaction and was beyond her control.

iv- Closing the interview

Check if the survivor has a ***safe place*** to go to, and if someone she trusts will accompany her when she leaves the health facility. If she has no safe place to go to immediately, efforts should be made to find one for her. Tell the survivor that she can return to the health centre at any time if she has questions or other health problems. Encourage her to return in two weeks for follow-up evaluation of STI and pregnancy. The survivor should be advised to use a condom with all partners for a period of 6 months (or until STI/HIV status has been determined). Give advice on the signs and symptoms of possible STIs, and on when to return for further consultation. Give clear advice on any follow-up needed for wound care or vaccinations. If the survivor has dependants to take care of, and is unable to carry out day-to-day activities as a result of her trauma, provisions must also be made for her dependants and their safety.

v-Documentation:

Proper documentation is important as it may valuable if the patient decides to seek legal support. The following should be recorded in the patient's file:

1. The occurrence, nature, and time of abuse and the perpetrator identity when possible. Using patient's quotes is recommended such as "patient states" or "patient reports".

2. Findings from the physical examination with an accurate recording of injuries: nature, shape, and colour. If possible, photographs of any physical injuries may be obtained if the patient permits. The photographs must include the patient's face or identifying features with the injury to be useful as evidence. If a camera is not available, the physician should make a sketch of the injuries or use body maps to record injuries. Health providers who have not been trained in injury interpretation should limit their role to describing injuries in as much detail as possible without speculating about the cause, as this can have profound consequences for the survivor and accused attacker.

Document your assessment of the emotional state of the survivor

3. The laboratory or radiological studies ordered, the medications prescribed, and the referral when done.

4. Comments on comorbidities; pregnancy, if present; and degree of disability.

Record the interview and your findings at the examination in a clear, complete, objective, non-judgemental way. Document your findings without stating conclusions about the rape. Note that in many cases of rape there are no clinical findings.

IV- THE INTERVIEWS

Below are the transcripts of the interviews. Enclosed in the boxes are the authors' suggestions for points to be raised in the discussions. Facilitators are encouraged to follow the sequence, but they are also free to tailor the discussions the way they feel more comfortable or fitting the group better.

Clip1- Recognising indicators- preparing the stage

Suha came into the clinic, feeling mad at the secretary

Suha - Doctor, this secretary of yours is not good, who does she think she is

Doctor -Why, what happened?

Suha -She doesn't know how to deal with people, she kept me waiting on the phone for over ten minutes. And now when I told her I want to go in to see the doctor, she tells me that I can't I don't have an appointment. Also she criticized me for taking appointments twice before and not showing up. What does it have to do with her? Why is she criticizing me? And now I told her that I want to see the doctor between appointments, she told me that I have to wait for my turn because I do not have an appointment. I do not understand.

Doctor - It seems you are very angry Madame Suha, calm down, what happened? Why are you angry?

Suha - I have just told you? It is a major hassle to get to you

Doctor- Ok calm down now I will talk with the secretary later; how are you? Do you still have colics?

Discuss consequences/ impact of violence; responding to angry patients
The paragraph illustrates the behavior of a survivor: angry, unsatisfied, non compliant, trying to gain control, defensive and misinterpreting things as addressed against them.
The physician reacted inappropriately to her anger. Asking "Why are you angry?" implies that she has no reason to be angry, which makes her feel poorly understood. A better way would be to recognize and validate the feeling like "I can see you are angry and I know that waiting for long can be stressful…"

Suha **- I didn't have good sleep and now I have headache and this dizziness. I am taking the medication you prescribed to me but as if I am not**

Doctor - Are you taking the medicine regularly?

Suha- **Sometimes I forget it.**

Doctor- Eh you must take it as you should and then we will talk about the problem

Suha- **Doctor, it is the same whether I take it or not. Perhaps you don't know how to treat me. Maybe I should do a scan for my head and abdomen, and may be an audiogram too**

Doctor- I'm the doctor and I know what should be done.

Suha- **Ok, as you want doctor.**

Discuss again consequences of violence on the survivor and highlight its effect on the doctor-patient relationship ; the importance of non verbal communication *Survivors frequently present with multiple complaints, are unsatisfied with the care they receive, and try to gain control of the relationship, making them difficult to manage. Physicians can get irritated easily and may show rejection, reply defensively or even offensively. Responding to patients aggressively makes them feel less comfortable and less likely to disclose personal information. It is preferable to use reflective replies or negotiation skills like,"What makes you forget to take the medication?"or "It seems you have worries about your health, let us go over your complaints and then we decide what is better for you."* *It is better for physicians to maintain good eye contact with the patients whenever possible, assume a relaxed posture and maintain a calm tone of voice.*

Doctor- You told me last time you were having this dizziness and pains, do you still have them?

Suha- **They are the same**

Doctor- When do they increase?

Suha- **I feel when I get angry or upset, they become more intense. Anyway, everything is upsetting.**

Doctor – ohh; it seems you are very sad .. ok, now we don't have much time to talk and there are patients waiting outside
(doctor starts writing on the file and seems busy)

Suha- **Life is soo full of running around, we cannot relax, my husband is always angry and the children are always fighting with each other and I am stuck in the middle.**

Doctor- it's ok, ok. I can see you are very sad and depressed. I will prescribe you a medication which is good for your nerves; you take one pill per day and let us meet another time, ok? Next time, we will talk more about this problem.

Discuss funnelling technique, preparing the stage, minimizing – non verbal communication, recognizing clues
When starting the interview with survivors, it is important to use the funnel technique, recognizing the clues that indicate the presence of violence, starting with broad, opening statements or framing questions, and then proceeding to direct questions. Reflecting feelings can also be a good starting point. Yet, it is better before to prepare the stage by making sure the person is alone, in a private place, without interruptions. It is also important to reserve adequate time, and seeming unhurried when discussing is asked personal issues with patients.
Minimizing the patient's concerns is to be avoided as well as giving "quick fix solutions." It is better to recognize the seriousness of the issue by showing readiness to help and to listen when time permits.

Clip2- Opening remarks and asking

Doctor- How are you today Mrs Suha?

Suha**- I'm getting from bad to worse**

Doctor –Why? Are you still in pain?

Suha **- I didn't sleep all night because of the pain, and the dizziness is really disturbing me and not letting me move around, and my tummy is always distended. when I eat my belly becomes like the balloon**

Doctor – You should pay attention to what you eat because some kinds of food would bring the colics like the cabbage and the bean

Suha **– I know sometimes it is from the food and sometimes it is from being upset**

Doctor – ohh upset? You? What do you have at home?

Discuss: directive questions, mis-interpretation, non verbal communication
When communicating with patients it is better to avoid directive or leading questions, and avoid misinterpretation. So interpreting the patient's statement "I am getting worse" as she is in pain and directing the question accordingly may take the interview in the wrong direction. Using direct questions may help in clarifying. "What do you mean by worse?" or "How is it getting worse?"
When encouraging patients to speak out, it is important to recognize the difficulty of such disclosure, yet using coercion as a way of encouragement is to be avoided as patients may interpret it as mingling in their personal affairs. Patients need to feel

comfortable and left to decide of whether and when they want to discuss personal issues. Encouraging and reassuring statements can help like "I know these are private issues and it may be difficult to talk about them, but I want you to know I am here to help you and am ready to listen to you whenever you feel ready to speak"

Suha- **Nothing really; not much different from other houses**

Doctor- Ohhh..You have to talk so I can help you

Suha – **I don't think you can solve my problems. I'm here because of my dizziness, headache and abdominal pain**

Doctor- You feel that you are sick; when your mood is down, your body gets tired.

Suha – **May be you are right , when I am stressed all my pains increase, but I am taking the medicine and it is not helping, on the contrary, the pains are increasing**

Doctor –What is stressing you?

Suha - **What is stressing me??? !!Well I have problems everywhere. This one keeps shouting and the other gets angry, and my husband is a nervous guy and the children are troublemakers..and he keeps taking out his anger on others ...**

Doctor – Do you mean you are being subject to violence?

Discuss: coercion, validating patients symptoms, asking about violence , paraphrasing or restating

-When addressing psychosomatic illnesses, it is better to recognize the patient's symptoms as genuine and avoid saying "It is all in your head" or alluding to it being unreal. Some people interpret this as being called crazy. Better validate patients symptoms while relating to psychological distress
-When asking about violence, it is advisable to avoid using the word "violence", as it may intimidate or embarrass people. Some people who are in a violent relationship may also not know they are in a violent relationship. Accordingly, it is better to ask about specific behaviours like: "He is taking out his anger on others? Would he hit anyone or shout at anyone?"
If the person seems reluctant to disclose violence, it is not advisable to coerce him/her through conditioning offering to revealing their secrets. The message is better be: I am ready to help regardless. Similarly, insisting to know details is counterproductive. Knowing details of the violent incident is only helpful if the patient feels better talking about it.

Moreover, introductory statements can be helpful in asking about violence "I know many patients who have similar complaints are living in relationships that make them feel unsafe. Are you in a relationship where you feel threatened or that makes you unhappy?"
-Paraphrasing or restating can often be used to facilitate the interview, to encourage the patient to speak out and to clarify certain points. Yet when paraphrasing, misinterpretation is to be avoided as it may lead mislead the interview in the wrong direction

Suha - **Violence?? No .. No.. definitely not!!! It didn't reach that far... Honestly doctor, my husband is very nice man when he is relaxed.. but when he gets angry, we better get away from him.. Children are afraid of him when he gets back home. But they can be really exhausting too.. and the man is really a hard worker.. he has to secure an income and all what we need at home..and you know everything is expensive… he has the right to get nervous.**

Doctor- Well yes he can't get upset for no reason.. children from one side and I am sure you do provoke him and may be you are not doing what he wants.

Discuss: justifying violence and blaming survivor

It is common for survivors, when narrating the violent incident, to justify violence. Health care providers may also blame the survivor for precipitating the violent incident thinking that this may lessen the anger and decrease the gap between the couple. However, this would increase the risk of further victimisation. Providers are expected, when dealing with survivors, to communicate that there is no justification for violence and that there are better ways to resolve conflicts. This is helpful in decreasing self blaming and improving self esteem. Similarly, health care providers should be cautious not use words, questions or statements that may directly or indirectly blame the survivor or accuse of causing the violent incident; as for example using the why questions" Why did he beat you" or asking " What have you done so you were beaten".

Suha- **I am really overwhelmed, am doing things beyond my capacity , I am running from one place to the other, home, cooking, work, laundry, many duties ….. What more can I do. Last time, when he got home, I started telling him about what his son did in school and what the teachers were complaining about and that he was making trouble in school. He told me to bring him lunch first and then we talk. When I said this problem is very important, he got nervous and started shouting.**

Doctor- well couldn't you have waited a little???!!! You could have prepared for him something to eat and postponed discussing the issue for later.

Discuss: Showing empathy, use of empowering messages. Can discuss blaming survivor again

Communicating empowering messages, giving recognition and showing empathy are essential elements of the interview. This decreases the survivors' feelings of isolation, and improves their self esteem. Showing empathy is also communicated through body posture, facial expressions, respecting episodes of silence.

Suha – **It doesn't matter, he is not pleased with whatever I do. He is always nervous Sometimes I say to myself it may be better if I die**

Doctor - No what are you talking about??!! it is not worth it... If you are feeling that bad, why don't you get a divorce.. leave the house

Discuss : Suicide, minimizing, suggesting collaboration and not giving solutions

Survivors are at higher risk of committing suicide or even homicide. It is recommended to ask the patient about suicidal or homicidal thoughts and if present to assess their seriousness and act accordingly. A common reaction to such disclosure is to minimize the emotion hence missing the opportunity to possibly save the patient.
Health care providers need also to refrain from giving solutions. It is better to discuss alternatives for solution and leave it to survivor to choose what is perceived to be a better fit. In this process, providers need to show concern and offer support, suggesting cooperation and collaboration.

Clip3- Responding

Suha**- Get a divorce?? I don't know…..where would I go... Two weeks ago I went to my parents' home, he followed me there and started crying, regretting what he did and saying he has changed. After I came back, it didn't take him more than two days to start hitting me again and he dragged me on the floor while pulling my hair saying if I leave home again he will humiliate me in front of everybody and would slaughter me**

Doctor- After all of this and you are still staying with this animal; if I were in your place, I would have left him long time ago

Discuss: non verbal response, use of loaded words- may discuss safety assessment, guidance

Let the participants interpret the response of both patient and physician (verbal and non verbal). She seems surprised/ shocked by the solution provided by the physician.

The physician shows anger and disdain which may make the patient feel humiliated. Along the same vein, it is better to avoid the use of loaded heavy words (animal, beast) when referring to perpetrator. Although the intent may be to alleviate the patient's anger, the hidden meaning may be degrading "If you are staying with an animal, then you are no better". In addition, giving oneself as example "If I were you" can be intimidating and should be avoided.
Safety assessment and planning are part of the management of the survivors and to be done, preferably at each encounter, whenever there is concern about patient safety. It entails asking about how the violence severity and frequency are progressing over time and what strategies did the survivor use to stay safe and whether they were successful.
A common question crosses the mind when listening to survivors, "why doesn't she leave"; a better question to ask is"why is she staying". Recognising why she is staying is helpful to recognise the "positive aspects" of the survivor's life, the coping mechanisms and what she has to lose if she took the decision of leaving hastily.

Suha - This applies to you, doctor; but I can't do such a thing myself

Doctor- Why don't you sue him? We can report him.

Suha –**No he will kill me. a week ago he threatened to slit my throat with a knife if I leave the house again**

Doctor- This is all nonsense, he wouldn't dare doing such a thing

Suha - **I can't he will kill me, I'm always terrified of what he may do. He threatened me he will take the children and wouldn't let me see them. And you are telling me that this shouldn't cause stress???!!!**

Discuss: Minimizing danger sign.. safety assessment and planning

Doctor – Did you try once to be more patient, to talk to him quietly, maybe he will wake up..

Suha **- I'm really trying even more than my best.. my health is barely good and the children are difficult to handle, they are being beaten.. and the girl is very difficult, she doesn't focus… what do you say if we get a fifth child, his heart may soften and he may change?**

Doctor - What???? Are you really considering getting a fifth child???

Suha - **You are right, I'm not thinking straight. What do you think doctor, how about if you talk to him, for sure he will listen to you. You are a well known doctor and I'm sure he will listen to you.**

Doctor - Alright let him come with you next time, and I will talk to him

Discuss: focusing, couple intervention

Survivors can get very confused, get lost in details, have contradictory statements, or think impulsively. Providers need to help them focus by showing contradictions or consequences of their impulsive thoughts. Survivors can also be manipulative and try to persuade providers to intervene with the perpetrator. Providers need to refrain from jumping to the rescue for several reasons, some of which include risk to the physician's personal safety, risk for the escalation of violence by the perpetrator, ineffective intervention (change of behavior is long process), increased dependency on the provider, while showing concern and providing support.

Suha – **ok I will tell him to come for a checkup because he has been having headache, and you talk to him, but please don't mention what I told you to him.**

Doctor - oh don't worry, your secret is safe with me. Your neighbour Suad told me too that her husband beats her and asked me to keep it a secret and I haven't told anyone

Discuss: Confidentiality

Confidentiality is of utmost importance in all encounters with patients and more so when dealing with violence survivors, because of safety concerns and the need to build trusting relationships.
Confidentiality can be communicated directly through informing the patient that what is being said will remain confidential within the limits of confidentiality that will be agreed upon. It is also communicated indirectly by not revealing information (whether personal or not) of other patients, to other persons, family members or even colleagues without having the consent of the person involved. This includes making sure that files, papers having identifiers are not visible to others..

Suha - **Maybe I will bring my daughter too, and try to solve her problem too.**

Doctor - Don't worry, next time you will bring your daughter for a check up and I will also talk to your husband. Now keep on taking the antidepressants once daily, and if one pill doesn't help, take two. From now till the we meet again, if anything happens you can talk to one of those groups that are women's right advocate groups, they may be able to help you , ok?? come back in two weeks time for your appointment, and don't be late like you usually do..

Discussion: Closing the interview, False reassurance or promises

Sometimes when closing the interview health care providers give falsely reassuring

promises. While well intended, such approach may not help survivors regain hope; on the contrary, this may place the survivor at risk of increasing disappointment and helplessness. When closing the interview, it is important to reassure the survivor that violence was not their fault, that no one deserves to be treated in a violent way, refer or provide with list of resources of agencies where they can seek help, schedule a follow up appointment, and end the interview with a positive statement, assuring of willingness to help. Highlighting negative behavior is to be avoided

Doctor alone: Uffff what a patient!!!!!! , what am I going to write on her file?? a nagger?

Discussion: Self care, documentation

Clip4: Improved version of Clip1

Suha came into the clinic, she is angry at the secretary

Suha - **Hey Doctor, this secretary of yours is not normal, who does she think herself?**

Doctor – why? what happened?

Suha **-she doesn't know how to deal with people well, she keeps me waiting on the phone over ten minutes. And now when I told her I want to go in to see the doctor, she tells me that I can't I don't have an appointment... and started criticizing me for taking appointments twice before and not showing up. And now I was telling her that I want to see the doctor in between appointments, she told me Sorry madam you cannot, you have to wait for your turn because you do not have an appointment!!. I do not understand..**

Doctor – yes you are right, sometimes waiting can be difficult.. what do you have today?

Suha **- I Have just told you what I have!!! It is a major hassle to get to you**

Doctor - Ok don't worry about it, I will talk to the secretary; you are more important now, how are you, you still have colics?

Suha – **Yes, I was having tummy pains all night and now I have headache and dizziness. I am taking the medication you gave me, but as if I am not!!**

Doctor - Are you taking the medicine regularly?

Suha - **I forget sometimes.**

Doctor - Why are you forgetting, are there too many things on your mind?

Suha - **Many things ..but anyway if I take it or not, it is the same. May be you are not getting what I have. What don't you order a scan for my head and abdomen, and may be an audiogram**

Doctor - Let's first see what's going on with you, and then we'll decide what are the tests you should be doing

Suha – **Ok as you want doctor**

Doctor - Last time you said to me that you were having pains and dizziness

Suha **– yes they are the same.. they come and go**

Doctor- and when do they increase?

Suha**: doctor, there is stress.. life is full of sorrow**

Doctor - Sorrow and stress????

Suha **- Life is full of running around, no one is satisfied.. my husband is always angry and the children are always fighting with each other and I am stuck in the middle.**

Doctor – Mmmmmmm .... it seems there are plenty of things that are tiring and upsetting you... what do you say if we have another meeting so we have ample time to talk more about it, I am sorry but there are a lot of patients waiting out I can't let them wait more .

Suha: **ok thank you**

Clip5: Improved version of Clips 2 & 3

Doctor - How are u today Md Suha

Suha **- I'm getting worse and worse**

Doctor –what is going on?

Suha - **I can't sleep from the pain, I feel it increases when I am tired or upset**

Doctor - It seems there are a lot of things upsetting you. Last time you told me that you are having lot of problems at home, what is going on?

Suha - **Nothing out of the ordinary, just like other people**

Doctor - I know these are private issues and it may be difficult to talk about, but if you talk about them may be you will feel relieved and maybe I can help you or do something

Suha – **I don't think you can solve my problems. I'm here because of my dizziness, headache and abdominal pain**

Doctor - The body gets tired when you feel psychologically down.

Suha - **You are right, I have noticed that when I am upset all my pains increase, but I am taking the medicine and it is not helping, the pain is increases**

Doctor –ok, let us talk about the things that are upsetting you. I promise you that everything you tell me will stay between us you and no one will know about it unless I find there may be a risk for your safety or the safety of another person; you can decide who you want me to talk to at that time. Agree?

Suha - **Well I agree, but now I can't think of someone you can talk to when needed, will let you know when this happens**

Doctor - Ok you told me that your husband gets angry … how does he behave when he gets angry?

Suha- **He behaves like all other men, he gets angry and he stops "seeing around him"**

Doctor - Does he beat you when he gets angry?

Suha- **Sometimes but not much**

Doctor- he screams and shouts?

Suha - **He is the edgy type. He gets angry quite fast and begins to shout .. you know things are expensive, and he is the only one who works at home to secure the daily expenses and get things for the children and for the house. Sometimes I feel he has the right to get angry.**

Doctor - We all can get stressed, but we shouldn't hit, shout or curse or else people will start killing each other. Tell more what is going on

Suha - **He doesn't like whatever I do. He gets angry very fast.. I can't speak a word, sometimes I think it may be better if I die**

Doctor - Are you thinking of suicide?

Suha - **Sometimes I feel I wish I die and get rid of this world but I have 4 kids, I have to raise them, and see them grow I am sure one day it will be better**

Doctor - It is good you are being positive, did you ever consider leaving home

Suha - **I left home once and went to my parents. I stayed there a week. He started crying and telling me he has changed; two days after I came back home, he hit me, dragged me to the floor while pulling my hair and told me if I leave home again he will insult me in front of everyone and would slaughter me**

Doctor - And do you think he will do that?

Suha - **Frankly he scares me, I am always frightened of what he may do, he threatened me that he will take the kids if I leave another time and would not let me see them .. and you ask why I am nervous??!!! I will have heart disease later too**

Doctor - Do you think if one time he gets angry, would he pull a knife? What can you do? How would you defend yourself?

Suha - **Oh I am considering having a fifth child.. his heart may soften and he may change..**

Doctor – Perhaps but I understood from you that you are not financially well off and you already have 4 kids, did he change after you had any of your children?

Suha - **you are right. I am no more thinking straight. May be, doctor, you can talk to him. You are a good and famous doctor, and he will definitely listen to you.**

Doctor - Did anyone from your family try to talk to him at least once? If I talk to him, he may change for a short period and then will go back to what he used to be. I don't think this is a good solution. What I can do is to give you the addresses of organizations who work on these issues and if you want you go to them and see what they can do to help you. From now till then, I am here if you need anything

Suha - **I don't know. Let me think about it.. I will bring my daughter and you will solve her problem**

Doctor –For sure bring your daughter to be examined and we will see what her problem. Meanwhile, think well about what we said and if you need anything you can talk to me

Clip6- The child

Doctor: talking in phone

Suha – **Bonjour Doctor**

Doctor -Bonjour how are you Md Suha

Suha - **last time I went out feeling much better, so I came today on time as agreed, and brought my daughter with me.**

Doctor – hopefully you will always be happy and no more have problems at home. By the way, how are things at home? Is there still fighting, hitting or beating?

Discuss: Child in the room *Some physicians argue that family violence can be discussed in front of children as they are already witnessing the situation within their home and are aware of it. Yet, many physicians agree that it is possible to discuss family violence with the patient in the presence of the child as long as the child is non-verbal or younger than three years of age. The choice of not raising the issue of family violence in the presence of children is often justified by the concerns that the child's presence can be a barrier to the disclosure of the parent, the possible negative emotional effects on the child upon listening to the conversation, and the fear that the child might reveal the conversation to the perpetrator, hence endangering the survivor parent and other family members as well. It is preferable to arrange for a private interview and ask about violence in the absence of the child.* (The Family Violence Prevention Fund, 2004; City & County of San Francisco Department of Public Health Community Public Health Services, 1996; Mc Calister, 2004)

Suha – **Ehh no It is ok it is ok, but I am not here today to talk about me, I am bringing my daughter.**

Doctor - Why, what does she have, your daughter?

Suha – (talking to her daughter) can't you stay quiet for a while? Then talking to doctor, **this girl is exhausting me, I don't know what is going on with her these past two years she is getting me tired. She is complaining from pain in her abdomen. I took her to a very good doctor and he did all the necessary blood tests, and he told me there is nothing wrong with her. But how come there is nothing wrong and she is again back peeing all over at home and even at school; and every day she wakes up in the morning and starts vomiting two or three times**

Doctor - How is her weight?

Suha – **Her weight is normal, it is not dropping and may be increasing a little**

(mother going to her daughter) Can't you stay quiet a bit? sit here and don't move, ok ?

Doctor - May God be with you, she didn't stop moving since she got in.

Suha - **I told you she is getting me exhausted , (to her daughter) stay still…**

Doctor - Is she always like this?

Discuss: indicators of child abuse, physician's non verbal communication with the child

Children survivors have several manifestations of abuse that health care providers are to be aware of; Hyperactivity is one, as well as multiple non specific complaints. The physician ignored the child, no greeting nor eye contact, apparently considering the child as problematic and sympathizing with mother.
Putting the child at ease is an important preparatory phase to the interview. Showing respect to the child by addressing him/her casually, maintaining an objective non biased attitude are helpful to gain his/her confidence

Suha - **Always..there are several complaints about her in school that she is not focusing. They said she is smart and she can give more, but she is not focusing, they even said she is beating her friends there**.

Doctor - Ah, shame on you, a good girl like you would beat other children??? Oh.. don't make me get upset with you. Please Md Suha can you wait outside so I can examine her and talk to her privately and then I will tell you what we did

Discuss: Being judgmental , lecturing, confidentiality

Frequently, the health care provider adopts the attitude of a parent while dealing with children, and tries to give advice or lecture the child thinking it is a good way of correcting a behavior. This is to be avoided as the parent can be the abuser. The child will feel judged and will have difficulty engaging in the interview, perceiving the provider as potential abuser. A good way to engage the child is to address him/her at his/her physical level (sitting next to the child if the child is sitting at the ground, for example) or cognitive mental level using words he can understand, while being non-judgmental. It is also recommended not to touch the child without taking his/her consent, as physical contact may create anxiety in children exposed to violence, particularly sexual abuse.
Confidentiality is a major issue when dealing with children especially teenagers. It is important that the child feels that the information he/she will declare to the physician will stay confidential unless there is risk of harm or danger to his/her safety. It is better to inform the parents that the information revealed by the child or teenager will stay confidential and they will be informed when a harm or hurt is

expected to happen.

Suha – (talking to the child) **: You will listen to the doctor now, ok (mother go out)**

Doctor – Good girl, what is your name? You don't want to answer me? Ok can you do some drawing, I will get out the coloring pens for you. You want to tell me what is going on at your home. How are things at home? Are they always fighting? Are you good in shool?

Girl- (yes)

Discuss: Interviewing and examining the child alone, questioning, observing non verbal cues of the child

For an adult survivor, asking about exposure to violence and performing a physical exam are better done alone. However, in the case of a child, the comfort of the child is a prime concern. An abusive parent is closer to a child than a well intentioned care provider. Hence, it is recommended to ask the child if he/she would like to have the accompanying person stay in the room during the interview or exam. It is an opportunity to observe the parent-child interaction and how the child responds to questions for example, when the child looks at the parent for approval..
When interviewing the child, it is always better to start with informal chat to break the ice. When the child seems to be at ease, the provider can proceed with open ended questions while letting the child speak without interruption. Direct questions can be used for clarification but better avoid questioning which sounds like interrogating or asking questions in a way that implies the child is not saying the truth. Whenever possible, avoid making the child repeat narrating the incident several times because children may get emotionally upset; an abused child, wanting to please, may also change the story thinking that the interviewer did not like the previous version. It is also important to keep in mind the child's cognitive development; for example, young children do not have a clear notion of time and may confuse yesterday with tomorrow, one hour with 6 hours, may not understand the difference between huge and big. Thus, the presence of such contradictions in the child's story doesn't imply lying or making up stories.

Doctor - And are beating the children at school?

Girl- yes

Doctor –Ok, you have to promise me that you will be a good girl no matter what

happens at home and you will listen to what they tell you so that they don't beat you, ok? Bravo you are a good girl. Ok, let me now examine you , come

Discussion: Making assumptions, lecturing, examining a child

When asking children about violence, providers make commonly false assumptions about the identity of the perpetrator or the place where the incident happened and ask questions accordingly. It is better to ask open ended questions like "Who hurt you?", "Where did this happen?"
Occasionally, health care providers engage in a long discourse of what the child is supposed to do, using vague words "You have to behave" or "listen to your parents". This is to be avoided as the child may not know what he is supposed to do so he is "behaving" or "listening". Because of this attitude, the child will see in the doctor "another parent".
When wanting toexamine a child, better take the permission after explaining to thew child what will be done during the exam. For the safety of the provider, it is best to examine the child with the parent present, to protect the provider from potential future accusations of abuse.

Girl- mom

Suha**- (her mother gets in) what is going on my dear, come sit**

Doctor-I don't know It seems your daughter is scared, I could not talk to her or even examine her, not at all. Anyway we need to do a urine test as she may have urine infection, and see if she needs antibiotics if the test turns out to be abnormal.

Suha - **Ok doctor**

Doctor - she is very attached to you

Suha **– My children are all I have in life, but if she follows what I tell her to do I will give her anything she wants.**

Doctor – ok, did you listen to what your mother was saying? Ok you have to promise me you will be a good girl. So let us meet when the results are out

Discussion: closing the interview with a child

When closing the interview, avoid justifying violence "Your parents are overwhelmed and you were misbehaving", "your parents beat you because they care for you", lecturing blaming or telling the child what to do" your parents are working hard to secure a good living for you, is this how you show appreciation? Why don't you reward them by following what they tell you do?"

Clip7: Improved Scenario of clip 6

Suha **- I swear last time when I left I was feeling much better, this is why I am coming today on time as we agreed, I also brought my daughter with me.**

Doctor - You and your daughter are always welcome. What is your name cutie, how are you?

Suha - **What , you don't want to reply to the doctor? She is really getting me exhausted, I don't know what is going on with her these past two years. She started first complaining from abdominal pain. I showed her to a good doctor and he did all the tests possible (talking to her daughter: can you sit down a bit) and told me that she has nothing. How come she has nothing and she pees all over the place at the home and even at school. Every morning she wakes up and wants to vomit two or three times.**

Doctor- ok does she is eat well?

Suha **- It is good**

Doctor - Does she have other symptoms like fever, headache

Suha**- no nothing besides her abdominal pain**

Doctor- and how is her weight?

Suha - **It is normal as you can see ,she is not losing weight and she could be adding in weight (mother going to her daughter) can you stop and come and sit here, sit.**

Doctor – Can you make a drawing for me? a car or a sun, whatever you want

Suha **– See , the doctor is getting upset with you**

Doctor – No I am not upset with you

Suha – **At school, the teachers are complaining from her saying that she is not focusing a lot on her studies and she is distracted. They said she is smart and can give more, but she is not focusing I don't know why. Her teachers told me that she is even beating her friends several times in school.**

Doctor - Why do you think she is beating the children

Suha **– May be because they beat her, so she beats them back!!!**

Doctor - so she may be imitating someone.

Suha - **Perhaps, you know better, remember what I told you the last time**

Doctor - **Honey, what did you draw, what is this?**

Girl- Sun

Doctor – Wow quite good, and what is this? what did you draw here?

Girl- Home

Doctor – Home, This your home? Beautiful.. how beautiful are the roof and windows, bravo good girl right, can I examine you now???

Girl-nods her head

Doctor - Can I place the stethoscope on your tummy ok , I will come to you

Special situation: Refugee

Doctor - Please come in

Suha - last time when I left I was feeling much better, this is why I am coming today on time as we agreed, I brought my daughter with me.

Doctor - You and your daughter are always welcome. How are you beautiful, what is your name

Suha - Greet the doctor and tell her what your name is.

Doctor- Hi how are you?

Suha - she exhausted me doctor, I don't know what is going with her these two years , she is getting me so tired and driving me crazy. She has been suffering for a long time from abdominal pain. I took her to a good doctor and he did all the tests possible and told me that she has nothing. How come she has nothing and she pees all over the place at the home and even at school. Every morning she wakes up and wants to vomit two or three times.

Doctor – How is her eating habits?

Suha - well

Doctor - Does she have other symptoms like fever, headache

Suha -Sometimes she has abdominal pain.

Doctor - how is her weight?

Suha - She is not losing weight but probably she is adding in weight (mother going to her daughter) oh my God you are making me dizzy , get down and sit here down and don't move any move.

Doctor - Come here dear, come and make a drawing for me

Suha - Stop..sit down …the doctor is upset from you.

Doctor -No I'm not. What do you say if you make a little drawing for me, you can draw whatever you want, car , sun

Suha - They are always complaining about her at school, that she is not focusing, they said she can give more, that she is smart but she is not focusing. She used to focus before more than now but nowadays I don't know what happened to her. There are complaints about her behavior at school and she even beats her friends in school.

Doctor - Why do you think she is beating the children

Suha - Perhaps they beat her, so she beats them!!!

Doctor - could she be imitating someone for example

Suha - Perhaps, did you forget what I told you the last time

Doctor - no never

Suha - Honey, let me see what did you draw, , wow how beautiful is this drawing , bravo, what is this?

Girl - Sun

Doctor - And this

Girl - Our home

Doctor - what a beautiful windows and doors. Now let us place this drawing here , and if you let me examine you, ok

Girl- The girl nods

Doctor - Just I want to put the stethoscope on your tummy ok?

Special situation: Refugee

Clip 1: Breaking the ice

Lama -Good morning doc.(*Patient is very shy and confused)*

Doctor -Good morning Lama. It has been long time, where have you been. What is new?

Lama -Doctor, I'm not feeling well. I'm very dizzy.(*Not maintaining good eye contact.)*

Doctor -Dizzy? Dizzy you mean dizzy? what else

Lama – nothing just dizziness and tired doctor, yesterday I could not go out to bring water (*Becomes tearful)*

Doctor – ehh yes the circumstances you are leaving in are not easy.. it is normal to feel tired..what else.(seems busy)

For discussion: not paying attention to non verbal cues, tears; misinterpreting, language barrier
Language can be a barrier that prevents survivors from expressing their complaints and disclose violence when present. When wanting to ask about abuse, avoid using the accompanying person as interpreter. Using an interpreter from the staff of the centre is the best solution but may not be available. It is better to identify people from the refugee committee that are trustworthy and can abide by confidentiality rules.
Many times, survivors´words are not consistent with their body language. Like in this scenario, the patient denied distress but she was tearful. It is better, in this situation, to confront tactfully the patient, pointing out the discrepancy noted like saying "but I can see you are about to cry as if there is something deeply upsetting you." Misinterpreting the distress to be solely related to the living conditions can prevent the refugee from disclosing other causes of distress. Funnel technique can encourage patients to talk, like "I can see you are quite upset. Would you like to talk about it for me to see how I can help"

Lama – No no it is just dizziness , do you want to give me a medication?...(seems in a hurry)

Doctor - In a while, I see. Do you have other symptoms? Like nausea, vomiting, headache, I don't know or numbness in your limbs? Fever? Decrease hearing? did you lose consciousness once? did you take your blood pressure? Do you have other things? tell me.

Points for discussion: asking several questions in a row without waiting for answers, focusing on bodily symptoms
When asking about associated symptoms, it is better to ask about each symptom separately, it allows the survivor to answer appropriately. It also gives the impression that the physician is not in a hurry.
Again the doctor is missing clues, misinterpreting the symptoms and making assumptions that the survivor's symptoms are related to her living conditions. It is apparent that the physician is avoiding the psychological distress of the patient, making it more difficult for her to express herself. It is better to use broad opening statements like *"You have been living in this situation for a long time. Did anything happen a month ago?"*

Lama- All my body aches, mostly my head, and above all, the dizziness and fatigue. Yesterday I took a full pack of analgesic but it didn't help (tearful)

Doctor – Lama, what is wrong, it seems you are sad or something is bothering you. Tell me quikly what is wrong because there are patients waiting out

Lama – No No I am not upset …. All is well, better than other people. Thank God (smiling)

Doctor –It seems that you are afraid that this dizziness is related to a cancer or other… No don't worry about this dizziness it is an easy problem to handle and treat

For discussion: indicators of violence; lack of time as a barrier; active listening; misinterpreting *The patient is presenting with many non specific psychosomatic complaints, which may be related to psychologic distress. Interpreting her upset as worry about dizziness without exploring other causes of psychologic distress doesn't facilitate disclosure. Asking about sensitive isues should be done in private; active listening skils and non hurried attitude are important .*

Lama – Ok doctor do you want to give me a medication because I am in a hurry. My children are waiting alone

Doctor -Oh I see. How old are they?

Lama -7 and 9 years

Doctor –This means you got married early ; because in the file you are 27 years old now

Lama -Yes I got married when I was 16 years.

Doctor - Yes I know in your community they marry girls early, isn't it a pity that they marry you at this young age to bring children to this world? ok I will give a medication to be taken 3 times daily and you will follow up in a week. This is for you

Lama - Thanks doctor

For discussion: respect of cultures *Physicians working with refugees need to get familiar with their traditions, habits and beliefs. Although some of these may need to be addressed as they can affect the health and well being of women, as early marriage in this case, the approach needs to be respectful, so as not to intimidate or alienate the refugee. A better approach would be" How was your experience being married at a young age?"*

Clip 2: Facilitating Disclosure

Doctor- Lama, how are today

Lama- Doctor I am not good, dizziness is getting worse and I can't sleep , I wake up in morning and my heart is beating fast. My weight has dropped. I have irregular periods and abdominal pain. Will you give me a medication?

Doctor -I won't give you a medicine till I know what is going on with you. I see In your file that you had anemia, are you eating well?

Lama - I had anemia long time ago. I was treated for it and I am well now…. Thank God; and now I eat whatever is available; there is quite of hard work. I am working to feed my kids

Doctor - what do you work?

Lama - clean houses on demand, Sometimes I don't have enough money to cover the needs of children; and on top of this, people don't leave you alone, they just add to your sorrow. (silence) please doctor give me vitamins so I feel more energetic
.
Doctor - what do you mean by people don't leave alone? Is there anyone bothering you
(puts his hand on her hand, she jumps)

Lama - No No who would want to bother me? why would anyone bother me? No no nothing of the sort

Doctor -Lama what's going on? this is the first time I see you like this, It seems that something major has happened and is affecting you... what is bothering you?

Lama – stays silent- confused

Doctor – Don't be afraid you can tell anything and whatever you tell me will stay between us.

For discussion: preparing for asking about violence, physical contact, confidentiality. *The facilitator is advised to review with the participants how to prepare the set up for asking about violence, have brochures available in clinic,posture, opening introductory statements, listening and facilitation skills, and confidentiality.* *Physical touching is to be avoided without prior permission from the refugee. It may be culturally inappropriate or disturbing for survivors of sexual violence*

Lama – I can't talk.

Doctor – Why you can't? what are you afraid of?

Lama - silence

Doctor – What Lama you don't want to talk?

Lama- Doctor….last week

Doctor- what happened last week?

Lama -Our neighbor.

Doctor – What does your neighbor has to do with this?

Lama – no , no , nothing

Doctor -What's the story? tell me don't be afraid

Lama -I went at night to get water from the fountain in the camp, and he was there waiting for me..

Doctor -Waiting for you? What do you mean waiting for you?

Lama -Yes, he was waiting for me. it is not the first time, he has been following me and bothering me for some time, but this time he…..he….bothered me a lot

Doctor -Bothered you a lot? What did he do to you? Why did you go in the night? Couldn't you have gone in the morning?

For discussion: facilitating disclosure: active listening, respecting silence, not to pressure for disclosure, blaming survivor *To facilitate disclosure andrecieve the necessary information, it is better for the physician to keep the survivor confortable while narrating talking about the incident: respecting episodes of silence, validating feelings, not pressuring to proceed. The provider has to be careful, when asking questions or commenting on the incident, not to insinuate blame for the survivor. Sexual violence, like other forms of violence is the responsibility of the perpetrator and should not be related to what the survivor did or the way she was dressed.*

Lama -He attacked me. I couldn' t defend myself. He threatened he'll kill me …..and then things happened..

Doctor -What do you mean things happened? Explain it further to me.. and you say he threatened to kill you? As if there is no order in this world? why you couldn't defend yourself?

Lama - (crying)

Doctor -It seems it was a terrible thing what you went through!! And then what do you do, what happened? did you escape?

Lama – I don't know I think passed out.. I don't know.. I don't remember.. someone killed me

Doctor – You don't remember? Is this possible??

Lama- All what I remember is that he told me you can go but…but if you want money you can come to home to take money for your children and he threatened to kill me if I told anyone

For discussion: types of violence that refugees can be exposed to; what information needed to collect from the survivor; psychological impact of rape, the importance of not showing disbelief

Refugee conditions are associated with increased risk of sexual exploitation, violence, and early marriage and trafficking. It may better to screen for them like askig "Is anyone making you feel uncomfortable", "Is anyone asking you to engage in sexual actsagainst your will?"

History taking should include, when possible, date and time of the assault, whether it was a single incident or repeated over days; whether physical force was used; if oral, vaginal or anal penetration occurred; number of assailants; whether the assailant was a stranger or an acquaintance; and whether the survivor lost consciousness during or after the assault.it is also important to ask about past medical history including allergies, last menstrual period, current contraceptive methods, medications including alternative or herbal remedies, family or social support.

It is possible for rape survivors to have lapses of memory loss or lose consciousness during the act of rape. It is better to recognize it as a possible reaction and not show disbelief or pressure the survivor to remember details.

Clip 3: Reassurance and preparation for physical exam

Doctor –and what are you planning to do?

Lama – (crying) I don't know what to do doctor.. now I'm dead doctor. This man ended my life. I am thinking of killing him and kill him.

Doctor – Be patient, don't put yourself into more trouble. You will get over it for sure. This has happened to others and they got are living well now.

Lama – Crying

For discussion: appropriate response, validate feelings, asking about seriousness of suicide and homicide

S*uicidal and homicidal thoughts after rape. It is important to recognize the feelings without and inquire further about seriousness of these thoughts, by exploring whether the survivor is trying to set plans for suicide or homicide. The physician should not refrain from asking "How are youthinking of killing yourself". If there is already a set plan, then an immediate psychiatric evaluation should be sought. If the survivor has not set plan yet, then the provider can ask about reasons for wanting to live and validate and reinforce these reasons. Trivializing or minimizing suicidal thoughts may deter the patient from expressing her true feelings or thinking.*

Doctor- We have talked a lot now, let us go for what is more important and examine you. Please can you go over the examination table and lie over your back?

Lama- why on my back? I think I will get more dizzy

Doctor- Lama I want you to lie on your back so I can examine your tummy, chest, and make sure that your genitals are intact. Go ahead, I will call the nurse to help you

For discussion: taking permission for exam, pelvic exam, presence of a chaperon

It is important to highlight that if the survivor presents after the rape and she is in pain from trauma she could have received, it is advisable to give her analgesics and make sure the vital signs are stable before proceeding with the evaluation. Physical exam is to be done after giving a description of what it entails and taking the survivor's approval. It is to be made clear that the survivor has the right to change her mind and go back on her approval anytime during the physical exam. A pelvic exam is NOT indicated unloess the patient is actively bleeding or has vaginal discharge suggestive of infection. If the patient presents soon after rape and is planning to file a report, then the exam is better be done by a specialised doctor versed in collecting evidence, if her condition allows waiting. The presence of a staff member while doing the exam is recommended.

Clip 4: Discussing management / A multidisciplinary approach

Doctor -Your physical examination is good Lama, you don't need an acute medical or surgical intervention. Now tell me when was your last menstrual period?

Lama -2 weeks ago. Why are you asking?

Doctor -Do you use contraception?

Lama – I don't need to, my husband is dead.. could I get pregnant from this?

For discussion: needed medical interventions: preventing pregnancy, STIs, tetanus, mitigating psychologic impact
Discuss different situations: survivor presenting within 72 hours of the assault, more than72 hours.
The facilitator is advised to refer to annex IV for information about medical management of rape survivors depending on how soon after the rape did the survivor present for care. The treatment recommended in the annex is tailored according to the medications supplied by UNFPA and made available for refugees for free. Other regimens could apply depending on what is available.

Doctor -The probability of you getting pregnant is low less than 5%. Let us talk about something more important, which is your safety and your kids safety. Since he is your neighbor, then there is a good chance that you will meet him again

Lama –Ehh...I'd rather die but not meet him for once again

Doctor- Look, from now on you should not go out alone, always go out with a group of people, let a friend or family member be with you and avoid the places where he can be present

For discussion: how to set safety plan
Since the aggressor is close to survivor, it is crucial to set a safety plan with het to prevent further victimization and also to give her a sense of security. The provider should not dictate a safety plan as he is not familiar with the set up of the refugee, or with what can be done. The refugee may be intimidated and would agree with the provider, not daring to express her concern that the plan may be difficult to apply considering her living conditions.A better approach would be to suggest a safety plan and then ask if it is feasible to be implemented, and then modify according to the feedback of the survivor.

Doctor – Lama, do you want to report the incident?

Lama -Report? To whom?

Doctor -To responsible legal authorities

Lama -No, no please doc don't report to anyone. I am scared of what people may say about me or may call my kids, God forbid. No no please don't tell anyone. .

Doctor -Lama, as you wish you know more what is best for you, I will not report if you don't want to. But someone like this animal should be punished.

For discussion: reporting, coercion into taking decisions
Legally, the health care providers are bound to report to authorities all cases of rape they come across in their clinical practice. However, the survivor is to be made aware of the consequences of the reporting som of which may include rape incident may become known to her community. This may entail her being labelled, or even risking honor killing by her family. Accordingly, the provider is advised not to push her to report the incident as she will be bearing the consequences of it.

Lama –No, I don't want. I don't want doctor. The most important thing is to protect my kids. I live for them.

Doctor –we can talk about it later, you can change your mind later

Lama – No no I don't think so

Doctor- I'll write you the names of social organizations that take care of survivors of sexual violence; they can provide you with guidance and support if you decided to talk to them or visit them (guide her how to contact specialized agencies in case she decides to report)

Lama- I don't want to go to them

Doctor- Keep the addresses and phone numbers with you, you might need to use it one day

Lama- thank you doctor

Doctor - I want to tell you a few things in this regard, you might develop some bothersome feelings like sadness, anxiety and insomnia

Lama – ehh doctor , know I feel this feelings and every day it will decrease. Sometimes I

think I'd rather be dead than to have these feelings. They are very bothersome and don't let me think

Doctor –yes I know this is why I am telling you about them and am going to give you medicines.I'll write you an anxiolytic medication called diazepam to take it every day for a week and get back to me later

Lama – Thank you doctor

For discussion: referral, knowledge of resources available, follow up, closing the interview, documentation.
The care of sexual assault survivor is also multidisciplinary and the provider may need the help of other disciplines like psychologist to provide support to the survivor. When advising referral, the provider needs to explain that the referral is being done for better care and it is not the end of the clinical relation and assure availability when needed. A follow up appointment two weeks from the rape incident is advised to check for possibility of pregnancy, STI, and reassess the psychological state. A closer follow up may be needed in case of suicidal thoughts. Several UN agencies have set in place referral networks for violence survivors that vary by region and are regularly updated. The provider is advised to be familiar with them.
The documentation has to include: the information received from the survivor regarding the incident (date, time, nature, identity of perpetrator) using the patient words; the physical exam with description of the injuries if present (if the patient refuses the exam or part of it, this should also be documented) without stating conclusions about the rape; the assessment of the psychological status; the medical management; safety plan; referral; and follow up plan.

Improved scenario: Refugee

Lama -Good morning doc.(*Patient is very shy and confused)*

Doctor -Good morning Lama. It has been long time, where have you been?

Lama – I have been busy

Doctor – how can I help you today?

Lama -Doctor, I'm not feeling well. I'm very dizzy

Doctor -Dizzy? What other feelings are you having ?

Lama – nothing just dizziness and tired doctor, yesterday I could not go out to bring water (*Becomes tearful)*

Doctor – Too much tired? , what is making you so tired?

Lama – I don't know doctor , do you want to give me a medication to get rid of this

dizziness?...(seems in a hurry)

Doctor –not yet, relax, I still have many questions to ask you first. Do you have nausea?

Lama – No

Doctor – vomiting?

Lama- No no nothing of the sort only headache and all my body aches sometimes. I am very much in pain doctor. Yesterday I took a full pack of analgesic but it didn't help (tearful)

Doctor – Lama, I can see you are upset, what is going on?

Lama – No No I am not upset …. All is well , better than other people. Thank God (smiling)

Doctor – Thank God better than others, but as if you are upset with something

Lama – Ok doctor please give me a medicine because I have to go. I can't be late. My children are alone at home.

Doctor –Feel free if you are in a hurry but I care about you and am next to you. I promise you no matter what you tell me , things will stay between us unless I feel you may be in danger, then we will ask help from someone. What do you say?

Lama - Thank you doctor, but my kids are very small,7 and 9 years and they are alone at home. I should go

Doctor – As you want. I wish you could stay so we can talk. May be next time you have more time. I will give you medicine one tablet three times just to alleviate your dizziness, but it is better if I know why you are dizzy. Come back for follow up in a week

Clip 2: Facilitating Disclosure

Doctor- Lama, how are today

Lama- Doctor I am not good, dizziness is getting worse and I can't sleep, I wake up in morning and my heart is beating fast. My weight has dropped. My periods are irregular and I have pains lower in my abdomen. Give me a medicine, any medicine please..

Doctor – let us talk about each symptom separately. You said you have abdominal pain, irregular periods, and your weight is dropping ,and I see in your file that you had anemia,Which problem would you like to talk about first?

Lama - I had anemia long time ago. But I took medication and it got treated …Thank God; but the problem is in having fatigue doctor. I should work to feed my kids

Doctor stays silent

Lama – I clean houses on demand, Sometimes I don't have enough money to cover for the children′s food; and what gets things even worse, is that people don't leave you alone, they

just add to your sorrow. (silence) please doctor give me vitamins so I feel more energetic

Doctor - People don't leave alone? What do you mean? Is there anything bothering you

Lama - No No who would want to bother me? No no nothing of the sort, why would anyone bother me?

Doctor -Lama what's going on? What is bothering you? You want to talk? Sometimes when you talk you would feel better.

Lama – stays silent- confused

Doctor – Don't be afraid you can tell anything and whatever you tell me will stay between us.

Lama – I can't talk doctor. (crying)

Doctor – silence

Lama – Doctor, last week... my neighbour...I went at night to get water from the fountain in the camp., and he was there waiting for me (covers her face with her hands). It is not the first time he does, he always follows me and bothers me, but this time, he bothered me a lot

Doctor -Bothered you a lot?

Lama -He attacked me..I couldn' t defend myself. He threatened he'll kill me …..and then things happened..(cries)

Doctor – Silence.. It seems it was a terrible thing what you went through!! If you want to wait a bit for you to relax and then we can continue.

Lama – I don't know what happened. I may have lost consciousness. I don't remember..

Doctor – Sometimes it happens following a great shock, people may forget

Lama- All what I remember is that he told me you can go but…but you can come to my home to take money for your children and he threatened to kill me if I told anyone

Clip 3: Reassurance and preparation for physical exam

Lama – (crying) I don't know what to do doctor.. I'm now dead doctor.. I am thinking of putting a end to his life. Kill him and kill myself

Doctor – Kill him and kill yourself? What are you considering doing?

Lama – I don't know, these thoughts keep crossing my mind. Sometimes I remember my kids and say it is enough. I try to forget.

Doctor- Great, good thinking. If you feel that you are about to act upon those thoughts , call me or the centre immediately to help you. And now I want to examine you. Please can you go over the examination table and lie over your back?

Lama- why on my back? (quite irritable) I think I will get more dizzy

Doctor- we can begin by examining you while you are sitting then when you are feeling more comfortable, we can continue while you are on your back. Don't worry, if something bothers you just let me know and I will stop immediately.

Clip 4: Discussing management / A multidisciplinary approach

Doctor – Lama your physical examination is good, you don't need medical or surgical intervention. Now tell me when was your last menstrual period?

Lama -2 weeks ago. Why are you asking?

Doctor -Do you use contraception?

Lama – I don't need to, my husband is dead.. could I get pregnant from him?

Doctor -The probability of you getting pregnant is low less than 5%. We can prevent this by putting IUD. Do you have any secretion?

Lama – Why? Is there an infection?

Doctor- better if you take medication for infections. And now we need to talk about an important point, your safety and that of your children, he is your neighbour so there is a god chance that you will come across him a lot

Lama –Ehh...I'd rather die than meet him once more

Doctor- What will you do if he threatens you again? What do you say If you start going out within a group and stop going out alone, what if you have a friend or family member always with you, and try to avoid the places where he is usually present. Do you think if you do this you will be safe?

Lama –Perhaps, I will try

Doctor – Great Lama, do you want to report the incident?

Lama -Report? To whom?

Doctor -To the concerned legal authorities

Lama -No, no please doc don't report to anyone. I am scared of what people may say about me or may call my kids, God forbid.. No no please don't tell anyone . .

Doctor – You know your society better than me. What you are saying is possible to happen

Lama –No, I don't want. I don't want doctor. By God I don′t want a thing.. All I care about is the safety of my kids. I live for them.

Doctor – Great, you are a mother who assumes well her responsibility. About reporting, perhaps you can change your mind later, and then we can see what to do.

Lama – No no, I don't think I will change my mind

Doctor- I will write the names of the non governmental organisations that provide care for the sexually abused people and they can you provide support and guidance if you decided to make them contribut

Lama- I don′t want to visit them doctor

Doctor- Keep the addresses and phone numbers with you, you may need them one day

Lama- Thank you doctor

Doctor - I want to tell you now about things that may happen to you later, you might develop some bothersome feelings like sadness, anxiety and insomnia

Lama – ehh doctor, I have these feelings now and they are worse day by day.Sometimes I think I'd rather be dead than to have these feelings. They are very bothersome and don't let me think

Doctor –These feelings are possible to happen, but if they start controlling you or you start having thoughts of hurting yourself or others, you should seek immediate hep

Lama – Ok doctor

Doctor – I will write you now the name of a medication, called Diazepam that will take of your anxiety (diazepam) I want from you to take it every night for a week

Lama – Ok

Doctor – Don't forget to take the medication
Doctor – I want to see you daily for a week. Whenever you feel you want to get rid of your life, You go straight away to seek medical care. Agree?

Lama – Ok

Doctor – Don't forget I am next to you to help you. I will see you tomorrow

Lama – Thanks Doctor

Doctor – Take care

دخلت سهى العيادة وهي غاضبة حانقة على السكرتيرة.

سهى – **دكتورة هيدي السكرتيرة اللي عندك منا طبيعية. مين مفكرة حالها**

طبيب - ليش شو في شو صار

سهى –**ما بتعرف تتعامل مع العالم كل ما تلفن بتنطرني عشر دقائق ولما وصلت قلتلها بدي فوت لعند الحكيمة قالتلي لا ما فيكي ما عندك موعد وصارت بتنتقدني انو قبل بمرتين اخدت موعد وما اجيت. انو شو خصها؟ ولما اصرّيت بدي فوت بين المواعيد قالتلي سوري مدام ما فيكي تفوتي بدك تنطري بالدور لانك مش آخدة موعد . انو ما فهمت.**

طبيب - لا شكلك كتير معصبة مدام سهى . ، روقي شو في شو في ؟ ليه معصبة؟

سهى - **ما بعدني عم قلك بدنا معاملة تنفوت لعندك**

طبيب - طيب روقي هلق بحكيها بعدين انا للسكرتيرة انت كيفك؟ ... ، بعدك ممغوصة؟

للنقاش: - أعراض العنف و تاثيره النفسي على الاشخاص و تصرفاتهم ، كيفية التعامل مع المرضى الغاضبين،

سهى - **ما نمت طول الليل وهلأ صار في وجع راس وهالدوخة طول الوقت. مع انو عم اخد الدواء يللي عطيتيني ياه. بس مثل قلتها**

طبيب - عم تاخدي بانتظام ؟

سهى - **عم بنسى اوقات**

طبيب – ايه لا بدك تاخدي مزبزط وبعدين منحكي بالموضوع .

سهى - **دكتورة اخدتو ولا ما اخدتو متل بعضها. يمكن ما عم تعرفيلي بركي لازم اعمل صورة لبطني ولراسي وبلكي بخطط دينيي كمان.**

طبيب - ، انا الحكيمة وانا بعرف شو لا lزم تعملي.

سهى –**طيب متل ما بتريدي ،**

للنقاش: اهمية قراءة التعابير الغير جسدية، تاثير العنف على تصرفات الشخص (غضب، عدم امتنان، محاولة التسلط، التصرف كضحية) و بالتالي على علاقة الطبيب يالمريض (الغضب، الشعور بعدم الارتياح بسبب التقليل من قدرته على الاشفاء)

طبيب – طيب وانت قلتيلي هيديك المرة انو كان هندك لأوجاع والدوخة ، بعدن؟

سهى - **بعدن متل ما هني**

طبيب - امتى بيقووا ؟

سهى – **بحس لما بعصب وازعل اكتر . ما هي كلها زعل بزعل**

طبيب - لا الهيئة كتيرزعلانة .. طيب معليش هلق ما في عنا كتير وقت لنحكي لان في ناس ناطرين برا (تبدأ الطبيبة بالكتابة على الملف وتبدو مشغولة) .

سهى - **ما الحياة ركض بركض. ما في الواحد يرتاح . جوزي بيضل منرفز والولاد بضلو عم يتخانقوا بين بعضهم وانا علقانة بالنص**

طبيب - بسيطة بسيطة .طب انا شايفتك كتير مكتئبة وزعلانة، رح اكتبلك دواء هيدا الدوا للاعصاب بتاخدي مرة بالنهار منو ومنشوف بعضنا مرة الجاية. اوكي؟ والمرة الجاية منرجع نحكي اكتر عن الموضوع.

للنقاش:التواصل الغير كلامي ، التعرف على المؤشرات، اسلوب "القمع" لطرح الاسئلة، التحضير لمقابلة تتعلق بالعنف، التقليل او الاستخفاف بالمشكلة، اعطاء المهدئات

Clip 2

طبيب – كيفك اليوم مدام سهى

سهى - **والله من سيء لأسوأ**

طبيب – ليش بعدك موجوعة ؟
سهى - **ما نمت طول الليل من وجعي. و الدوخة كثير زاعجتني ما عم تخليني اتحرك. و بطني عك بضل منفوخ. ما اكل لقمتين بيصير قد البالون ☺**

طبيب – بدك تنتبهي شو عم تاكلي يعني في اكلات بتعمل نفخة متل الملفوف الفول..

سهى- **ايه بعرف هلق مرات من الاكل بس - مرات من الزعل**

طبيب –اوف عم تزعلي ؟ شو في عندكن بالبيت؟ خير؟

للنقاش: طرح الاسئلة الموجهة ، التفسير المسبق

سهى - **ما شي زيادة متلنا متل كل هالبيوت.**

طبيب – لا بدك تحكيني لساعدك

سهى – **ما بظن رح فيكي اتحليلي مشاكلي . واصلا انا جايي عشان وجع راسي وبطني ودوختي.**

طبيب - انت بتحسي حالك مريضة. نفسيتك لما بتتعب جسمك بيتعب

سهى - **يمكن معك حق بحس انو اوجاعي ابتزيد لما بتوتر . مع انو عم باخد الدوا بس ما عم يساعد. بالعكس الاوجاع عم بتزيد**

طبيب - طب وشو اللي عم يوترك ،

سهى – **شو اللي عم بوترني !! ما هي كلها سمات بدن ومشاكل. هيدا بيصرخ وهيدا بينرفز وجوزي كتير اصلا عصبي والولاد عم بعذبوا وهو بيضل بدو بيفش خلقو**

طبيب – شو يعني عم تتعرضي لعنف؟

للنقاش: تاكيد اعراض المرض، كيفية السؤال عن العنف و الكلمات التي يجب تفاديها، الانصات النشط : اعادة الجمل او صياغتها، عدم اساليب الضغط على المريض للافصاح و التشديد على ان المساعدة متاحة دائما. كيفية الرد اذا كانت الاجابة نعم او اذا كانت كلا

سهى –**عنف ؟ لا اكيد شو عنف!! لا لا اكيد ... ما وصلت لهون... بصراحة دكتورة زوجي ما في احسن منو لما بيكون رايق بس لما يعصب لازم نزيح من الطريق ، الولاد صاروا عم بخافوا منو لما بيجي. بس هني كتير عم بعذبوا وهو زلمي تعّيب ، بدو يأمن المصروف، بدو يامن كل شي للبيت وبتعرفي انت غلا. أنو حقو يعصب.**

طبيب –انو مش عم بعصب لوحدو . الولاد من جهة و انت اكيد كمان بتستفزيه وبركي ما بتعمليلو اللي بدو ياه

للنقاش: التعرف على المواقف الدفاعية، عدم اعطاء مبررات للعنف او لوم الضحية

سهى - **انا عم اعمل اكتر من طاقتي، انو عم بركض من محل لمحل، بين البيت والشغل، والعزيل والتنضيف والطبخ، والنفخ ، الواجبات... بدي اعمل اكتر من هيك .. هيديك المرة وصل عالبيت بلشت عم خبرو عن ابنو انو قديش صاير كسلان والمعلمة حتى عم تشتكي منو انو صاير شيطان . قالي حضريلي الأكل وبعدين منحكي قالتلو هيدا الموضوع مهم كتير قام عصب وبلش يصرخ**

طبيب - طيب انت ما كان فيكي تطولي بالك شوي. كنتي عملتيلو لقمة واجلتي الموضوع لبعدين

للنقاش: التعاطف و كيفية اظهاره، اهمية اعطاء رسائل دعم و التاكيد ان لا مبرر للعنف، عدم لوم الضحية و الاكيد على ان العنف ليس بسببها و ليس بيدها التحكم به

سهى – **مش مهم شو ما عم اعمل ما عم يعجبو. عم بضلو منرفز. مرات بقول يا ريت موت وارتاح**

طبيب - لا شو هالحكي، اعوذ بالله ما بدا الشغلة هلقد ما بستاهل. اذا هلقد متضايقة ليش ما بتتركي؟ اتركي البيت. طلقي

للنقاش: عدم التخفيف، كيفية السؤال عن الانتحار، عدم اسقاط حلول بل التعاون لايجاد حل مناسب،

Clipi3

سهى - **اتطلق؟ ما بعرف... وين بروح... من جمعتين رحت عند اهلي قام لحقني وصار يبكي ويتندم يقلي خلص رح اتغير ولما رجعت ما في يومين رجع ضربني وصار يجرني من شعري عالأرض وقال اذا بعد ابتتركي البيت لح شرشحك قدام العالم ويمكن يدبحني**

طبيب - كل هيدا وبعدك معو هالحيوان؟ انا محلك كنت تركت البيت من زمان

للنقاش: التاكيد على عدم الانحياز وعدم استخدام الكلمات المثقلة او النعوت المسيئة، تقييم الامان و السلامة، عدم اعطاء امثلة شخصية

سهى - **انت دكتورة ، انا ما فيي اعمل هيدا الشي ؟**

طبيب - طيب ليش ما بترفعي دعوى عليه؟ اذا بدك منبلغ عنه

سهى - **اكيد لا بقتلني. من جمعة سحب علي السكين وقال لي بدبحك اذا بعد بتتركي البيت**

طبيب - هيدا كلو حكي بيحكي ما بيسترجي يعمل شي...

سهى - **ما فيّ بخاف منو، بضل مرعوبة شو ممكن يعمل. اصلا هددني انو بياخد الولاد وما بيخليني شوفهون... ووبتقوليلي ليش معك اعصاب؟؟؟!!!..**

للنقاش: عدم التقليل من خطورة العنف، تقييم الخطورة ووضع خطة السلامة، ، الابلاغ (معرفة القوانين)

طبيب – طيب جربتي شي مرة تطولي بالك ، تحكي على رواق بركي بيوعى

سهى - **عنجد عم اعمل أكتر ما فيني. انا صحتي على قدي و الولاد بيعذبوا و بياكلوها قتلة و البنت صايرة كتير صعبة بتعذبني و ما عم تركز على الدرس وكسلانة. قولك منجيب بعد ولد خامس بركي بيحن قلبو و بيتغير**

طبيب - معقول ؟ من كل عقلك بتجيبي ولد خامس ؟.

سهى - **معك حق . ما عم فكر مزبوط . طب دكتورة بركي انت ابتحكي معو اكيد رح يسمعلك ، انت دكتورة شاطرة ومعروفة واكيد بيسمعلك**

طبيب - طيب، جيبي معك المرة الجاية وبحكيلك معو

للنقاش: اهمية مساعدة الضحية على التركيز و تحديد الاولويات، الارشاد الصحيح و مناقشة الحلول، التدخل مع الزوجين

سهى - **اوكي رح قلو يجي يعمل فحوصات لأنو عم يشكي من وجع براسو وهيك انت بتحكي بس اعملي معروف ما تجيبي سيرة اني خبرتك شي**

طبيب – لا اكيد لا ولو ، سرك ببير غميق. هاي جارتك سعاد قالتلي انو زوجها بيضربها وانا ما قلت لحدا.

للنقاش: السرية،

سهى - **بركي بجيب بنتي. هيك منحاول نحللها مشكلتها**

طبيب - خلص المرة الجاية تعي انت بنتك منفحصها وزوجك بحكيلك معو كمان وما تعطلي هم. هيك حياتك بتسيؤ كتير منيحة. طب خدي دواء الأعصاب اللي عطيتك ياه مرة بالنهار واذا ما ارتحت على الحبة، خدي حبتين. ومن هلق لوقتا اذا صار شي بتحكي هيدول الجمعيات تبع حقوق المرا بركي بساعدوكي. اوكي؟ وبعد جمعتين بتجي عالموعد وما تتاخري متل كل مرة.

للنقاش: عدم اعطاء وعود صعبة التحقيق و التشديد على الموضوعية. الاحالة (معرفة المراكز و الخدمات المتاحة) ، كيفية انهاء المقابلة بايجابية

سهى -الطبيبة لوحدها: اففففف مش معقول شو هالمريضة و شو بدي اكتب عملفها...نقيقة

للنقاش: كيفية الاهتمام بالنفس، التوثيق

:

Clip 4 سناريو افضل ل clip 1

دخلت سهى العيادة وهي غاضبة حانقة على السكرتيرة.

سهى – **دكتورة منا طبيعية هالسكرتيرة يللي عندك مين مفكرة حالها**

طبيب - شو في شو صار

سهى - **ما بتعرف تتعامل مع العالم كل ما تلفن بتنطرني عشر دقائق . ولما وصلت قلتلها بدي فوت لعند الحكيمة قالتلي لا ما فيكي منك آخدة موعد..لا وصارت بتنتقدني انو قبل بمرتين اخدت موعد وما اجيت انو شو خصها ، . ولما اصريت بدي فوت لعندك بين المواعيد قالتلي لا مدام سوري ما فيكي بدك تنطري بالدور لأن ما عندك موعد.انو ما فهمت**

طبيب –معك حق اوقات النطرة بتكون صعبة ، طب انت قليلي شو بك اليوم؟

سهى - **بعدني عم قلك شو بني.. بدو الواحد معاملة حتى يفوت لعندك ؟**

طبيب - طيب خلص ما تعتلي هم انا هلق بحكي مع السكرتيرة. بس هلق انت الاهم... كيف صرتي، بعدك ممغوصة؟

سهى - **ايه بعدني طول الليل وجع بطن وهلأ صار في وجع راس ودوخة كمان ي. مع انو عم اخد الدواء يللي عطيتيني ياه. بس مثل قلتها**

طبيب - عم تاخدي بانتظام ؟

سهى - **اوقات عم بنسى**

طبيب – ليش عم بتنسي، في شي شاغلك بالك ؟

سهى-**في كثير اشيا.. بس اصلا اخدتو ولا ما اخدتو متل بعضها. يمكن ما عم تعرفيلي بركي لازم اعمل صورة لبطني ولراسي وبلكي بخطط دينيي كمان.**

طبيب – خلينا اول شي نشوف شو بك و بعدين منشوف شو الفحوصات اللي لازم تعمليون .

سهى - **طيب متل ما بتريدي**

طبيب –هيديك المرة قلتيلي كمان انو عم تعاني هيك من أوجاع ودوخة ، وين صرنا ؟

سهى - **بعدهن محلون بروحوا و بيجو**

طبيب – طيب وايمتيى بتحسيون بيقووا ؟

سهى –**دكتورة في زعل، الحياة هم وغم**

طبيب - هم وغم؟؟؟

سهى - **ما الحياة ركض بركض. ما حدن مرتاح اصلا جوزي بضلوا معصب والولاد بضلو عم يتخانقوا بين بعضهم وانا علقانة بالنص**

طبيب - هممممم... الهيئة عنجد في كتير اشيا تاعبتك وامور زاعجتك.. شو رايك ناخد سوا موعد هيك المرة بكون عنا وقت نحكي اكتر . هلق بعتذر يعني في ناس ناطرين برا ما فيني نطرون اكتر من هيك
سهى – اوكي ، مرسي

Clip5 سناريو افضل ل clip 2 , 3

طبيب - كيفنا اليوم مدام سهى

سهى - **والله من سيء لأسوأ**

طبيب - ليه خير شو عم بصير ؟

سهى - **ما عم اقدر نام من الوجع. وعم حس انو عم بيزيد عالتعب وعلى الزعل**

طبيب - في زعل كتير الهيئة، المرة الماضية قلتيلي في مشاكل عندكن بالبيت. شو عم بصير

سهى- **يعني ما كتير اشيا زيادة. متلنا متل كل هالناس**

طبيب - بعرف انو الحكي بهالمواضيع حساس لانو امور خاصة ، بس اذا حكيتي بتخففي عنك بركي بقدر ساعدك بركي بقدر اعمل شي .
سهى – **ما بظن انو رح فيكي اتحليلي مشاكلي ؟ اصلاانا جايي كرمال وجع راسي وبطني ودوختي.**

طبيب - الجسم بيتعب وقتا النفسية كمان بتعتب

سهى - **معك حق بحس انو اوجاعي ابتزيد لما بتوتر مع انو عم باخد الدوا بس ما عم يساعد. بالعكس الوجع عم بزيد**

طبيب - طيب . خلينا نحكي عن الأشياء اللي بتوترك . وانا بوعدك كل شي بتحكي بيضل بيناتنا. الا اذا حسيت انو في حدن بخطر انت ، او حدا تاني، ساعتها انا بدي اضطر بلغ بس اكيد بعد موافقتك

سهى - **موافقة... بس هلق ما بعرف لمين قلك تخبري. بوقتها منحكي**

طبيب - اكيد ...قلتيلي انو جوزك بنرفز شو بيعمل وقتا بينرفز؟

سهى - **متلو متل كل هالرجال، بيطلع خلقو كتير وببطل شايف قدامو**

طبيب - ووقتا بينرفز بيضربك؟

سهى - **مرات بس مش كتير**

طبيب - بيعيط وبيصرخ؟

سهى – **انو هو هو طبعو نرفوز بعصب كتير وبصير يعيط ابتعرفي انت الغلا وهو الوحيد اللي عم يشتغل بالبيت لازم يامن كل شي من المصروف وغراض الولاد وغراض البيت. مرات بحس انو معو حقو يعصب.**

طبيب – كلنا معنا حق نعصب ، بس مش كل ما عصبنا بدنا نكسر ونسبسب ونؤذي بعض يعني والا كل بتقتل بعضها. و شو بيصير كمان ؟

سهى - **هيك شو ما عملت..شو ما عملت ما بيعجبو. بينرفز وبعصب كتير بسرعة وببطل فينا نحكي كلمة مرات بقول يا ريت موت وارتاح.**

طبيب - عمتفكري بالإنتحار؟

سهى –**بحس مرات انو عبالي ارتاح من هالدني بس انو عندي 4 ولاد لازم اهتم فيون وكبرون والا ما تفرج**

طبيب - منيح في عندك نظرة متفائلة... فكرت شي مرة تتركي البيت

سهى - **في مرة تركت البيت ورحت عند اهلي لخقتي وصار يبكي ويتندم ويقول خلص رح يتغير . رجعت ما في يومين رجع ضربني وصار يجرني من شعري وقال اذا بعد بترك البيت مرة لح يشرشحني قدام العالم ورح يدبحني**

طبيب - وانت بتحسي انو معقول يعمل هيك

سهى - **بصراحة بخاف منو، بضل مرعوبة شو ممكن يعمل. اصلا هددني انو رح بياخد الولاد اذا بفل بعد مرة وببطل يخليني شوفهون... وبتساليني كيف بضل معي اعصاب؟؟؟!!!.. رح بيصير معي بالقلب كمان.**
طبيب – طيب فكرتي شي مرة لا سمح الله اذا كان معصب ورفع عنجد سطينة عليكي انو شو فيكي تعملي كيف معقول اتدافعي عن حالك؟

سهى - **عم فكر جيب ولد خامس بلكي بحن قلبو وبيتغير... ؟**

طبيب - يمكن بس متل ما فهمت انو انتوا حالتكن المادية مش كل هالقد عندكن اربع ولاد في شي تغير بعد كل ولد؟

سهى - **معك حق . ما عم فكر مزبوط . بس دكتورة بركي انت ابتحكي معو ، انو انت دكتورة شاطرة ومعروفة والا ما يسمعلك**

طبيب – طيب في شي حدا من عايلتك جرب شي مرة يحكي معو؟ اذا انا حكيت معو بتغير لفترة قصيرة وبعدين بيرجع متل ما كان. هيدا الحل ما بتخيل بفيد. انا اللي بقدر اعمل ، بقدر اعطيكي عنوان كذا جمعية بيهاموا بهالموضوع اذا بدك فيكي تروحي لعندون تشوفي شو بيقدروا يعملولك كيف بيقدرو يساعدوكي. ومن هلق لوقتا انا هون، شو ما تعوزي انا هون

سهى - **ما بعرف . خليني فكر فيها . بس جبلك بنتي منحللها مشكلتها**

طبيب - اكيد جيبي بنتك منفحصها ومنشوف شو قصتها وانت بهالوقت فكري بالموضوع وشو ما تعوزي فيكي تحكيني

Clip 6

الطبيب : تتحدث على الهاتف

سهى - **بونجور دكتورة**

طبيب – بونجور كيفك مدام سهى

سهى - **بصراحة انا فليت من عندك مرتاحة هيديك المرة مشين هيك اليوم اجيت عالموعد متل ما اتفقنا وجبتلك بنتي معي**

طبيب - إنشا الله دايما هيك تكونوا مرتاحين ويبطل في مشاكل عندكن بالبيت . كيف الوضع اصلا بالبيت؟؟ بعد في خناق وقتال وضرب ؟؟؟

سهى – **لاماشي الحال ماشي الحال، بس انا مش جاية اليوم تاحكي عن حالي انا جايبتلك بنتي**

للنقاش: التحدث عن العنف بوجود طفل في الغرفة.

طبيب - ليه شو بها البنوت ؟

سهى - **تخاطب إبنتها مامي في مجال تجمدي شوي؟؟بصراحةهالكتني ، ما بعرف شو صايرلا هالستنين ، مدوختني وكتير تاعبتني. صرلها فترة عم تشتكيبطنا عم يوجعا . اخدتها عند حكيم كتيرشاطر عمللها كل الفحوصات ا وقال لي انو ما بها شي. بس كيف ما بها شي وهي رجعت تعمل تحتها بالبيت حتى ابالمدرسة كمان ، وكل يوم الصبح ب بتوعى بدها تستفرغ مرتين، ثلاثة.**

طبيب - ووزنا كيف عم بيكون؟؟؟
سهى - **وزنا عادي منيح ما عم تنقص يمكن عم اتزيد شوي (تذهب الأم لعند ابنتها) مامي في مجال نهدى شوي؟؟ تعي نقعد خلص يلا**

طبيب –إسم الله اصلاً ما هديت من اول ما فاتت

سهى - **قلتلك عم تهلكني يلا إجمدي**

طبيب -هي دايماً هيك؟

للنقاش: مؤشرات العنف عند الاطفال، التحضير للمقابلة مع الطفل، التواصل مع الطفل

سهى - **عطول، وصايرين كتير عم يشتكو منها ، إنو ما عم اتركز على دروسا، ، مع إنو قالولي إنا شاطرة وزكية وبيطلع منا بس إنو ما عمبتركز. حتى قالولي إنا عم تضرب اصحابا**
طبيب - اه ولو يا عيب الشوم بنوت متلك شطورة بتضرب الولاد؟لالالا ما تخليني إزعل منك ، ، معليش مدام سهى فيكي تضهري شوي ؟ لافحصها على رواق وبحكي معا شوي وبرجع منقلك شو عملنا .

للنقاش: احكام مسبقة، كيفية التعامل مع الطفل و الابتعاد عن اسلوب المحاضرة،

سهى - **رح تسمعي كلمة الدكتورة ؟ اوكي(وخرجت الأم)**

طبيب. شو يا شطورة ؟ شو إسمك؟ما بدك اتردي عليي ،يلا بترسميلي هون رسمات إتسلي بالالوان. شو كيف الوضع عندكون بالبيتدايما في مشاكل؟ إنتي شطورة بالمدرسة شي؟،

للنقاش: مقابلة و الكشف على الطفل لوحده، اسلوب الاسئلة الموجهة، السرية مع الاطفال

بنت- (هزت براسها نعم)

طبيب - طيب وعم تضربي الاولاد بالمدرسة؟

بنت - (هزت براسها نعم)

طبيب إنتي بالبيت لما بتعذبين بابا بيضربك ما هيك؟؟

بنت - (هزت براسها نعم)

طبيب - ، طيب بدك توعديني من هلأ ورايح ،لو شو ما صار تقعدي عاقلة بالبيت شطورة وبتسمع الكلمة هيك ت ما يضربوكي اوكي ؟برافو عليكي يا شطورة إنتي يا شطورة . طيب ليكي خليني إفحصك يلا تعي

للنقاش: كيفية اجراء لمقابلة مع الطفل ، التعامل مع الطفل الذي يرفض التكلم، عدم استعمال الاسئلة الموجهة و اصدار الاحكام المسبقة، مراقبة التعابير الغير لفظية، عدم ملامسة الطفل او تكذيبه

بنت **- ماما ،**

سهى- (دخلت الأم) **شو في حبيتي شو في شو صار ؟، تعي قعدي**

طبيب - ما بعرف شكلا بنتك كتير خايفة، ما قدرت لا إحكي معا ولا إفحصاولا شي طيب على كل الاحوال بدنا نكتبلا على فحص بول تنعرف اذا عندها التهابات بالبول ، ولنشوف اذا بدنا نعطيها انتيبيوتيك في حال لقينا شي اوكي ؟

سهى **- اوكي دكتورة**

طبيب - هيئتها متعلقة فيكي كثير،

سهى - **ولادي كل حياتي ، بس هي لو ابتسمع الكلمة شوي** ، كنت بعطيها يلي بدها اياه

طبيب - اسمعتيماما شو قالت ؟. بدك توعديني تكوني عاقلة . طيب لكن بعد الفحص منرجع منشوف بعضنا

للنقاش: عدم الحكم على المظاهر . كيفية انهاء المقابلة مع الطفل و الاحالة،الابلاغ، التوثيق

Clip 7 سيناريو افضل ل clip 6:

سهى - **والله يا دكتورة انا ضهرت من عندك كتير مرتاحة هيديك المرة مشين هيك اليوم رجعت عالموعد متل ما اتفقنا وجبتلك بنتي معي**

طبيب - اهلا وسهلا فيكي وفيها عطول. ، شو اسمك يا حلوة كيفك ؟

سهى - **شو ما بدك تردي على الحكيمة؟؟، يعني عن جد هالكيتني ، ما بعرف شو صايرلا هيدي السنتين، اول شي بلشتتشتكي انو عم يوجعا بطنها . اخدتها عند الحكيم وحكيم كتير شاطر عمل نا كل الفحوصات اللازمة(مامي قعدي شوي في مجال؟تخاطب إبنتها)وقال لي انو ما بها شي. بس ما عرفت كيف ما بها شي ورجعت تعمل تحتا بالبيت ومرات بالمدرسة كمان ، وكتير مرات عم توعى الصبح دها تستفرغ مرتينو ثلاثة.**

طبيب - طيب واكلا كيف؟؟

سهى - **كتير منيح اكلا**

طبيب - عم ببتلاحظي عوارض تانية عليها ؟ متل وجع راس , حرارة يمكن

سهى - **لا ابدا ما عدا وجع بطنا ما في شي**

طبيب - ووزنا كيف؟

سهى - **كمان كتير عادي متل ما شايفة ما نقص يمكن عم يزيد شوي(تذهب الأم لعند ابنتها) مام خلص يلا تعي إقعدي هون يلا إقعدي**

طبيب - ، ارسمي لي بدك ياه شمس سيارة لي بدك

سهى - **شفتي , الحكيمة زعلت منك**

طبيب - لا ابدا ما زعلت منك.

سهى - **بالمدرسة معلماتا شوي عم يشتكو منها ، ما عم اتركز كتير على الدرس وكتير عم تلتهي ، مع إنا شاطرة وزكية وقالو بيطلع منا شي بس انو ما بعرف ليش بس خلص ما عم بتركز بقى ومعلماتا قالولي انو مرات كتير عم تضرب رفقاتها بالمدرسة**

طبيب - وليش برايك عم تضربن؟

سهى - **بحس يمكن عم بضربوها فبترجع، ابتضربون!!!!**

طبيب - انو عم اتقلد حدا او شي

سهى ، **بركي ما انتي بتعرفي خبرتك هيديك المرة**

طبيب حبيبتي شو عم ترسمي ؟ شو هول؟شو هيدا؟؟،

بنت- شمس

طبيب : واو شو حلو

طبيب – وهيدا شو ؟ شو عم ترسمي هون؟؟؟

بنت - بيتن

طبيب – بيت هيدا بيتكن ؟ شو حلو ليك شو حلو السطح و الشبابيك. برافو يا شاطرة فيني إفحصك هلق؟؟؟

بنت - تهز براسها موافقة

طبيب - فيني حط هيدي السماعة على بطنك شوي ، اوكي، انا رح إجي لعندك

Clip1

مقابلة مع لاجئة

المشهد الأول (كسر الجليد)

لمى- **صباح الخير دكتور (المريضة خجولة و ملبكة)**

طبيب- صباح الخير لمى صار لك زمان وين هالغيبة ؟ شو في جديد ؟

لمى - **دكتور حاسة حالي ماني منيحة و عندي دوخة** (من دون التواصل بالنظر).

طبيب - دوخة ؟ دوخة قصدك دوخة؟ ايه وشو كمان

لمى - **ولا شي يعني دوخة و تعب دكتور مبارح ما قدرت اطلع من البيت جيب مي ...** (تدمع عينيها)

طبيب - اي يعني انتوا الظروف اللي عايشين فيها مش قليلة .. طبيعي انك تحسي بالتعب ... غيرو شو في . (يبدو منشغلا)

للنقاش: طريقة فتح الحوار ، عدم ملاحظة التعبير الجسدي، كيفية تسهيل الحوار ، تفسيرات مسبقة

لمى - **لا لا بس دوخة حتعطيني دوا ؟..**(تبدو مستعجلة، تهم بالوقوف)

طبيب - بعد شوي. قوليلي قبل عندك عوارض تانية ؟ لعيان، استفراغ، وجع راس، شو بعرفني.. تنميل باصابيع ايديك او اجريك؟ في حرارة؟ ضعف سمع؟ شي مرة غبت عن الوعي مثلا ؟ عم تاخدي ضغطك؟ شو في تاني شي قليلي

للنقاش: التركيز على العوارض الجسدية، (تعليق: طرح الأسئلة الكثيرة المتتالية في الوقت نفسه، يجعل من الإجابة امر صعب و يشعر المريضة بالاستعجال و ضيق الوقت)

لمى - **كل جسمي عم يوجعني ، اكتر شي راسي دكتور وفوق كل هاد دوخة و تعب. مبارح اخدت علبة مسكن كاملة وما نفعت معي** (تدمع)

طبيب - لمى، شو بك، الهيئة زعلانة او في شي زاعجك. قوليلي شو بك بس بسرعة لانه في عالم كتير ناطرين برا

لمى - **لا، لا ماني زعلانة..ماشي الحال احسن احسن من غيرنا. الحمدالله** (تبتسم)

طبيب - هيئتك خيفانة ما يكون هيدي الدوخة خصها بسرطان او شي..لا ما تعتلي هم الدوخة هي موضوع سهل كتير وعلاجها سهل كتير

النقاش: اعادة لمؤشرات العنف ،اهمية الاصغاء النشط و طرح الاسئلة المفتوحة الغير موجهة، التركيز على

العوارض الجسدية لا يساعد على الإفصاح عن ما يزعجها

لمى - **طيب دكتور حتعطيني دوا لانو مستعجلة. ولادي ناطريني لحالن**

طبيب - اه عندك ولاد ؟ شو عمرهم؟
لمى - **7 و 9**

طبيب - يعني انت متزوجة بكير لانو بالملف عندي عمرك 27 سنة بس

لمى - **ايه ، تزوجت وعندي 16 سنة** .

طبيب - ايه عندكن البنات بيتزوجو صغار. يا عمي مش حرام بهالعمر يزوجوكم و تجيبو ولاد عهالدني.. يللا رح اعطيكي دوا بتاخدي منو 3 حبات بالنهار وبتريديلي خبر بعد اسبوع. يللا هاي لالك

لمى - **شكرا دكتور**

للنقاش: اهمية احترام الثقافات

المشهد الثاني : تسهيل عملية الإفصاح

طبيب - لمى، كيفك اليوم

لمى - دكتور ماني منيحة **الدوخة زايدة وما عم اقدر نام بفيق و قلبي عم يدق بسرعة . وزني نازل. و فوق هاد عادتي الشهرية مو منتظمة و عندي اوجاع باسفل بطني. حتعطيني دواء؟**

طبيب - لا بفضل ما اعطيك ولا دوا حتى اعرف شو بكي . هون عندي مبين انو كان عندك فقر دم، عم تاكلي منيح؟

لمى - **كان عندي فقر دم من زمان. بس عالجتو ومشي الحال ..الحمدالله. هلق بأكل اللي بيتيسر. بس في تعب وعم اشتغل لطعمي ولادي** (بحزن)

طبيب - شو عم تشتغلي؟

لمى - **بشتغل بتنظيف الشقق السكنية وقت الطلب. بتعرف اوقات ما بكون في مصاري تكفي حاجة الولاد. بس المشكلة انو العالم ما بيتركوك بحالك فوق همك بيزيدو هم. (** صمت مطاطئة**) دكتور منشان الله عطيني مقويات بس لحتى اتنشط**

طبيب - شو يعني الناس ما بينركوك بحالك؟ شو المقصود؟ في مين عم يزعجك؟ (يضع يده على يدها ، تنفر)

لمى - **لا لا مين بدو يزعجني ؟ يعني ليش بدو يزعجني حدا. لا ما في هيك شي ابدا**

طبيب - لمى شو بكي ؟ هيدي اول مرة بشوفك هيك كانو في شي مؤثر فيكي ... شو اللي زاعجك ؟

لمى - تصمت لمى حائرة.

طبيب - ما تخافي فيكي تخبريني اللي بدك ياه و كل شيء بتحكي هون بيضل بيننا

للنقاش: التحضير للسؤال ، الملامسة الجسدية، السرية

لمى - **ما فيني احكي**

طبيب - ليش ما فيكي؟ من شو خايفة؟

لمى - **تصمت**

طبيب - شو يا لمى ما بدك تحكي؟

لمى - **دكتور.. الاسبوع الماضي**

طبيب - شو صار الاسبوع الماضي؟

لمى - **جارنا**

طبيب - شو دخل جاركم بالحديث

لمى - **لا لا ولا شي خلص**

طبيب - شو القصة؟ احكيلي يللا ما تخافي

لمى - **رحت المسا لعبّي مي من نبع المخيم وكان ناطرني**

طبيب - ناطرك؟ كيف يعني ناطرك

لمى - **ايه كان ناطرني وهاي مو اول مرة ، على طول بلاحقني وبيزعجني،بس هالمرة ضايقني كتير كتير**

طبيب - زعجك كتير؟ شو عملك؟ وانت ليه لحتى تروحي المسا ؟ ما كان فيكي تروحي الصبح؟؟؟

للنقاش: عدم الضغط للافصاح، لوم الضحية، الانصات و احترام فترات الصمت

لمى - **دكتور هجم علي وما قدرت دافع عن حالي وهددني بالقتل. وصار اللي صار**

طبيب - شو يعني صار اللي صار شرحيلي اكتر ؟ و شو يعني هددك بالقتل؟ شو الدني سايبة؟ ليش ما قدرت تدافعي عن حالك؟

لمى - (تبكي)

طبيب - الهيئة امر فظيع اللي مرقت فيه!! و بعدين شو عملتي شو صار ؟ هربتي ؟

لمى - **ما بعرف يمكن اغمى علي.. ما بعرف.. ما بتذكر ... حدا بيقتلني**

طبيب - ما بتتذكري؟؟؟ معقول؟؟؟!!!

للنقاش: ما المعلومات التي يجب معرفتها من الناجيات من العنف الجنسي ، اهمية عدم التشكيك باقوال الناجية. تقييم السلامة،

لمى - **كل شي بتذكروا انو قلي فيكي تروحي بس.. بس اذا بدك مصاري فيكي تجي لعندي عالبيت تاخدي مصاري منشان ولادك وهددني بالقتل اذا بقول لحدا.**

المشهد الثالث: الطمأنة /التطمين والتحضير للفحص الجسدي

طبيب - و شو عم تفكري تعملي؟

لمى - (تبكي) **ما بعرف دكتور ؟ انا ميتة هلق . هادا الشخص نهالي حياتي حياتي .عم فكر اقتلو و اقتل حالي واخلص.**

طبيب - طولي بالك، ما توقعي حالك بمشاكل اكثر. رح تتخطي هالمشكلة عالاكيد. في غيرك صار معهن هيك و هني عايشين تمام

لمى – **بكاء**

للنقاش: اثار العنف النفسية، التجاوب بواقعية، تاكيد المشاعر. التعاطف. السؤال عن جدية الانتحار او القتل

طبيب - طيب، كترنا حكي . خلينا بالمهم هلق بدي افحصك.. لو سمحتي عالشاريو ونامي على ظهرك.

لمى - **ليه ليه بدي نام على ضهري دكتور.. يعني بخاف دوخ بزيادة**

طبيب - لمى، بدك تنامي على ظهرك لحتى اقدر افحص بطنك وصدرك و شوف اعضائك اذا سليمة (انزعاج واضح).بللا رح احكي الممرضة خليها تجي هي تساعدك

للنقاش: التحضير للفحص السريري. اهمية طلب الموافقة . وجود شخص اخر خلال الفحص

المشهد الرابع: مناقشة الية التدبير / مقارنة متعدد الأوجه

طبيب - فحصك الجسدي منيح لمى. وما بحاجة لتدخل طبي او جراحة، وهلق قولي لي امتى كانت اخر دورة شهرية ؟

لمى - **منذ اسبوعين، ليه عم تسال ؟**

طبيب - عم تستعملي وسيلة لمنع الحمل

لمى - **يعني ما في ضرورة لهيك شي لانو زوجي متوفي . معقول كون حامل منو؟**

للنقاش: ما هي التدخلا ت الطبية في هذه الحالة؟ منع حمل، الامراض المتناقلة جنسيا، كزاز... طرح احتمالات: الاعتداء الجنسي قبل 72 ساعة، قبل 72 ساعة- اسبوع، قبل اكثر من اسبوع

طبيب - احتمال ضئيل، يعني عامة عم نحكي ب 5%، خلينا نحكي عن شي مهم اكتر، اللي هو ، سلامتك وسلامة ولادك، بما انو هو جارك يعني عم تلتقي في من وقت للتاني ؟

لمى - **ايه يعني .. بس بفضل اني موت على اني شوفوا مرة تانية**

طبيب - شوفي من اليوم و رايح ما لازم تضهري لوحدك.. عطول لما تضهري اضهري مع مجموعة او خلي يكون معك حدا من اهلك ، من اصحابك وجربي تحاشي المحلات اللي هون بكون فيا

النقاش: خطة سلامة

طبيب - لمى، بدك تبلغي عن الحادث ؟

لمى - **بلغ؟ لمين بدي بلغ؟ ؟**

طبيب - الى الجهات القانونية المسؤولة

لمى - **لا، لا، دكتور منشان الله لا تبلغ حدا ، يعني بخاف يحكوا علي الناس او يسمعوا ولادي شي كلمة لا سمح الله. لا لا لا منشان الله، ما بدي.**

طبيب - لمى، متل ما بدك انت بتعرفي الاحسن الك قلت لك ما الي حق لبلغ عنك. بس شخص متل هالحيوان لازم يتعاقب

للنقاش: التبليغ ، معرفة حقوق اللاجئين عدم ارغام على قرار

لمى -**ايه دكتور بس لا لا خلص ما بدي. انا اهم شي سلامة ولادي. ما انا عايشة منشانن**

طبيب - ممكن نحكي عن هالموضوع بعدين، يمكن مع الوقت تغيري رايك

لمى - **لا، لا ما بظن**

طبيب - حاكتب لك اسامي المنظمات الإجتماعية التي بتهتم برعاية الناجين من الإعتداء الجنسي، والي ممكن تعطيك الدعم والتوجيه اذا قررتي تحكيهم او تزوريهم (تعليق: ارشادها حول كيفية الإتصال بالجهات المختصة في حال اختارت الإبلاغ)

لمى - **لا، لا ما بدي زورن**

طبيب - خلي العنوان معك وهيدا عنوانهم وارقامهم وما بتعرفي يمكن تحتاجي الهم شي نهار .

لمى - **شكرا دكتور**

طبيب - خلينا نحكي هلق شوي عن نفسيتك التعبانة بدي اعطيك دوا لانو ممكن يصير معك ارق، خوف.....

لمى - **ايه ايه دكتور من هلق عندي هالمشاعر .. مرات بتمنى موت لاخلص منا ..بتشللي تفكيري**

طبيب - اي بعرف منشان هيك عم قللك ومنشان هيك بدي اعطيك علاج

لمى -(تهز راسها)

طبيب - حاكتبلك دواء بيشيل للقلق اسمه diazepam لتاخديه كل يوم لمدة اسبوع وردي علي خبر ساعة اللي بدك

لمى - **شكرا دكتور**

للنقاش: الاحالة (معرفة الموارد المتاحة في المنطقة) ، المتابعة ، انهاء المقابلة، التوثيق

سيناريو افضل

لمى - **صباح الخير دكتور (المريضة خجولة و ملبكة)**

طبيب - صباح الخير لمى صار لك زمان وين هالغيبة ؟

لمى - **كنت مشغولة شوي**

طبيب - ان شاء الله خير، شو فيي ساعدك اليوم؟

لمى - **دكتور، حاسة حالي ماني منيحة وعندي دوخة** . (من دون التواصل بالنظر)

طبيب - دوخة يعني . وشو عم تحسي كمان ؟

لمى - **في دوخة وتعب كتير. مبارح ما قدرت اطلع من البيت جيب مي** (تدمع عينيها)

طبيب - تعب كتير؟؟ شو يللي عم يتعبك ؟

لمى - **ما بعرف دكتور.. بس حتعطيني دوا منشان اخلص من الدوخة؟**.(تبدو مستعجلة)

طبيب - لا روقي بعد ما خلصنا، في اسئلة بعد بدي اطرحها عليكي لحتى اعرف شو عم تحسي عوارض . عم تحسي لعيان ؟

لمى -**لا**

طبيب -استفراغ؟

لمى - **لا ما في هيك شي ابدا. بس في وجع راس وجسمي اوقات كتير بيوجعني ..كتير، كتير موجوعة دكتور. مبارح اخدت علبة مسكن كاملة ما مشي الحال**

طبيب - (يصمت لفترة) لمى، انا شايفك متضايقة و زعلانة. شو القصة

لمى - **زعلانة ؟ لا،لا. ماني زعلانة .ماشي الحال..احسن من غيرنا**. الحمدالله (تبتسم)

طبيب - الحمدلله احسن من غيرك بس الهيئة في شي زاعجك.

لمى - **دكتور لو سمحت اعطيني اي دوا لان لازم روح. ما فيني اتاخر. ولادي لحالهم بالبيت**

طبيب - على راحتك اذا مستعجلة . بس انا بيهمني امرك و بدي كون حدك . وبوعدك كل شي بتقليلي ياه بيضل بيننا الا اذا شفت في خطر عليك ساعتها منطلب مساعدة حدا. شو رايك؟

لمى - **شكرا دكتور بس المشكلة ولادي كتير صغار. يعني 7 و 9 سنوات وقاعدين لحالهم بالبين ولازم امشي لعندهم**

طبيب - على راحتك.انا بيتمنى لو تبقي نحكي شوي. بس يمكن المرة الجاية بيكون معك وقت شوي. حاعطيك هالدوا حبة 3 مرات يس ليخفف الدوخة بس الافضل نعرف ليش عم تدوخي. ردي عليي خبر بهالاسبوع

المشهد الثاني : تسهيل عملية الإفصاح

طبيب - لمى، كيفك اليوم

لمى - **دكتور ماني منيحة . الدوخة زايدة وما عم اقدر نام . بفيق و قلبي عم يدق بسرعة . وزني نازل. و العادة الشهرية تبعي مانا منتظمة ابدا وفي اوجاع باسفل بطني. عطيني دوا.. اية دوا منشان الله.**

طبيب - خلينا نحكي على رواق نحكي عن كل وحدة لوحدا . قلتيلي عندك وجع بطن، و العادة مش منتظمة، ووزنك عم ينزل و كان عندك فقر دم متل ما مبين عندي بالملف. بشو بدك تبلش نحكي بالاول؟

لمى - **كان عندي فقر دم من زمان. بس اخدت ادوية وعالجتو. الحمدالله. . بس المشكلة بالتعب دكتور. يعني لازم اشتغل لطعمي ولادي.** (بحزن)

طبيب - صمت

لمى - **بشتغل بتنظيف الشقق السكنية. يعني بتعرف مرات المصاري ما بتكفي لحتى اصرف على ولادي اكل وشرب وهيك. ومو هون المشكلة. المشكلة العالم ما بتركوك بحالك. يعني بزيدوا هم فوق همك. . (صمت مطاطئة) منشان الله دكتور عطيني اي مقويات بس لحتى اتنشط.**

طبيب - العالم ما بينركوك بحالك؟ شو المقصود؟ خبريني. في شي عم يزعجك

لمى - **لا، لا. يعني مين بدو يزعجني. ما في هيك شي ابدا. ليش لحتى يكون في حدا بدو يزعجني؟**

طبيب - شو يا لمى؟ الهيئة في شي زاعجك، بدك تحكي؟ مرات الواحد لما بيحكي بيرتاح

لمى - **تصمت لمى حائرة.**

طبيب - ما تخافي فيك تخبريني اللي بدك و بوعدك كل شيء بتقليلي ياه بضل بيناتنا

لمى - **ما بقدر دكتور** .(تباشر بالبكاء)

طبيب - **صمت**

لمى - **دكتور الاسبوع الماضي- جارنا - رحت لعبي مي المسا من نبع المخيم. كان ناطرني** (تخبئ وجهها بين يديها) .. **وهاي مو اول مرة بينطرني. على طول بينطرني وبيزعجني. بس هاي المرة ضايقني كتير . كتير**

طبيب - ضايقك كتير

لمى - **هجم علي وما قدرت دافع عن حالي وهددني بالقتل .. وصار اللي صار (تبكي)**

طبيب - صمت: الهيئة امر فظيع اللي قطعتي في !! اذا بدك توقفي شوي. ترتاحي وبعدين منرجع منكمل.

لمى - **ما بعرف شو صار. يمكن غبت عن الوعي او شي. ما بتذكر.**

طبيب - مرات بتصير عالصدمة انو الواحد ينسى لما الصدمة بتكون قوية.

لمى - **بس بتذكر انو تركني روح. بس قلي اذا بدك شي تعي لعندي عالبيت وبعطيكي مصاري منشان ولادك. وقلي اذا بقول لحدا انو ممكن يقتلني.**

المشهد الثالث: الطمأنة /التطمين والتحضير للفحص الجسدي

لمى - (تبكي) **ما بعرف شو بدي اعمل دكتور؟ انا هلق ميتة.عم بفكر انهيلو حياتو خلص. عم فكر اقتل حالي واقتلو.**

طبيب - تقتلي و تقتلي حالك؟ شو عم تفكري تعملي؟

لمى - **ما بعرف. بتجيني كتير هاي الافكار بعدين بتذكر وبقول خلص. بحاول انسى.**

طبيب - عظيم ، تفكير سليم. اذا حسيت انو ممكن تعملي شي دغري بتحكيني او بالمركز لنساعدك. و هلق بدي عذبك تفضلي لجوا وشلحي تيابك. في شرشف تغطي في كرمال افحصك. وبليز استلقي على ضهرك لان بدي افحص كل جسمك.

لمى - **ليش على ظهري؟ (توتر واضح)- ما فيني دكتور منشان الله .... يمكن دوخ بزيادة**

طبيب - ممكن نبلش بالفحص انت و قاعدة وبعدين لما ترتاحي منرجع منكمل انت ونايمة . وما تعتلي هم اذا تضايقتي دغري بتوقفيني.

المشهد الرابع: مناقشة الية التدبير / مقارنة متعدد الأوجه

طبيب - لمى فحصك الجسدي كتير منيح . ما بتحتاجي ولا لاي تدخل طبي ولا عملية خبريني ايمتى آخر مرة كانت الدورة الشهرية

لمى - **منذ اسبوعين، ليه عم تسال ؟**

طبيب - عم تستعملي وسيلة لمنع الحمل

لمى - **يعني ما في ضرورة لانو زوجي متوفي . معقول كون حامل منو ؟**

طبيب - الاحتمال ضئيل، عامة اقل من 5%، وفينا نتحاشاه بتركيب لولب. عندك شي اي افرازات مش طبيعية؟

لمى - **ليش؟ في التهابات او شي**

طبيب - من الافضل نعطيك ادوية لتفادي الالتهابات. وهلق خلينا نحكي عن نقطة مهمة جدا، سلامتك وسلامة ولادك، بما انو هو جارك يعني في امكانية اتصال مستمر بينك وبينو

لمى - **ايه بس بفضل اني موت على اني شوفو**

طبيب - شو بتعملي اذا تعرض لك مرة اخرى او هددك؟ شو رايك انو تصيري تضهري عطول ضمن مجموعة وما بق تضهري ابدا لوحدك. او عطول يكون معك حدا صديقة..حدا من اهلك وحاولي ان تتجنبي المناطق اللي بتعرفي انو بروح عليها . ما بعرف اذا بتعملي هيك ما برايئك انو بتنحمي؟

لمى - **ممكن، ما بعرف بس رح جرب اكيد**

طبيب - عظيم لمى، بدك تبلغي عن الحادث؟

لمى - **لمين بدي بلغ؟**

طبيب - الى الجهات القانونية المسؤولة

لمى - **لا، لا، دكتور ما بدي بلغ لحدا. منشان الله يعني بخاف يحكوا علي الناس او يتعرضوا لولادي..يسمعوهم شي كلمة لا سمح الله . لا، لا . خلص ما تقول لحدا دكتور. منشان الله**

طبيب - لمى، انت بتعرفي مجتمعك اكتر مني. هذا الاحتمال وارد .

لمى - **ما بدي. ما بدي دكتور. منشان الله ما بدي شي . كل شي بدي ياه هو سلامة ولادي. ما انا عايشة منشانهم.**

طبيب - عظيم. شعور حلو و نبيل و انت ام وبتحملي مسؤولية. بخصوص التبليغ ممكن مع الوقت تغيري رايك و ومنشوف ساعتها شو فينا نعمل.

لمى - **لا، لا. ما بظن دكتور اني غير رايي.**

طبيب - حاكتب لك اسماء المنظمات الإجتماعية الي بتهتم بالناجين من الإعتداء الجنسي، و الي ممكن توفر لك كل الدعم والتوجيه اذا قررتي تشاركيون (تعليق: ارشادها حول كيفية الإتصال بالجهات المختصة في حال اختارت الإبلاغ)

لمى - **ما بدي زورون دكتور**

طبيب - احتفظي بالعنوان وارقام الهاتف، يمكن تحتاجي الهم شي يوم من الأيام . خلي العنوان معك وهول ارقام تلفوناتن. ما بتعرفي يمكن تعوزيون شي نهار

لمى - **شكرا**

طبيب - خلينا نحكي شوي عن شو ممكن يصير معك بعدين: يمكن تحسي مشاعر مزعجة متل حزن، قلق ، ارق

لمى - **ايه دكتور. انا من هلق حاسة بهالمشاعر وكل يوم عم بتزيد. اوقات بتمنى موت منشان بطل حس فيون. كتير مزعجين وبشلوا التفكير.**

طبيب - هيدي المشاعر ممكن تصير، بس اذا حسيتي انو بلشت تسيطر عليكي او بلشت تجيكي افكار متل انو تاذي حالك او انو تنتحري لازم دغري تطلبي المساعدة الطبية فورا.

لمى - (تهز راسها)**حاضر دكتور**

طبيب - حاكتبلك دواء بيشيل للقلق اسمه diazepam بدي ياكي تاخدي كل ليلة لمدة اسبوع

لمى - **ماشي**

طبيب - بدي شوفك كل يوم على مدة اسبوع. و متل ما قلت لك، باي وقت بتحسي انك بدك تخلصي من حياتك لازم تجي فورا للعناية الطبية. اوكي؟

لمى - **حاضر**

طبيب - وما تنسي تاخدي الدوا (تعليق: توضيح تعليمات المتابعة)

لمى - **شكرا**

طبيب - ما تنسي انا حدك و حجرب ساعدك لحتى تقطعي هالمحنة . بشوفك بكرا

لمى - **شكرا دكتور**

طبيب - انتبهي عحالك

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ANNEX I: Examples of questions/statements that can be used while communicating with survivors

a- Sample Direct Verbal Questions

When asking about *interpersonal violence among adults*:

- "Are you (or have you ever been) physically hurt or threatened by your spouse?"
- "Have you ever been hit, kicked, slapped, pushed or shoved by your spouse or other family member(s)?"
- "Since you've been pregnant, were you hit, slapped, kicked, or otherwise physically hurt by someone?"
- "Do you have guns in your home? Has your spouse or other family member(s) ever threatened to use them against you?"
- "Did someone cause these injuries? Was it your spouse or other family member(s)?"
- "Has your spouse or family member(s) ever threatened to hurt you or someone close to you?"
- "Are you (or have you ever been) in a relationship in which you felt you were treated badly? In what ways?"
- "A re you (or have you ever been) in a relationship with someone who yells at you, puts you down, or calls you names?"
- "Has your spouse or family member(s) ever destroyed things that you cared about?"
- "Do you feel controlled or isolated by your spouse or other family member(s)?"
- "Do you ever feel afraid of your spouse or other family member(s)?"
- "Has your spouse or other family member(s) ever prevented you from leaving the house, seeing friends, getting a job, or continuing your education?"
- "Has your spouse ever forced you to have sex when you didn't want to or forced you to engage in sex that makes you feel uncomfortable?"
- "Has your spouse ever refused to practice safe sex?"

When asking about *child neglect or maltreatment:*

- "Has your spouse ever threatened or abused your children?
- "Is your child home alone at times?"
- "Do you ever feel so frustrated with your baby/ child that you don't know what to do?"
- "Is your child still in school?"
- "Do you think your child may be depressed?"
- "Do you worry about the friends your child has?"
- "Do you think that your child may be smoking, drinking, and/or using drugs?"
- "When riding in a car is your baby/ child ALWAYS in a car seat or booster seat, or wears a seatbelt (as applicable to child age)?"

- "When riding a bike does your child ALWAYS wear a helmet?"
- "Are there guns in your home or in any home where your baby/ child spends time?"
- "Are medicines and cleaning supplies locked and out of reach?
- "Is there a swimming pool where you live? If so, is there a self-latching gate and fence around the pool?"
- "Has your child taken water safety or swim lessons?"
- "Does your teenager drive? If so, do you have concerns about the way he/she drives?"

b- <u>Sample Framing Questions (Indirect Questions):</u>

- "We all fight at home. What happens when you and your spouse (or other family member) fight or disagree?"
- "Because violence is so common in many people's lives, I've begun to ask all my patients about it."
- "I know I have been seeing you in clinic for a few years now. I have started to ask all my patients more about their relationships." "What happens when you and your spouse disagree?"
- "I don't know if this is a problem for you, but many of the women I see as patients are dealing with abusive relationships. Some are too afraid of uncomfortable to bring it up themselves, so I've started asking about it routinely."
- "If a family member or friend was being hurt or threatened by their spouse or other family member(s), do you know of resources that could help them?"
- "I'm concerned that your symptoms may have been caused by someone hurting you."

c- <u>Sample Support Messages</u>

- "I am asking you about this because I am concerned for your safety."
- "No one deserves to be hurt or threatened by her/his partner."
- "I'm sorry this happened. You don't deserve this. It's not your fault.
- "Many people who are being hurt by their partners are afraid or ashamed to talk about it. I want you to know that I would like to talk about this if this ever happens to you."
- "There is help here and in other places for people who are being hurt by their spouses or other family member(s)."
- "Sometimes people are afraid to talk about this because they think their family and friends will find out. Let me explain the privacy of your care."
- "Patients do not have to have police intervention unless they want it".
- "We can help you even if you don't have legal documentation."
- "If this ever happens to you please let us help you. We would never ask you to do anything you are not ready to do."

ANNEX II: Important legislation for health care providers

SOH MOH Victims of Violence.pdf

ANNEX III: Resources available to family violence survivors

KAFA (enough) Violence & Exploitation http://www.kafa.org.lb/
Lebanese non-profit, non-political, non-confessional civil society organization committed to the achievement of gender-equality and non-discrimination, and the advancement of the human rights of women and children
Address: 43, Badaro Street, Beydoun Bldg, First Floor. Badaro
Phone:961-1-392220
Fax: 961-1-392220
Email: kafa@kafa.org.lb

Kafa Hotline for victims of intimate partner violence: **03-018019**
socio-legal counselling, legal representation, psychotherapy, covering forensic doctors' reports, referral to shelters

KAFA hotline for migrant domestic workers who are physically and sexually abused: 76-090910
socio-legal counselling, legal representation, referral to shelters

YWCA Lebanon: http://www.lebanonywca.org/saynotoviolence.html
Young Women's Christian Association is a volunteer movement whose mission is to achieve social justice through programs for community development.
Locations in cities across the country (Beirut, Ach-Chiyah, Bauchrieh, Hadath, Jbeil, Tripoli, Ablah, Sidon, Tyre, Marjeyoun)

Hotline: 01-367300

Rassemblement Democratique des Femmes Libanaises (RDFL – The Lebanese Women Democratic Gathering)
http://www.rdflwomen.org/
Secular non-governmental women organization which works with the democratic forces and represents a part of the advocacy secular democratic women's movement, on basis of international pacts and treaties
Address: Zekak Al Blat, Batriarkieh, Nahhas Str., Al Rayes & Hammoud Bldg., 1st Floor
P.O Box 14-5620 Beirut Lebanon
Phone: (01)370120
Fax: (01) 370189
Email: rdfl@inco.com.lb
RDFL Hotline: 01-370120

Caritas Migrant Center
https://www.facebook.com/CaritasLebanonMigrantCenter/info
The Caritas Lebanon Migrant Center is an autonomous, specialized center of Caritas Lebanon (a Jesuit Christian Charity founded in Lebanon in 1976). Combining both individualized legal and social support as well as advocacy efforts with the public and

relevant government agencies, CLMC carries out different activities in support of respect for the human rights of migrants.
Address: Takla Center - Facing Futuroscope - Charles Helou Blvd, Sin El Fil, Beirut
Caritas Hotlines: 03-092538 and 03-290066

The Lebanese Coalition to Resist Violence Against Women (LECORVAW)
http://www.lebanesewomen.org/about1.html
A nongovernmental organization which aims to break the silence on the issue of domestic violence and to promote women's human rights and equality between man and women in all fields.

Beirut	Damascus Road – Sodeco – Bassoul Building, 2nd Floor Telefax: 01 612 846 – 01 612 899 **Hotline**: 03 829 809
Tripoli	Amine Moukaddem Sreet – Abdel Wahab Building, 2nd Floor Telefax**:** 06 624 060 **Hotline**: 03 416 735
Email	Beirut: lecorvaw@inco.com.lb Tripoli: l_corvaw@idm.net.lb

Women's Shelters:

Maryam & Martha: http://maryamandmartha.org
Lebanese NGO that shelters and rehabilitates abused and isolated women, provides support reinforcement, and identification of opportunities and works towards changes which impact women who are financially, socially and physically vulnerable.
Phone: 09-236961/2 03-553121

Centre de Formation Professionelle du Bon Pasteur/Soeurs du Bon Pasteur (Sehaile/Keserwan)
Located in Sehaile in Keserwan, the center, which is affiliated with the Catholic Church, provides sanctuary and protection for girls and young women from all over Lebanon who have been abused. The center accommodates 40 young women aged between 13 and 22 years, providing them with full boarding, vocational training and an illiteracy elimination program.
Phone: 03-827532

Other resources for domestic workers:

Migrant Community Center:
https://www.facebook.com/MigrantCommunityCenterLebanon/info
MCC is a community center where migrant workers can come to meet, organize, discuss issues and hold celebrations and miscellaneous events. Members of the MCC are free to communicate and to work on cases that involve abuses that have been inflicted on

domestic workers, such as, physical abuse, non-payment of wages and incidents related to discrimination.
Address: Shartari bldg, 2nd floor, Boutros Dagher Street, Gemmayze (near La Tabkha), Beirut
Phone: 01 444283
Email: MCCbeirut@gmail.com

Other resources for patients:
ABAAD (Dimensions)-Resource Center for Gender Equality: http://abaadmena.org/
Non-profit, non-politically affiliated, non-religious civil association founded in June 2011 with the aim of promoting sustainable social and economic development in the MENA region through equality, protection and empowerment of marginalized groups, especially women. Specific projects include working with men to prevent gender based violence.
Address: Furn Chebbak, Sector 5, 51 Bustani Street, Najjar Bldg., Ground Floor
P.O.Box: 50-048 Beirut-Lebanon
Tel/fax: 01 283 820; 01 283 821
Mobile (office): 70 283 820
Men's Center Phone: 71 283 820

ANNEX IV: Treatment of sexual assault survivor

Treatment will depend on how soon after the incident the survivor presents to the health service. Patients who present less than 72 hours after the incident are treated slightly differently to patients presenting later (WHO/UNHCR, 2004).

	< 72 hours since incident	**> 72 hours since incident**
Prevent sexually transmitted diseases	- Give prophylactic antibiotics to treat gonorrhoea, chlamydial and syphilis - Give the shortest (and easiest) course possible [eg. 400mg cefixime + 1g azithromycin orally will be sufficient presumptive treatment for gonorrhoea, chlamydia and syphilis]	Test for STIs and treat accordingly
Prevent HIV	It is believed that starting PEP as soon as possible (and, in any case, within 72hours after the rape) is beneficial. [PEP = 2 or 3 antiretroviral (ARV) drugs given for 28 days. PEP can start on the same day as emergency contraception and preventive STI regimens. Note that follow up scheduling differs if PEP has been given.	Offer voluntary counselling and testing after 3 months. Follow up visits depend on whether PEP is given: if PEP: 1 week, 6 weeks, 12 weeks; if no PEP: 2 weeks and 12 weeks.
Prevent Hep B	hepatitis B vaccine within 14 days of the incident. If fully vaccinated, no additional doses of hepatitis B vaccine need be given. Provide medication only in exceptional	If she has not been fully vaccinated, vaccinate immediately, no matter how long it is since the incident.
Prevent tetanus	If there are any breaks in skin or mucosa, tetanus prophylaxis should be given unless the survivor has been fully vaccinated. If the wound is clean, minor and recent (<6hrs old), use **tetanus toxoid** (active protection) rather than **tetanus immunoglobulin** (passive protection). The complete course takes 6-12 months to complete.	If she has not been fully vaccinated, vaccinate immediately, no matter how long it is since the incident. If there remain major, dirty, unhealed wounds, consider giving tetanus immunoglobulin if this is available

Prevent pregnancy	Taking emergency contraceptive pills (ECPs) within 120 hours (5 days) of unprotected intercourse reduces the chance of pregnancy by 56-93%. Progesterone only pills are recommended. ECPs are not a form of abortion.	If pregnant, counsel on all options. <5 days after incident, a copper IUD will prevent > 99% of pregnancies. There is no evidence of efficacy of ECPs >5 days post-incident
Wound care	Clean and suture any wounds. Provide analgesia and antibiotics if severe/dirty.	Treat, or refer for treatment, all unhealed wounds, fractures, abscesses, and other injuries and complications.
Mental health care	All survivors should be offered a referral to the community focal point for sexual and gender-based violence, if coexists. Explain to the patient that symptoms of anxiety (eg dizziness) are common	Provide social support and psychological counselling. Consider referral to psychiatry in extreme cases.

ANNEX V: Evaluation form: Addressing domestic violence: improving the health care response

Date: / /

Age: Gender: F M

1-Rate your overall impression of the facilitators on the following criteria:

	Poor				Excellent
a. Knowledge of material	1	2	3	4	5
b. Preparedness	1	2	3	4	5
c. Communication skills	1	2	3	4	5
d. Attentiveness	1	2	3	4	5
e. Comfort level with training material	1	2	3	4	5
f. Ability to engage participants	1	2	3	4	5

Comments:_____

2-Rate your overall impression of the workshop on the following criteria:

	Strongly disagree				Strongly agree
a. Introductory presentations are informative	1	2	3	4	5
b. The filmed scenarios are technically good	1	2	3	4	5
c. messages from the scenarios were clear	1	2	3	4	5
d. Role play is a good idea	1	2	3	4	5
e. The workshop will make a difference in my practice	1	2	3	4	5
f. I feel more confident now in dealing with violence survivors	1	2	3	4	5
g. I would recommend this workshop to others	1	2	3	4	5

3-What were the most useful informations the workshop?

_____

_____

4- What were the least useful informations of the workshop?

_____

_____

5-How could this workshop be improved? Any suggestions or feedback?

_____

_____

6-Did the workshop meet your expectations? Yes No,

Please
explain:____
____
____

ANNEX VI: pre/post test

Addressing domestic violence: improving the health care response

Number Age Sex Please circle one: Pre test/Post test

1) Choose the correct answer:
   a- In Lebanon, domestic violence is quite prevalent.
   b- Physicians in Lebanon are not legally required to report child abuse when suspected.
   c- It is not advisable for physicians to interfere in cases of domestic violence because it is a social and personal matter.
   d- Asking someone about exposure to abuse is insulting and embarrassing.

2) Which of the following should raise suspicion of abuse? (more than one answer)
   a- Suicidal attempt
   b- Complaints from school about bad behavior
   c- Secondary enuresis and encopresis
   d- Patient displaying aggressive behavior

3) Examples of psychological abuse include (more than one answer):
   a- Threatening of separation or divorce.
   b- Prohibiting access to transportation or telephone.
   c- Threatening the child of beating if homework is not done
   d- Repeatedly telling a child “you are a failure and you are a burden on me”

4) Health consequences of violence include:
   a- Ischemic heart disease.
   b- Irregular menstruation.
   c- Peptic ulcer disease
   d- All of above.

5) When communicating with violence survivors, it is better to avoid:
   a- Restating/paraphrasing. as the repetition may be disturbing
   b- Funneling technique because direct questions are easier to answer
   c- Validation as it acknowledges negative feelings like anger
   d- Giving approval and advice as it may misguide violence survivors.

6) Starting with indirect or framing questions and then moving to direct questions is an example of:
   a- Seeking clarifications
   b- Exploring
   c- Funneling.
   d- Attempting to place in sequence.

7) When communicating with violence survivor it is better to avoid (more than one answer):

a- Using directive or why questions.
b- Asking specifically if there was beating, shouting…
c- Using the word violence when asking.
d- Justify the violent incident to decrease the anger feeling

8) *"You mention headache, bad sleep, infected finger and weakness in the legs, shall we start with headache and talk about others later"* this statement is an example of:

a- Focusing.
b- Paraphrasing.
c- Exploring.
d- Summarizing.

9) In which circumstances you should not ask about violence?(more than one answer)

a- In the presence of family members.
b- When a child is present in the room.
c- If you cannot arrange private place.
d- When there are concerns about your safety.

10) When patient refuses to disclose violence, it is suggested to do all the following except:

a- Provide a list of resources available to violence survivors.
b- Emphasize privacy, confidentiality and safety.
c- Show disbelief and encourage disclosure.
d- Explain that violence is common and it is hard for people to disclose it