
Treating Immigrant and Refugee Patients Who Have Experienced Intimate Partner Violence

Overview

Currently, foreign-born individuals make up 12.6% of the U.S. population; emphasizing a need to make cross cultural awareness and culturally sensitive care a national health initiative.

Immigrants to the United States come from a wide range of countries; the largest numbers come from Mexico, China, the Philippines, and India. In terms of refugee populations, the largest numbers come from Cambodia, Columbia, Cuba, Ethiopia, Haiti, Liberia, Iran, Sudan, Somalia, Ukraine, Russia, and Vietnam. In a survey of 24,000 women from 10 countries throughout the world, the World Health Organization (WHO) found that physical or sexual violence by an intimate male partner in a lifetime occurred at an average of 43 percent.

While several U.S. population-based studies have reported prevalence estimates of IPV for Latinas, virtually no research has shown the prevalence of IPV among immigrant/refugee groups. Despite this lack in data, homicide reviews and analyses have consistently documented an overrepresentation of immigrant and refugee women among IPV-related homicide victims compared with U.S. born women.

Types and Risk Factors of IPV in Immigrant and Refugees

- Women may be harassed or abused in ways that are uniquely demeaning in their own culture, which may not be easily understood by outsiders (e.g. slapping with shoes in an Islamic culture). This may make them less likely to report violence or may impact the ways in which they choose to seek help.
- Some types of marriages and relationships involve uneven social and economic resources for foreign-born women, making them especially vulnerable to their partners' control. These relationships include marriages to U.S. military personnel, marriages through international brokers or dating services, and international arranged marriages.
- For immigrant women, trauma associated with IPV may be compounded by problems associated with immigration and acculturation. Their cultural background can also shape how women experience and respond to violence (e.g., manifestations, consequences, and individual and community reactions).
- Various factors that put immigrant and refugee women at risk for IPV include:
 - *Cultural Acceptability of Violence.* This includes the threshold of what constitutes violence and what is acceptable violence in a community.
 - *Social Isolation.* When immigrants arrive, they may be faced with limited social support. Isolation from parents, friends, relatives that they left back home can make women feel alone, burdened, and unwelcomed, leading to distress.

- *Language proficiency.* IPV perpetrators may use limited English proficiency skills to limit the movements of the abused or control what the survivor can or cannot do. For example, perpetrators who possess greater English language skills might silence their victims by serving as the family's sole communicator in the U.S. Language proficiencies of survivors may also serve as barriers to obtaining services.
- *Immigrant/Refugee Status and Legal Vulnerability.* Abusers may use immigration status to threaten deportation and also to prevent abuse from being disclosed. Despite the availability of the Violence Against Women Act (VAWA) that can prevent or interrupt an actual deportation of an IPV immigrant survivor, some women may not know their legal rights.
- *Economic Insecurity.* A higher proportion of immigrants/refugees and their U.S.-born children under age 18 compared with native children live in poverty (16.9% compared with 11.4%). Furthermore, a much higher proportion of foreign-born individuals lack health insurance (33.8% compared with 13.0% for native-born individuals) and thus may have difficulty navigating the health care system.
- *Ethnic Identification.* Reporting of IPV can be viewed by some immigrant and refugee populations as a major problem to the collective identity of the community. As such, there is a strong pressure to maintain a positive image of their community and remain silent about the problem of IPV, especially when communities already feel discriminated against. Furthermore, women may choose to suffer in silence so as to not be ostracized from a community where divorce or separation is frowned upon.

Seeking Safety Behaviors IPV in Immigrant and Refugees

- The confluence of race/ethnicity and culture that impact risk factors also have influence on help seeking behaviors of survivors.
- Many survivors choose to utilize informal methods of help seeking by obtaining help from close friends, family, or religious leaders before taking it out of the community to organizations and healthcare providers
- Many women expect little from police or from IPV institutions for fear of prejudice, racism, or fear of deportation of themselves or their abuser if they were to seek outside help.

Screening and Safety Assessment

Screening

- Patients with mental health symptoms or disorders (depression, anxiety, post-traumatic stress disorders (PTSD), self-harm/suicide attempts) should be screened for IPV in health care settings as part of best clinical practice.

- Survivors should be evaluated for safety and homicide risk and undergo a general health screening. Other areas to assess include history of substance abuse/misuse and social support.
- In 2007, the Centers for Disease Control and Prevention released the screening tool Intimate “Partner Violence and Sexual Violence Victimization Assessment Instruments for Use in Healthcare Settings: Version 1,” that is widely used by providers.

Safety Assessment

A vital role for healthcare providers is to assess the safety of a survivor and develop a plan to ensure immediate safety of the survivor. Healthcare providers may connect survivors to a nurse, social worker, advocate, community resource, or health care workers who are trained in violent prevention.

Suicide Assessment

Studies have found a link between the number of previous traumatic events and the risk of attempting suicide. Mental health providers should conduct a suicide risk assessment in all interactions with IPV survivors. Mental health care providers should:

- Conduct the assessment in a private, confidential space.
- Provide interpreters as needed.
- Discuss the reasons for assessment with your patients. It will reduce their fear, anxiety and the risk of aggression.
- Describe with as much detail as possible what is happening or going to happen which will increase a sense of control and decrease fear and anxiety.
- De-brief with staff involved in the process.
- Work with the patient on a safety plan. This will increase a sense of control and collaboration.
- Focus on coping strategies for risky situations. It will help survivors’ identity and reinforce strengths, social supports and motivations to seek help. Available safety planning resources can be found at <http://www.sprc.org/resources-programs/patient-safety-plan-template>

Danger Assessment

Every year 1,500-1,600 women in the US are killed by their intimate partners. About 1 in 5 women killed or severely injured by an intimate partner had no previous warning; the fatal or life-threatening incident was the first physical violence they had experienced from their partner. The following tools are used to help determine this risk.

- **The Danger Assessment** is a widely validated tool that determines the level of danger an abused woman has of being killed by an intimate partner.
 - It consists of two sections: a calendar and a 20-item scoring instrument. The calendar records the severity and frequency of IPV during the past year.

- The 20-item instrument uses a weighted system to score yes/no responses to risk factors associated with intimate partner homicide.
- The tool is available in English, Spanish, Portuguese and French. Training and certification are available in many forms including an online version.
- It is also available in the form of a smartphone application for users who want to learn about the level of risk in their current relationships.
- ***The Danger Assessment-Revised (DA-R)*** is a tool that was also found to predict re-assault in abusive female same-sex relationships. This tool is also available, and it predicts only re-assault, not lethality.
- ***The Lethality Screen for First Responders*** is an assessment tool that was developed using the Danger Assessment as a guide. The instrument is currently being used by law enforcement in Maryland.
- Training options for the Danger Assessment are available at:
<https://www.dangerassessment.org/TrainingOptions.aspx>

Key Considerations for Treating Immigrant and Refugee IPV Survivors

Treating survivors of IPV in the context of immigrant and refugee communities requires highly trained, community-based advocates who understand the dynamics and consequences of IPV. Providers should have the working knowledge of the legal framework governing immigrants and refugees in the U.S. and be sensitive to the cultural experiences of women in the survivor community.

There are many nuances and challenges to working with immigrant and refugee populations in order to provide help and safety. They include, but are not limited to:

- Providing a safe place for women to disclose their personal stories without fear of judgment, prejudice, or discrimination. Difficulty getting survivors to talk about painful, personal, and shameful experiences. This includes providing crisis-oriented, community-based, confidential counseling that includes immediate and ongoing safety planning in a culturally sensitive atmosphere.
- Having language services on site for all languages including access to interpreters who speak the language of every potential victim of IPV.
- Having a working knowledge of legal system and systems of protection including the Violence Against Women's (VAWA) Act or U-Visa. Providing education about justice system options to help stop and prevent violence, the direct provision of legal services or the referral to available, and accessible legal service providers.
- Delivering supportive, ongoing advocacy to help survivors build additional life skills and to negotiate systems that might help them enhance safety and obtain needed services.
- Supplying information about other services or assistance to meet survivors' needs for housing, food, economic resources and mental health counseling
- Improving relationships with institutions such as the police, the courts, or IPV institutions so women and the community see them as allies as opposed to organizations that may subject them to more trauma (i.e. deportation, removal of children, financial burdens).

- Helping to change cultural norms regarding intimate partner violence by creating a social environment in which community leaders and the public acknowledge and condemn intimate partner violence and support survivors.
- Several service providers said that the only way they reached survivors was by providing an array of services—language classes, driver’s education, employment assistance, art classes— that created environments in which women eventually felt comfortable enough to report abuse

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