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Intimate Partner Violence in Immigrant/Refugee Populations

Burlington, Vermont

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2a – Problem Identification

- Violence of any kind is a **serious infraction on human rights** and those committed against women are no different.
- The most common type of violence against women is that which is committed by an intimate partner (e.g. boyfriend, husband) and is a **pervasive** issue that exists across countries, races, cultures, and economic levels. (Devries)
- Globally, between 10 to 69% of women report having been physically assaulted by an intimate partner during their lifetime (Krug). **Central Africa** and **South Asia** have the highest prevalence of intimate partner violence (IPV) at 65.6% (95% CI 54, 78) and 41.7% (95% CI 36, 47), respectively. (Devries)
- The spectrum of violence ranges widely, including, but not limited to, chronic emotional abuse, forbidding contact with friends/support system, and honor killings. (Watts)

2b – Description of Need

- In the US, 1.3 to 5.3 million women are subjects of IPV annually, especially those who are **younger** or a **minority**. (Modi)
- In 1994, the **Violence Against Women Act minority (VAWA)** was enacted to protect women from IPV. With the recognition of higher rates of IPV in Native American women, IPV in same sex relationships, and the increasing prevalence of human trafficking, new provisions were added in 2013. However, **immigrant women**, who make up 12% of the US population, suffer higher rates of IPV than their American-born counterparts and there are no specific provisions in the VAWA to protect them. (Vaughn)
- Numerous barriers to seeking help exist in the immigrant population. In cultures where collectivism and family values prevail over individualism, IPV is often viewed as a private issue to be resolved behind closed doors. Thus, **many victims do not perceive IPV as abnormal**, but on the contrary, go on to **normalize** their experiences. (Liang)
- Adding to the difficulty of seeking help is the **language barrier** and the limited degree of integration into American culture and values. Prior negative experience with law enforcement whereby the victim reached out but feels trivialized and the abuser was not arrested all serve to add to feelings of **isolation** and **helplessness**. (Liang)

3 – Public Health Costs

- There are significant societal and health consequences of IPV that go beyond physical injuries. In addition to pain, suffering, and decrease in quality of life, victims also experience **higher rates of PTSD, depression, anxiety, suicide, and substance abuse**. (Modi)
- Pregnant women who are abused have poor birth outcomes including **fetal demise** and **preterm delivery**. The children of abused victims are often also abused themselves, and develop abusive behaviors later in life. (Modi)
- IPV places a significant financial burden on society as a whole. Total health care costs are estimated to be 19% higher in IPV victims. Additionally, the total number of work days missed attributable to IPV equates to a **loss of 32,000 full-time jobs annually**, amounting to up to **\$10 billion lost**. (Modi)

4a – Community Perspective

- In 2015, 316 refugees relocated to Vermont. The majority were from Bhutan and Somalia—2 countries whose regions were cited as having high rates of IPV
- **“About 70% of our prenatal patient base are New Americans”**, notes Karen Schumacher, a social worker at Community Health Centers of Burlington (CHCB) who specializes in helping pregnant women, “it takes awhile to build that relationship,” noting the rapport between the patient and the healthcare professional, “I wish there was a way to identify these patients earlier”.
- “Refugees get sessions on IPV in the camps where they have sought refuge and once they relocate to the US, they have orientation, where the topic is again discussed,” states Jacqueline Sandoval, another social worker, who admits that despite this, many patients still are not willing to come forth regarding their abuse

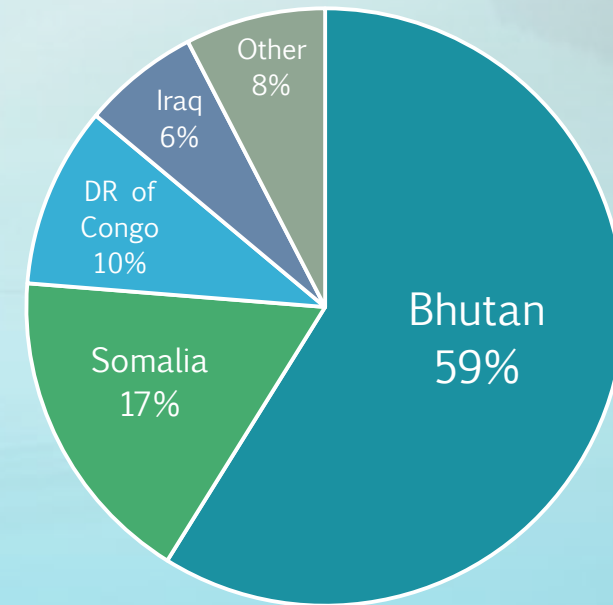


Fig. 1 – Distribution of refugee resettlement by country in Vermont in 2015. (*Other includes Burma, Burundi, Congo, Cuba, India, and Soviet Union)

4b – Community Perspective (cont.)

- “One of the issues is that patients will sometimes mention being physically hit by their husbands but doesn't want anything done about it. To them, family values go above everything else. It is **their priority to protect the familial unit, even if it means continued abuse**”, reports Schumacher.
 - She adds, “Sometimes the abuse extends to the in-laws, since, for many of these patients, it's tradition to move in with the husband's family after marriage.”
 - “In my experience,” said Dr. Michelle Dorwart, one of the providers at CHCB, “[Refugee] patients will often defend their husbands despite being shoved by them while pregnant.”
- Complicating the issue is that many patients **see the existing resources and services as interfering with their private lives**. According to Schumacher, “One Nepali woman seen at CHCB never admitted to any domestic abuse by her husband. However, at a later time, passerbys on the street called the police after they witnessed him punching her. So he was given a restraining order. However, the patient adamantly wants him back and wants the restraining order lifted.”

5a – Intervention/Methodology

- Individual, interpersonal, and sociocultural factors play a key role in influencing a victim's **appraisal** of as well as definition as to what is and isn't acceptable in a given situation. In order to make the decision to seek help, a woman must 1) **recognize that the problem is undesirable** and 2) that it won't go away without help from others. (Liang)
- Prior research has pointed out that **women-defined services**, that is, using culturally sensitive terms that immigrant women themselves have come to identify with in their appraisal of IPV, as opposed to service-defined support, have had more success in terms of utilization.
- Additionally, evidence show that if victims were to seek help, they more often rely on **informal supports** (i.e. friends), thus it's helpful to inform the community as well.

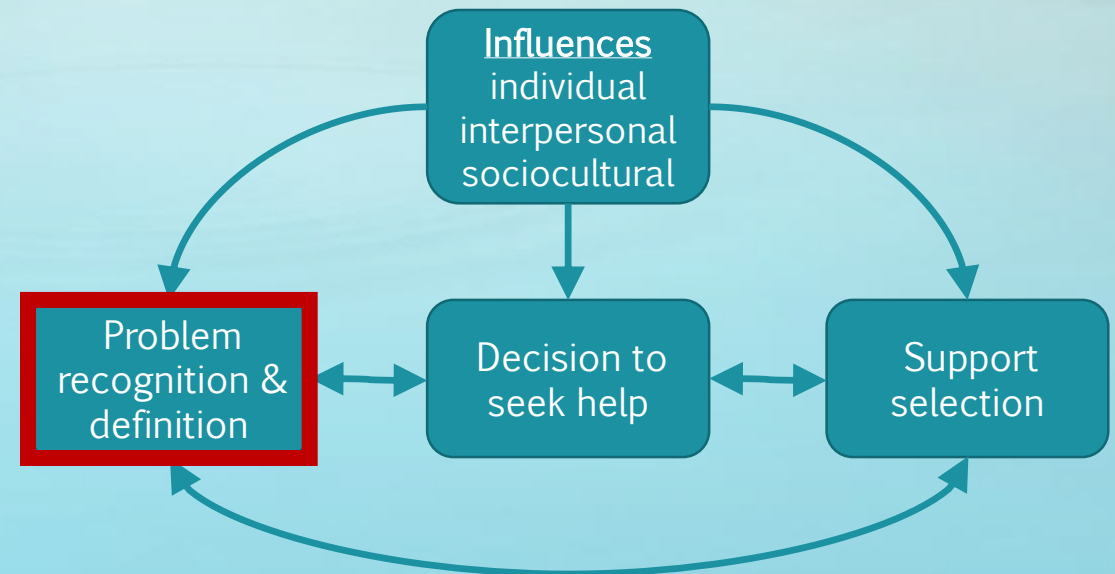


Fig. 2 – A model of help seeking and change. (Liang)

5b – Intervention/Methodology (cont.)

- **Goal** – Empower identified and unidentified victims of IPV by starting an ongoing appraisal process that allows them to, over time, define their abuse as unacceptable and make the decision to seek help.
- **Scope** – All immigrant/refugee women in the community who come to CHCB for health care
- **Implementation** – The intervention itself will be in the form of a self-reflection questionnaire handed out by staff to all female immigrant/refugee patients. It should be stressed to the patients that the completed form will be confidential. After completing the questionnaire, they are then asked to reflect about the thoughts and feelings they had during it and discuss any questions or thoughts they have with a healthcare professional (physician, nurse, social worker, etc.). At the same time, the healthcare professional, with the patient's permission, is provided the questionnaire so they will also be able to elicit points for discussion.

6 – Results

- The questionnaire's aim is to **create an internal dialog** for victims and potential victims of IPV by prompting them to ask themselves
 - how satisfied they are with their marriage
 - whether they believe they are worthy of happiness
 - whether specific negative behaviors by their husbands, behaviors that have been previously identified by immigrant women as constituting emotional, sexual, and immigration-related abuse, are acceptable to them
- The responses will also **bring to light discrepancies between experience and appraisal** and allow both the patient and the healthcare professional to bring up questions and discussion to allow for greater understanding in terms of **how abuse is defined and perceived** and barriers to seeking help.
 - For example, if a patient admitted to a particular abusive behavior by their husband, but then felt that that was acceptable to them, the healthcare professional could start a conversation by asking the patient to elaborate on her thoughts.

My Thoughts On Life At Home—A Questionnaire

This is a self-reflective exercise on your life at home, in particular your relationship with your husband, as studies have shown that that can have a major impact on your wellbeing. There are no right or wrong answers. Take note of your thoughts and feelings after you complete this exercise and ask yourself, “is it okay for me to feel this way?”

Please note that **everything you fill out on this form will be confidential**. No part of this form will ever be shared with anyone outside of your immediate medical care team, including your husband or parents, without your permission.

Instructions: Circle “yes” or “no” on the right for each statement.

1. Which best describes the degree of happiness, everything considered, of your present marriage or committed relationship? Circle one below.

very unhappy	unhappy	mildly unhappy	happy	very happy	extremely happy	perfectly happy
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2. I am worthy of happiness.	yes	no
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3a. My husband has prevented me from becoming friends with Americans, or people who grew up in America, at least once.	yes	no
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3b. This is acceptable to me.	yes	no
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4a. My husband has prevented me from contacting or visiting my parents, siblings, or children, including any relatives overseas at least once.	yes	no
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4b. This is acceptable to me.	yes	no
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5a. My husband has prevented me from learning to speak English at least once.	yes	no
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5b. This is acceptable to me.	yes	no
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6a. My husband limits my access to money	yes	no
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6b. This is acceptable to me.	yes	no
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7a. My husband doesn't allow me to find a job outside the home that pays money.	yes	no
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7b. This is acceptable to me.	yes	no
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8a. My husband has called me stupid, crazy, or another derogatory term in front of my children, other family members, or friends at least once.	yes	no
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8b. This is acceptable to me.	yes	no
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9a. My husband has criticized how I look at least once.	yes	no
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9b. This is acceptable to me.	yes	no
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10a. My husband has criticized my cooking ability at least once.	yes	no
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10b. This is acceptable to me.	yes	no
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11a. My husband always decides when and where we have sex, even if I don't want to.	yes	no
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11b. This is acceptable to me.	yes	no
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12a. My husband has told me that we are going to have more children, even when I don't.	yes	no
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12b. This is acceptable to me.	yes	no
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13a. My husband has told me we are not going to have more children, even when I want to.	yes	no
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13b. This is acceptable to me.	yes	no
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7a – Effectiveness & Limitations

- IPV is a sensitive, complex, and multifactorial issue whose victims often carry the **stigma of guilt, shame, and self-blame**
- This already difficult-to-discuss topic is made even more difficult in the context of the immigrant community, where familial good and **collectivism come before individual happiness** and gender inequality is often striking
- Added to this is the fact that often, victims are reluctant to come forth or seek help from formal sources (healthcare providers, police, etc.) and instead, turn to their friends and other informal sources for help
- Most of all, many victims themselves **do not even perceive their abuse as unacceptable or reason to seek help**

7b – Effectiveness & Limitations (cont.)

- As such, it would be exceedingly difficult to objectively quantify the benefit of this intervention. However, since the intervention is aimed to help victims think about their abuse differently, a **proposed evaluation of effectiveness** could be to ask the screening questions already being asked and seeing whether there's a change in perception of their treatment by their abuser, or whether more women are coming forth to identify themselves as victims of IPV.
- In the case of the latter, though, it would be difficult to know whether their coming forth is a direct consequence of the intervention. One suggestion is to ask about whether they've received the questionnaire in a prior visit and if so, if it had helped them re-think their situation.

8a – Future Direction/Projects

- One reason that victims of IPV choose not to seek help is the language barrier and lack of services provided in their native languages. Thus, for this intervention to provide the most use to victims, it should be **translated** and made available in the languages of at least the top refugee populations in Vermont—Nepali, Somali, Swahili, and Arabic.
- This intervention only targets the very first of many steps involved to getting the help that victims need. A next step could be qualitative studies that explored reasons why immigrant victims do not seek help so as to better understand how to develop better resources. Studies have already shown that one reason is that the support offered do not assist them in increasing their safety. (Raj) For example, once a victim finishes a mental health session, she still has to go back to the abusive environment.

8b – Future Direction/Projects (cont.)

- Along the same lines, studies that analyzed why certain resources were chosen over others and the consequences for choosing so (i.e. impact on the victims' lives and well-being) would also be helpful
- **Community-based education** is also needed with the goal of increasing awareness of IPV, including the types of abuse that constitutes IPV in the immigrant/refugee community and what does and doesn't constitute help in this setting
 - The tragic story of Banaz Mahmud, a Kurdish girl living in the UK who was chronically and severely abused by her husband, who went to the police for help 5 times before she was murdered by her own father and uncle, serves to remind us that the people we usually rely on for support in Western countries—our family—may be the very people some need to run from

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