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Foundation

Intimate Partner Violence in Immigrant and Refugee Communities: Challenges, Promising Practices and Recommendations



A Report by the Family Violence Prevention Fund
for the Robert Wood Johnson Foundation

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Introduction

This document describes intimate partner violence (IPV) in immigrant and refugee communities in the United States. IPV is a widespread, costly, and complex social problem nationwide, with serious health and safety implications. When IPV occurs in immigrant and refugee communities, additional challenges and complexities make it especially difficult to address. This paper examines the issue from a variety of standpoints, including the legal rights and practical challenges facing immigrant and refugee victims of violence, the ways systems are responding, and the promising practices that offer hope for these women, many of whom would otherwise remain in grave and persistent peril.

This report contains four main sections:

1. Background information, including a definition of IPV, data about the incidence of this problem in general and among refugees and immigrants, and discussion of special dynamics in refugee and immigrant communities.
2. An overview of the needs and challenges of immigrant and refugee IPV victims and service providers as well as brief case studies of practices that draw on interviews in 2007 with leaders and staff of seven programs across the United States.
3. Recommendations for funders, service providers and policy-makers.
4. A discussion of IPV research and evaluation issues that need to be addressed in refugee and immigrant communities.

In preparing this document, we have drawn on a variety of sources. We rely on Mieko Yoshihama's review of existing literature (see [Appendix B](#)) on IPV in immigrant and refugee communities. We refer to our interviews with seven programs that assist IPV victims. We draw on insights gathered from a March 2008 meeting in which representatives of those programs joined Family Violence Prevention Fund (FVPPF) and Robert Wood Johnson Foundation (RWJF) personnel to share information, frustrations, successes and recommendations. Finally, Appendix A includes a discussion of the legal structure that relates to immigrants and refugees and Appendix B includes Yoshihama's literature review.

Some of our conclusions are fairly straightforward: For instance, nonprofits that serve IPV victims in these communities and mainstream service providers—such as police departments and courts—should have interpreters who speak the language of every potential victim of IPV. Other conclusions require more discussion. Everyone agrees that ideally, a long-term prevention effort in any community needs to raise community awareness of and change attitudes toward IPV. But some service providers that have been successful in helping individual women have concluded that their success depends, in part, on avoiding open discussion of IPV; if they addressed the issue head-on, they fear that victims would not seek their help and they would lose the trust of the community.

We hope that this report will be a valuable resource for programs that serve IPV victims, for program funders, researchers and federal, state and local policy-makers, as well as help practitioners and funders find a balance between idealism and pragmatism.

Wendy Yallowitz, *program officer*

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Executive Summary

In 2007 the Robert Wood Johnson Foundation (RWJF) asked the Family Violence Prevention Fund (FVPF) to gather information on the challenges, prevention and treatment of intimate partner violence (IPV) in immigrant and refugee communities. The FVPF team reviewed current literature on IPV in immigrant and refugee communities; examined existing prevention and treatment programs targeted at IPV; and interviewed a number of stakeholders. This report describes what the FVPF researchers learned. It discusses the challenges that confront immigrants and refugees in regard to IPV; describes promising models of prevention and treatment of IPV in immigrant and refugee communities; outlines the findings of a stakeholder meeting that offered recommendations; and summarizes suggestions for funding.

The literature review by Mieko Yoshihama, Ph.D., L.M.S.W., A.C.S.W., Associate Professor, University of Michigan School of Social Work (see [Appendix B](#)) stressed that research on IPV in immigrant and refugee communities is limited and often flawed. It can be misleading to aggregate different groups in one study; it is difficult and expensive to study each population group. Victims and organizations that serve them may be reluctant to participate in studies due to concerns about confidentiality and safety. And, as Yoshihama stated, “there exists a very limited body of literature on program evaluation.”

Based on the available data, Yoshihama concluded that “IPV is *not* more prevalent, and, in fact, is probably less prevalent, among immigrant and refugee population groups compared to other groups.” But IPV does exist in such groups, and Yoshihama identified several factors that make it especially difficult for victims in these populations to seek or obtain help. Among these are: Abusive partners may use the victim’s immigration status against her, in effect, threatening deportation. Language barriers and a lack of familiarity with the U.S. social system may prevent a victim from seeking help. A victim may also be afraid that if she reports violence to the authorities, she and/or her partner will be treated with insensitivity, hostility, and/or discrimination. That fear may be justified; mainstream organizations may lack sociocultural understanding and/or may have discriminatory or insensitive attitudes toward immigrants and refugees.

Yoshihama also observed that in the context of a displaced community struggling to survive in what could be a hostile and discriminatory environment, “acknowledging IPV as a problem is viewed as detrimental to the collective survival of the community.” Therefore, “there is strong pressure to maintain a positive image of their community and remain silent about the problem of IPV.”

Yoshihama also identified patriarchal cultural attitudes and victim-blaming as problems in these communities—though hastening to add that they are also problems in every community in the United States.

The interviews with individual service organizations and the remarks of service providers at the March 2008 meeting generally confirmed Yoshihama’s observations. They also illustrated how difficult it would be for organizations to act on Yoshihama’s goal that “changing community members’ attitudes and social norms is critical not only to lessening victim-blaming and promoting help-seeking, but ultimately, to preventing IPV.” The strategies that service organizations have adopted to win victims’ trust and avoid

alienating the communities, though successful in enabling the organizations to help individual victims, were often not necessarily recognizable as long-term prevention and community-change strategies.

Among all organizations interviewed, there was general agreement on certain key points. Language barriers are a critical problem; both nonprofit service organizations and “mainstream” organizations like the police need, but often lack, the ability to communicate with victims to be able to serve them effectively. Beyond language, the service organizations interviewed, said that they often needed to overcome “cultural incompetence” toward—even discrimination against—immigrant and refugee groups by mainstream service providers (such as the police). Likewise, they needed to overcome victims’ lack of trust for those institutions. (Some refugees are themselves fleeing from police abuse in their home countries.) Another point that came up repeatedly was lack of cooperation from Voluntary Resettlement Agencies (VOLAGs), which are institutionally geared toward keeping families together, in working with refugee IPV victims.

There was general agreement on the kind of services that should be offered to women who do seek help. Core service needs include:

1. Crisis-oriented, community-based, confidential counseling that includes immediate and ongoing safety planning;
2. In some instances, temporary shelter for the victim and her children;
3. Education about justice system options to help stop and prevent violence, the direct provision of legal services or the referral to available, accessible legal service providers;
4. Supportive, ongoing advocacy to help victims build additional life skills and to negotiate systems that might help them enhance safety and obtain needed services; and
5. Information about other services or assistance to meet victims’ needs for housing, food, economic resources and mental health counseling generally offered to the population at large (subject to eligibility requirements) by mainstream providers.

The tensions within the organizations and (usually implicit) disagreements among the organizations center on what might crudely be called the “trust vs. prevention” paradox. Programs’ activities to win and keep the trust of individual women and their communities were not necessarily designed to address one of the major goals identified by Yoshihama: “changing community members’ attitudes and social norms.” Several service providers said that the only way they reached victims 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.

That fact, in itself, is consistent with undertaking a strong prevention effort. And skills training—by making women more self-sufficient—can serve a prevention purpose. But some of the organizations, quite deliberately, *never* openly identified themselves as engaged directly in IPV prevention, for fear of alienating the community. (If a victim identified herself, she would quietly be directed to IPV services.) It’s hard to raise community awareness about IPV if it is never even discussed.

Even the organizations that believed they should be engaging in aggressive community-changing activity had a hard time identifying successful efforts. Organizations reported little or no success in engaging existing ‘community leaders’ (such as religious leaders) in the fight against domestic violence. Most found it difficult

to develop community activists on the issue; some found that even when they tried, it was hard to get survivors to go back into their communities to act as victim advocates and to raise awareness of IPV; shame, and fear of retaliation, was cited as a barrier. Some organizations said that they did not have the resources to engage in community organizing, but would if they did. Some said they had abandoned community organizing to focus on direct service, but regretted that fact and planned to reorient themselves toward organizing and prevention.

It is important to note, however, that because of the dire need some organizations seemed satisfied with their progress serving victims of IPV, despite their lack of an aggressive long-term community-changing strategy.

Thus, the discussions with the contacted service providers did not contradict Yoshihama's conclusion that "changing community members' attitudes and social norms is critical," but the comments did suggest that it may not always be practical to expect every organization to engage in such an effort directly and explicitly. And these findings underscored that if funders expect serious community organizing from service organizations, they need to recognize that resources must be allocated specifically to that effort.

Recommendations

Recommendations for Funders:

There are some general truths that apply to domestic violence programs serving immigrants and refugees, just as they apply to programs serving other women. By themselves or with partners, programs should offer comprehensive services because victims of violence need: shelter and safety planning; help coordinating with police and courts; as well as a range of supports that may include employment, housing, and services for children.

In all their work, programs should support women's self-sufficiency, providing help without fostering dependency. But funders in this area must also focus on factors that apply specifically to immigrant and refugee communities:

Fund Programs That Take the Steps Necessary to Win Victims' Trust. Funders should recognize that there are significant barriers that make it extremely difficult for service providers to win the trust of immigrant and refugee victims. Programs that provide a variety of services—from the victim's urgent need for direct services to language classes to 'community centers' to employment services—by themselves or with partner programs may, over time, have a better chance at building that trust. Therefore, funders should support community-based programs that provide an array of services reasonably calculated to both meet clients' needs and win their trust, keeping in mind that there are no one-size-fits-all formulas. This may include funding programs that do not make domestic violence the centerpiece of their agenda but that understand and address, however indirectly, the dynamics of IPV and maintain a firm basis in the community.

Fund Efforts to Improve Mainstream Services. Funders should support efforts that can help mainstream service providers better serve victims of violence who are immigrants and refugees—either when funding these providers directly, or through separate projects designed to help many programs learn to better serve these populations all at once.

At present many mainstream IPV programs lack adequate language capacity and have not ensured that they can address the sociocultural needs of immigrants and refugees. Programs serving refugees face the additional challenge of meeting the needs of victims without creating hostility within resettlement service agencies that, as a rule, try to avoid splitting family units.

Law enforcement and other parts of the justice system often lack adequate training and language capacity to respond effectively to victims who are immigrants and refugees. Some police agencies react with hostility to training about the sociocultural considerations and challenges of immigrant and refugee victims.

All mainstream service providers and systems agencies, including VOLAGs, need to give employees comprehensive training on the dynamics and consequences of intimate partner violence, as well as sociocultural considerations.

It is vitally important that police, courts, health care providers, shelters and VOLAGs approach domestic violence in appropriate and effective ways in immigrant and refugee communities. Funders need to take this into account when issuing grants. A community may need advocates (1) who can get the mayor's ear to tell him or her to insist that the

police chief make the department more accessible to immigrant and refugee victims of violence; (2) who can work effectively with the health care system; (3) who can help domestic violence service agencies develop the language capacity to help immigrants and refugees new to the community; and (4) who can work effectively with VOLAGs. But while *together* these four actions can save lives, funding implementation of just one or two of them may have little or no impact at all, even if the funded advocates are effective in carrying out their discreet assignments. A holistic approach is essential.

It is worth noting, however, that language capacity is such a critical and overriding issue that even an organization that did nothing but pay for reliable interpreters to work with the police, courts, hospitals and shelters on IPV issues would be valuable.

Some program leaders recognize that they are not meeting the needs of immigrant and refugee victims of violence, but they simply do not have the resources to dramatically expand language interpretation services, train colleagues in the judicial, health care and other systems, and provide the holistic set of services these victims need. Other program leaders need to broaden the horizon of services they could and should provide. A focus by funders on leadership development to share best practices in serving these populations would be invaluable.

Provide the Resources Necessary to Develop Community Leaders and Change Attitudes.

Funders should recognize that developing community leaders and engaging community members to help change social and community norms takes significant resources. If a community has a coherent plan to do so, or an organization with strong connections to the community has a program that is likely to work well there, funders should consider supporting these efforts even if they will not include direct services to aid individual victims of violence and their families.

By the same token, funders should recognize that some organizations seem to be effective in combating domestic violence in immigrant and refugee communities without an aggressive, overt effort to educate the community or engage in other prevention activities. It is likely that these programs do more to help individual victims and their families survive than to prevent violence.

Ask Questions About the Program's Strategy. Funders should learn about a program's strategy and whether it makes sense in the context of what has or has not worked in the past by asking the following questions:

- Is the agency going to dedicate significant resources to changing the culture and practices of mainstream service providers such as the police, or not?
- Will the organization try aggressively to develop a cadre of survivor advocates and, if so, are they willing to pay them?
- Does the agency serve only victims of domestic violence or does it provide a broader range of services in the community? Does the organization advertise the full range of services it provides?
- Does it have the financial resources to succeed as well as a sustainability plan?
- Is it going to openly and actively work to “change community norms,” or not? If so, how?

Program Evaluation. With respect to program evaluation, funders should ask organizations to not only keep track of obvious indicators (number of people served, outcomes in individual cases), but also to monitor language and cultural competency, effectiveness of efforts to improve relations with mainstream service providers, leadership development within the community, and related issues discussed above.

Recommendations for Service Organizations

Service organizations should take into account all the factors that funders should. In addition—and perhaps above all—they should be purposeful in determining what role to play in addressing domestic violence, thinking through *all* the roles they can play and determining what makes most sense for them and what will be most beneficial for the community.

Recommendations for Policy-Makers

At the federal level, the Department of State should work with VOLAGs on IPV issues. Congress should also review policies that may place immigrant and refugee IPV at particular risk. For example, Yoshihama says, “In a provision of the Immigration Marriage Fraud Amendments of 1986 (8 U.S.C. § 1186a), a foreign spouse of a U.S. citizen is granted conditional residency status for two years, requiring the U.S. citizen to petition on behalf of his/her foreign spouse in order for the latter to obtain permanent residency. This policy provides partners (who may have a propensity toward intimidation) a virtual license to abuse.”

At the state and local level, policy-makers should ensure that police, courts, shelters, hospitals and social service agencies have (or have access to) reliable interpreters for as many languages as possible, to serve IPV victims. They should also ensure that personnel in those areas are trained (and ordered) to treat people from various sociocultural and national backgrounds with respect.

Recommendations for Academics (and for Funders Interested in Program Evaluation)

Research projects are needed to provide greater information about the incidence of IPV in specific communities, factors associated with perpetration, continuation, and cessation of domestic violence, and effective strategies to enhance victim safety and empowerment, as well as prevention approaches. Such studies should incorporate measures that prioritize victim safety and protect confidentiality. Data collected must avoid the problems cited by Yoshihama (such as misleading aggregation). Good research depends on good data. Analysts would have much more material to work with if service providers conducted more self-evaluation. As discussed above, funders can help ensure that meaningful self-evaluation takes place.

Section 1: Background

Definition

Intimate partner violence (IPV) is a pattern of assaultive and coercive behaviors designed to establish control by a person who is, was, or wishes to be involved in an intimate or dating relationship with an adult or adolescent. Assaultive and coercive behaviors include physical assault, psychological or emotional abuse, sexual assault, progressive social isolation, stalking, deprivation, intimidation and threats. Intimate partners, of the same or opposite sex, include current or former spouses (including common-law spouses), dating partners, or boyfriends and girlfriends. Intimate partners may or may not be cohabiting.¹

Incidence of IPV Generally

Primarily a crime against women, IPV occurs throughout the world, cutting across social, economic, religious, and cultural lines. In interviews with 24,000 women conducted in 15 sites in 10 countries, 15 percent to 71 percent of women disclosed physical or sexual violence by an intimate male partner at some point in their lives.²

Nearly one-third of American women (31%) experience physical or sexual abuse by a husband or boyfriend at some point in their lives.³ Annually in the United States, approximately 1.5 million women are raped and/or physically assaulted by an intimate partner.⁴ From 2001–2005, about 96 percent of females experiencing nonfatal intimate partner violence were victimized by a male and about 3 percent reported that the offender was another female. IPV is difficult to measure because it often occurs in private and victims are often reluctant to report incidents to anyone because of shame or fear of reprisal.⁵

Statistics regarding homicides reveal a similarly grim, gender-based impact. Females are at much greater risk for intimate killings and sex-related homicides. Thus, although intimate partner homicide has declined in the United States since 1998, the proportion of females murdered by an intimate has been increasing. IPV resulted in 1,544 deaths in 2004,

1 Preventing Domestic Violence: Clinical Guidelines on Routine Screening, Family Violence Prevention Fund, 1999, San Francisco; See MEASURING INTIMATE PARTNER VIOLENCE VICTIMIZATION AND PERPETRATION: A COMPENDIUM OF ASSESSMENT TOOLS, National Center for Injury Prevention and Control, Centers for Disease Control (2006), Glossary, available at www.cdc.gov/ncipc/dvp/Compendium/Glossary-References.pdf; CDC Fact Sheet: Understanding Intimate Partner Violence (2006), available at www.cdc.gov/ncipc/dvp/ipv_factsheet.pdf.

2 WHO Multi-Country Study on Women's Health and Domestic Violence against Women: Summary Report of Initial Results on Prevalence, Health Outcomes and Women's Responses. Geneva, World Health Organization, 2005, at p. 15, available at www.who.int/gender/violence/who_multicountry_study/summary_report/summary_report_English2.pdf.

3 The Commonwealth Fund, Health Concerns Across a Woman's Lifespan: 1998 Survey of Women's Health (May 1999).

4 Yoshihama, M., PhD, LMSW, ACSW. "Literature on Intimate Partner Violence in Immigrant and Refugee Communities: Review and Recommendations" (paper prepared for RWJF, July 2008).

5 Bureau of Justice Statistics, U.S. Department of Justice, Intimate Partner Violence in the United States, 1993–2005 (December 2007), available at www.ojp.usdoj.gov/bjs/intimate/ipv.htm#contents.

75 percent of them female. One-third of female murder victims were killed by an intimate, while approximately 3 percent of male murder victims were killed by an intimate. Further, more than two-thirds of victims who were known to be spouses and ex-spouses of their assailants were killed by guns.⁶

Incidence of IPV in Immigrant and Refugee Communities

According to a survey of literature conducted by Yoshihama for this project, available research indicates that IPV is *not* more prevalent, and *may* be less prevalent, among immigrant and refugee population groups than others.⁷ The few IPV prevalence studies that yield data for Latinas and Asian women report somewhat or considerably lower IPV rates for them compared to women of other races and ethnicities. However, virtually no population-based prevalence estimates are available for other immigrant and refugee groups. Thus, research on rates of IPV in immigrant and refugee communities is far from conclusive as the limited data that is available cannot be aggregated because there are essential differences among subgroups.

Furthermore, differences by race and ethnicity tend to decrease or even disappear when considering other factors such as socioeconomic status and partners' substance abuse.⁸ For additional discussion of limitations on research, see Section 4.

Yoshihama also reports that, while non-fatal IPV may be lower for Latinas and Asian immigrants and refugees, immigrants of Hispanic and Asian/other descent experience a higher risk of homicide in general than U.S.-born persons. Homicide reviews and analyses have consistently documented an overrepresentation of immigrant and refugee women among IPV-related homicide victims. These higher IPV-related homicide rates may indicate a failure and/or inadequate response by existing systems and institutions such as law enforcement and the courts.⁹

Dynamics of IPV in Immigrant and Refugee Communities

Many immigrant and refugee women experience IPV in the context of language difficulties, confusion over their legal rights, and the overall stress of adaptation to new cultural and social structures. While the exercise of power and control underlies all IPV, many immigrant and refugee women are especially vulnerable because of poverty and other factors.¹⁰ Examples of the impact of these disparities include:

6 Fox JA. and Zawitz MW. Homicide Trends in the U.S., Bureau of Justice Statistics, US Dept. of Justice (July 2007), available at www.ojp.usdoj.gov/bjs/homicide/homtrnd.htm#contents.

7 Yoshihama, *supra*, note 4, at p. 7.

8 *ibid.* at pp 6–7.

9 *ibid.* at pp 7–8.

10 See a detailed list of examples of power and control tactics used against immigrant women in *Somewhere to Turn: Making Domestic Violence Services Accessible to Battered Immigrant Women A "How To" Manual for Battered Women's Advocates and Service Providers* (AYUDA, May 1999). Chapter 1, "Overview of Domestic Violence and Battered Immigrant Issues", pp. 4–8, available at http://new.vawnet.org/Assoc_Files_VAWnet/BIW99-c1.pdf. See also the *Immigrant Battered Women Power and Control Wheel*, produced and distributed by National Center on Domestic and Sexual Violence, Austin, TX, available at www.endingviolence.org/files/uploads/ImmigrantWomenPCwheel.pdf and adapted from original wheel by Domestic Abuse Intervention Project, Duluth, Minn.

- *Limited language proficiency.* IPV perpetrators frequently rely on foreign-born women's limited English proficiency skills to control their behavior. For example, perpetrators who possess greater English language skills might silence their victims by serving as the family's sole communicator in English. The limitations of a victim's English language skills also serves as a barrier to obtaining services (see discussion in Section 2 below).
- *Disparities in economic and social resources.* While IPV cuts across all social and economic classes, and economics can affect all women's experiences with violence, some types of marriages and relationships involve uneven social and economic resources that can make foreign-born women especially vulnerable to their partners' power and control. These relationships include marriages to U.S. military personnel, marriages through international brokers or dating services, and international arranged marriages. Many of these marriages are based on stereotypical views of women as subservient and passive.¹¹

If services to refugees are provided to the family unit, for instance, batterers may threaten that resources will be cut off or the family deported if authorities learn about the violence.

- *Social isolation.* The isolation experienced by immigrant and refugee battered women can be severe because they may be isolated both within their communities and within the dominant U.S. culture. A number of factors affect isolation, including beliefs about the dominant roles of men, religious doctrines, shame and fear. Many foreign-born brides enter the United States without knowledge of their rights, socially isolated and financially dependent.¹²
- *Immigration status.* Immigration status can increase a woman's vulnerability to IPV and further reduce her options. Abusers use immigration status to threaten deportation and also to warn that the abuser could be deported if the violence were disclosed. Violence Against Women Act (VAWA) immigration remedies can prevent or interrupt an actual deportation of an IPV immigrant victim (see discussion above) but the threat remains and is exacerbated when a victim lacks information about her rights and options. Even though refugees reside legally in the United States, IPV abusers also use the threat of deportation as an effective control tactic because many refugee victims lack accurate information about their legal resident status.

¹¹ Yoshihama, *supra* note 4, at pp. 10–11.

¹² *ibid.* at p. 10. Abusive husbands of foreign-born brides frequently reinforce these factors to establish and maintain control.

Section 2:

Needs and Challenges of Immigrant and Refugee IPV Victims and Service Providers

Overview

The remaining sections of this document will discuss the needs of immigrant and refugee women for meaningful access to comprehensive intervention services—and the specialized challenges that service providers face. The remaining sections rely in part on interviews in 2007 with seven key informants from local programs whose work addresses the needs of immigrant and/or refugee victims of IPV.

Immigrant and refugee IPV victims need access to comprehensive, confidential advocacy services that address individual needs and desires through culturally appropriate interventions. Core service needs—just as for any victims of IPV—include:

1. Crisis-oriented counseling that includes immediate and ongoing safety planning;
2. In some instances, temporary shelter for the victim and her children;
3. Education about justice system options to help stop the violence and prevent future violence, and the direct provision of legal services or the referral to available, accessible legal service providers;
4. Supportive, ongoing advocacy to help victims build additional life skills and to negotiate systems that might help them enhance safety and obtain needed services; and
5. Information about other services or assistance to meet victims' needs for housing, food, economic resources, and mental health counseling generally offered to the population at large (subject to eligibility requirements) by mainstream providers.

As a practical matter, providing or overseeing the provision of these core services in the context of immigrant and refugee communities requires highly trained, community-based advocates who understand the dynamics and consequences of IPV, maintain a working knowledge of the legal framework governing immigrants and refugees in the United States, and reflect the cultural experiences of women in the client community. Specialized, culturally-focused services for foreign-born IPV victims have developed organically within communities around the United States, as represented by the seven programs interviewed for this project, because many mainstream services for IPV victims were inaccessible or unresponsive to foreign-born victims' needs. Interviewees described, for example, shelters that did not have staff members who could speak victims' first languages or understand clients' cultures (including religion, diet, customs, etc.). Similar problems limit victims' ability to access public services in the community at large, beyond IPV-related organizations (see additional discussion of barriers below).

Programs that work in immigrant and refugee communities to help victims of domestic and sexual violence address many of the same issues that violence prevention and service programs face in working with victims born in the United States, but they also must overcome significant obstacles that are specific to immigrants and refugees. In examining the work of seven organizations that do this work, the Family Violence Prevention Fund



learned a great deal about how they address the special circumstances, challenges and complexities that can put immigrant and refugee victims of intimate partner violence in grave and persistent danger.

The challenges facing any program working to stop IPV and help victims include:

- Difficulty getting victims to talk about painful, personal and (to some victims) shameful experiences.
- Convincing victims that they can be safe if they confront or leave their abusers. This means giving them full confidence that the program can: keep them safe from retaliation; provide food and shelter and meet other basic needs; ensure that they will not lose their children, and more.
- Reforming institutions such as the police and the courts so victims see them as allies.
- Developing leadership including a cadre of advocates (ideally including survivors) who will support individual victims and raise awareness in the community.
- Changing cultural norms regarding intimate partner violence by creating a social environment in which community leaders and the public acknowledge and condemn domestic violence and support victims.

Stopping domestic violence when it occurs in immigrant and refugee communities presents particular difficulties that accentuate the challenges described above. The challenges that service organizations face in helping immigrant and refugee victims largely mirror the barriers—described in Section 1 above—that tend to make those victims especially vulnerable and prevent them from seeking help:

- **Language barriers.** Without staff members or volunteers who can speak the language an immigrant or refugee survivor speaks, a program will not be able to do all it could

to help. All programs serving immigrant or refugee victims of IPV need to be able to communicate with those needing their help.

- ***Unfamiliarity with systems and legal rights.*** It is hard for any victim to talk to a stranger about her abuse. For an immigrant or refugee victim of IPV, English-speaking, American-born social service providers, legal experts or others may seem intimidating, unsympathetic or even terrifying. Often it takes time to convince victims that people want to help, in particular because some victims had bad experiences with ‘authorities’ from their home countries (for instance, if you have been victimized by a corrupt or violent police force, it may be hard to believe that a police officer here is trying to help you). Victims may not understand their legal rights and may fear deportation if they challenge their husbands. Some come from cultural backgrounds where men have near-absolute power, and it may be unimaginable to them that authorities would intervene on their behalf.
- ***Social and economic isolation.*** A victim in a small community of immigrants or refugees may worry that, if she leaves her abuser, she will have no safe place to go and will lose connection to her entire community. Even though some small communities can provide little help to victims of IPV, leaving the community may be unthinkable to a victim. As Refugee Family Services explains, some “have never been in the job market and are dependent on their husbands.”
- ***Lack of cultural competence by service providers.*** Some service providers—police, the court system, health care providers, even those in the domestic violence system—lack a fundamental understanding of the cultures of immigrant and refugee communities. Consequently service providers may lack the ability to work with community members in culturally competent ways and may not be as sympathetic as they could be to immigrant and refugee victims. Even if they are not antagonistic, they may think that violence is something that happens in “that community” and there is little or nothing to do about it. Here, too, the language barrier poses a real problem.
- ***Lack of community awareness about IPV.*** Because they do not understand intimate partner violence, community members may not want to ‘air their dirty laundry in public’ and may feel that any community member who talks about the violence is exposing the community to scorn. That does *not* mean that domestic violence is viewed more favorably or condoned in immigrant and refugee communities than in other communities. But it does make it harder for service organizations to identify and assist victims.
- ***Political and environmental landscape.*** Anti-immigrant sentiment runs high in many parts of the United States, fueled by the current political environment. Consequently, some immigrant and refugee communities may feel besieged and as a result, community members may be suspicious of outsiders and guarded in dealing with the outside world.

The seven organizations the Family Violence Prevention Fund team interviewed encountered various challenges at varying levels of intensity, and dealt with or overcame them in many different ways. A brief description of the programs and the services each provides follows.

Case Studies

Arab-American Family Support Center

The Arab-American Family Support Center (AAFSC) provides comprehensive social services to Arab-American immigrant families and children as they adjust to a new culture and navigate American laws and cultural norms. AAFSC addresses language barriers, encourages positive leadership, and promotes a stronger and more united Arab-American community. AAFSC's mission is to help Arab immigrant families acclimate comfortably to the American society around them, which enables them to become active participants in their communities. AAFSC provides a wide range of services to the Arab immigrant community, including English as a Second Language classes, legal assistance, youth development programs, domestic violence prevention and access to health care. In addition to these social services, AAFSC promotes a stronger and more united Arab-American community and provides a strong voice for this community in New York City affairs.

This Brooklyn, N.Y., based organization receives referrals from the Administration of Children's Services (ACS) when there is a claim of abuse or neglect in the family. When women are leaving their husbands, the agency tries to help with housing and employment, although staff members acknowledge that it can be difficult to find either.

The Center conducts home visits in response to ACS referrals, often encountering resistance from the family and the community at large because people think violence is "a private matter." Caseworkers can break through this resistance by taking the time to win women's trust: We "start ...by discussing issues with children—something the women are comfortable with." When women start to see that you're not blaming them, but have concern for them ...[they] open up." One example of success was when "in the... language class a woman came up to the teacher and said, 'the women would like to have a group on family issues.'"

Staff members have seen instances in which public welfare system providers were disrespectful and insensitive to immigrants—and mentioned the language barrier. They say "there are issues with shelter services that are not culturally competent." But the agency does not get involved in policy reform.

With respect to community engagement and awareness, agency staff says, "we are always trying not to make it a public thing, but educate the community." Staff also finds that "sometimes people in the community think what they're doing is good, but [some men] say they're empowering women and this is bad."

Asian Women's Shelter

The mission of the Asian Women's Shelter (AWS) is to eliminate domestic violence by promoting the social, economic and political self-determination of women. This agency has 17 staff members and 110 on-call advocates in San Francisco. The Asian Women's Shelter is committed to every person's right to live in a violence-free home and focuses specifically on addressing the cultural and language needs of immigrant, refugee and U.S.-born Asian women and their children. AWS has adopted a broad strategy that integrates culturally competent and language-accessible shelter services, educational programs, and community advocacy. Founded in 1988, AWS provides safety, food, shelter, healing, intensive case support, advocacy and other resources to assist women and children in rebuilding violence-free lives. Direct services include: Emergency-to-



Transitional Shelter; Women’s Services; Children’s Services; Queer Asian Women’s Services (QAWS); Volunteer Program; Internship Program; Follow-up Component; 24-Hour Crisis Line; and a Multilingual Access Model (MLAM).

Staff members have engaged community members in violence against women prevention activities—in part through the MLAM model which involves a 70-hour training for peer advocates and interpreters. They provide “peer-based services that are primary to the survivor.” These advocates are paid by the hour as they cannot afford to volunteer their time and the compensation “allows them to do this work.”

In addition to their direct shelter services, AWS says it is “connected to larger prevention and community organizing work.” It seeks to change community attitudes because leaders and staff found that “women were not able to safely return to their communities because of victim blaming.” They have not gained adequate funding to do community organizing. They work with community organizations like the Korean Community Center in the East Bay in order to get advice on changing community attitudes on domestic violence.

AWS staff report they have seen severe problems with mainstream services. “Most other programs aren’t serving this population” partly because of “language and cultural issues,” one leader said. “Last year, at one point in time, 50 percent of women were coming from jail because they had been wrongly arrested as the abuser, even though they were the victims. This is compounded by no other resources; these women weren’t reached by other remedies; they didn’t feel they could call the police; when the batterer called the police the women don’t speak the language, couldn’t tell their side of the story, and end up getting arrested.”

Staff also state that “[l]aw enforcement are no longer getting the dominant aggressor training, and what training they do [get] does not talk about immigrant women, language barriers, etc.” Staff mentioned a state legislative bill “to make clear primary aggressor and dominant aggressor.”



Casa de Esperanza

For 25 years Casa de Esperanza (CDE) has worked within the Latino community in St. Paul, Minn., providing services to victims of domestic violence. Established as a shelter for Latinas who were victims of domestic violence, CDE has expanded its work to develop Latina leadership to maintain the shelter’s cultural relevance, educate the community, and provide services to battered Latinas and their families. Their mission consistently guides their work: “to eliminate violence against women and children in the Latino community and the community at large.”

When the organization first started 85 percent of the resources were going into shelter services and only 15 percent were devoted to community education and support groups. Leaders decided to “change the culture” and it now advocates “for the whole family” and is working to establish itself in communities with resource and information centers.

CDE’s community engagement model included listening sessions in the Latino community, where participants were asked about their “hopes and dreams,” goals, and the kinds of supports needed in the community. This led to the development of information and resource centers for youth and adults in the community. Community education and outreach now includes two satellite offices located in the county domestic violence service center and at the Minneapolis police department to respond to questions and provide information to community members.

While CDE notes challenges in working with other nonprofits and concerns about mainstream organizations such as the police, the organization maintains connections with the police department and operates a resource center that serves as a bridge to other community groups.

CDE does talk about adopting a “strength-based” approach of providing support to women to solve their own problems rather than “taking care of them.” Some of the other organizations also addressed the issue of trying to strike the right balance in that respect.

License to Freedom

License to Freedom (LTF) is a nonprofit community-based organization that promotes nonviolence through community education, self-sufficiency and advocacy for refugee and immigrant survivors of domestic and relationship abuse in the East County and San Diego region of California. This agency has a two-person office that, until recently, provided direct crisis intervention services and outreach to Middle Eastern, African, and former Soviet populations.

LTF provides experiential and intensive educational sessions for members of the community through their community education model. Participants are encouraged to engage in listening, dialogue, action and reflection, with a minimum of time spent in lecture, and are able to develop, at their own pace and within their own culture, the new skills needed to build their self-sufficiency, to self-identify problems and resources, and to move towards taking responsibility for their own well-being. Rather than telling participants what to do and how to do it, the project guides the women through the process of self-discovery about their needs, regaining their strength, skills and understanding the necessary solutions as well as ways to achieve these solutions.

Leaders say that in the past it had “more collaborative programs, quilting services, art projects—through a diverse grouping of service agencies [that] got together...to give women an opportunity to meet.” During art projects, women would discuss and report their needs. At one point the office had a driver’s license education program, self defense, cooking class and boat rides. LTF states that it had an “incredible impact through these comprehensive activities;” it was “incredible for women to get together, learn their rights, share their experience, learn how to relax, find friendships, etc.”

With regard to interaction with other service providers, LTF reported a positive experience with police and a negative one with voluntary resettlement agencies (VOLAGs). One group activity was inviting the police to talk to women, helping overcome a significant barrier: “especially in the Middle Eastern community, women were tortured, witnessed torture by the hands of police, etc ... [It] had a large impact on women to talk to police.” But they said working with the VOLAGs was problematic: “VOLAGs don’t want their caseworkers to get involved in domestic violence issues ... [If a caseworker does get involved], “her position as a caseworker could be jeopardized, people may not like her anymore, she is seen as threatening families.” Also, “refugee assistance goes to the family; if the family splits, the VOLAGs are responsible for two entities instead of one unit.” LTF leaders say the VOLAGs could be very effective if they were committed to help.

With regard to changing community attitudes and recruiting women, agency leaders felt that there was potential, but that there are not enough resources for real community organizing and leadership opportunities for women. They said that there are “women who want to be activists” but there are little opportunities for involvement. They now realize they need to build community resources and increase women’s involvement to create change.

Ultimately, agency leaders decided they could be most effective if they stopped providing direct domestic violence services entirely, and instead focused on “community building, building up women leaders, putting things in the hands of the women.” They will still work as a referral agency to direct service providers but will concentrate on areas that they feel make a difference in women’s lives—community activities, including establishing a neighborhood community center for Middle Eastern women, and

restarting the drivers' education program. In terms of direct services, they concluded that "the mainstream system must respond."

MANAVI

MANAVI is a New Jersey-based women's rights organization that works to end all forms of violence against South Asian women living in the United States. "South Asian" women are those who identify themselves as being from Bangladesh, India, Nepal, Pakistan, or Sri Lanka. Through a wide variety of programs and with seven staff members, MANAVI ensures that women of South Asian descent in the United States can exercise their fundamental right to live a life of dignity that is safe and free from violence. MANAVI provides services equitably to women from all South Asian countries and does not discriminate based on national, religious or sectarian grounds. Their services include: individual counseling; legal clinics and referrals; support groups; court and medical accompaniments; and a transitional home.

MANAVI has worked to improve the practices of mainstream service providers. It has provided training, which was welcomed, to judges, prosecutors, and defense attorneys. With the help of a police training director, it was given training time with police officers, but it encountered great hostility there.

Leaders see serious language problems with mainstream service providers. There is a shortage of interpreters in courts and hospitals. Court reporters have been unreliable—in some cases controlling the conversation rather than just relaying statements. But, MANAVI says the organization has not been a part of any recent policy changes related to language access.

In addition, it has sought at the state level to change "anti-immigrant directives" from the state Attorney General's office, and to serve as a voice for immigrants and refugees in a governor's advisory committee.

Its staff members have sought to raise awareness in the community through an annual 'silent march,' 'tabling,' etc. They see some results in that the community acknowledges that domestic violence is a problem.

Agency staff have been less successful in identifying and developing "passionate volunteers who take their messages to the community," although they were able to do more of that in earlier years and still see it as key to community engagement. They find that women do not want to be associated with the "stigma of having suffered violence" and want to be anonymous. Women very rarely are publicly involved with MANAVI, not because they don't want to, but because of stigma and because they feel that anonymity is key to their safety."

MANAVI noted that they struggle with how to assist women without making them dependent—"how much handholding should we do?"

MUNA Legal Clinic: A Program of the Iowa Coalition Against Domestic Violence

The Iowa Coalition Against Domestic Violence (ICADV) is a statewide nonprofit organization that provides assistance and education to programs that serve battered women and their children, working to end violence in intimate relationships. The ICADV's MUNA Legal Clinic was created in 1997 to address the specific needs of immigrant clients across Iowa who have no other opportunities for legal representation. MUNA serves low-income immigrant survivors of domestic abuse and sexual assault

through a variety of family law and immigration legal issues. MUNA is a unique program that provides comprehensive services to immigrant survivors of domestic violence to ensure long-term survival of the abuse. Working with other state partners, including Iowa Legal Aid, the Iowa Coalition Against Sexual Assault, The University of Iowa College of Law, Drake Law School, and 28 project members located throughout the state, MUNA addresses survivors' family law and immigration needs within the same agency. Attorneys also partner with Special Legal Immigration Advocates to ensure a holistic and timely response to client's needs for counseling, economic advice, and legal services. Through the community organizing program, MUNA is present in the community engaging survivors and other community members to work on prevention and education in their communities. By preparing survivors to become stronger leaders, immigrant women and their children can have a voice in the system and are empowered with the tools to meet their needs.

MUNA has assisted more than 1,000 immigrant survivors with immigration and family law matters, including self petitions, U visas, cancellation of deportation, dissolution of marriage, child support, child custody and protection orders.

MUNA has always been a direct immigration related service provider to the immigrant women but it also connects to broader prevention and community organizing work. Originally the group was looser in structure but as it became part of the coalition it had to create a tighter structure. The ability of the women to provide more extensive services through the auspices of the coalition also meant that some of the more creative elements and looser method of functioning had to be discarded. Some of the women joined together to form LUNA (Latina Women United for a New Dawn) which provides more direct services.

Leaders find it a challenge to balance direct services with prevention and community work because there is so much anti-immigrant sentiment. There are many issues they confront—language barriers, varying levels of literacy, a different system that women have to navigate. Some women have been in the country for years but have never dealt with any of the systems. Others are newly arrived immigrants. The needs of the two groups are quite different. Severe mistrust of the police and anyone seen as being part of the system make it difficult for women to access some of the traditional avenues for safety available to U.S.-born women. The advocates have to work within these constraints and that can be a challenge, as can finding funding for such diverse work.

Refugee Family Services

Refugee Family Services (RFS) works to support the efforts of refugee women and children to achieve self-sufficiency in the United States by providing education and economic opportunity. RFS serves refugees in the metro Atlanta area, focusing on the women and children who are often left behind by other programs. Since the 1980s thousands of refugees have resettled in the metro Atlanta area. Today, RFS provides services to refugees who come from a myriad of cultures suffering the effects of protracted civil wars and massive human suffering: Bosnians, Somalis, Sudanese, Liberians, Burmese, Burundi, Vietnamese, Arabic and Kurdish-speaking Iraqis, and Meskhetian Turks. RFS provides a range of services to refugee women and their children including crisis intervention and shelter placements to ensure the safety and health of refugee women who are victims of domestic violence. RFS operates from a refugee community center and an activity center in close proximity to refugees who have resettled in Stone Mountain and Clarkston, Ga., two cities in the metro Atlanta area.



Refugee Family Services does not “lead” with domestic violence as an emphasis. Its leaders say, “As soon as we get these refugees to work with us through our other programs, like employment, we might get them to come to an informational session on what the U.S. laws are, then integrate some things about domestic violence into the session.” They explain that in the United States, “women have rights that are protected by law.” One emphasis is explaining to women that as refugees, they have legal status.

In fact, RFS staff members do not let people know up front that it has a violence prevention program, in order to “protect the caseworkers who have to go into the communities that may be hostile to the violence prevention work.” If someone discloses domestic violence to a caseworker, that person is given a number to call and linked to the appropriate services.

While RFS does not advertise that it works on domestic violence issues, the organization does engage in some community events on a limited basis. “If there is something going on amongst other service providers, [they] may participate” in a candlelight vigil or other prevention-oriented event. Some caseworkers have tried to work with ‘community influencers’ like religious leaders, but “this is very challenging...caseworkers are seen as having different views and...are not welcomed.”

However, RFS has had clients become advocates in the community after going through its domestic violence program. “Women decided on their own, after going through the program, to give back to the community and help women in need.” They also find that “a lot of clients...are referred by former clients...Women know that this is available in the community.”

With regard to working with other service providers, RFS staff members cite significant challenges, including overcoming language barriers. “Challenges arise when a woman goes into a shelter, and there is a communication gap.” They also find that VOLAGs often are not receptive to discussing domestic violence.

RFS has an innovative language program: Staff members distribute “I-speak cards,” written in both English and the client’s language. These “help clients going to emergency rooms, talking to police, etc.” The cards remind the provider that the woman has a right to an interpreter.

RFS leaders describe its violence program as a success. Initially, they doubted they would have many clients, but have served 75 in a nine-month period, and now have a long waiting list. They serve 100 clients a year in the violence prevention program.

Section 3:

Recommendations for Funders, Service Providers and Policy-Makers: Serving Today's Survivors, Preventing Tomorrow's Victims

Introduction

Based on interviews with service providers, as informed by the literature review, a series of (often overlapping) recommendations for funders, service providers and policy-makers have emerged.

There are some general truths that apply to domestic violence programs serving immigrants and refugees, just as they apply to programs serving other women. By themselves or with partners, programs should offer comprehensive services because victims of violence need shelter and safety planning, help coordinating with police and courts, as well as a range of supports that may include employment, housing, and services for children. (See the discussion of “core service needs” in Section 2 above.)

In all their work, programs should support women's self-sufficiency, providing help without fostering dependency.

Other recommendations are more specific to immigrant and refugee communities:

Recommendations for Funders

The Imperative to Win Victims' Trust. Funders should recognize that there are significant barriers that make it extremely difficult for service providers to win the trust of immigrant and refugee victims. Programs that provide a variety of services—from the direct services victims urgently need to language classes to community centers to employment services—by themselves or with partner programs may, over time, have a better chance at building that trust. Therefore, funders should support programs that provide an array of services reasonably calculated to both meet clients' needs and win their trust, keeping in mind that there are no one-size-fits-all formulas. This may include funding programs that do not make domestic violence the centerpiece of their agenda.

The Imperative to Improve Mainstream Services. Funders should consider supporting efforts that can help mainstream service providers better serve victims of violence who are immigrants and refugees—either when funding these providers directly, or through separate projects designed to help many programs learn to better serve these populations all at once.

At present, many mainstream intimate partner violence programs lack adequate language capacity and have not ensured that they can address the cultural needs of immigrants and refugees. Programs serving refugees face the additional challenge of meeting the needs of victims without creating hostility within resettlement service agencies that, as a rule, try to avoid splitting family units.

Law enforcement and other parts of the justice system often lack adequate training and language capacity to respond effectively to victims who are immigrants and refugees. Some police agencies react with hostility to training about the cultures and challenges of immigrant and refugee victims.

All mainstream service providers and systems agencies, including VOLAGs, need to give employees comprehensive training on the dynamics and consequences of intimate partner violence, as well as cultural considerations.

It is vitally important that police, courts, health care providers, shelters and VOLAGs approach domestic violence in appropriate and effective ways in immigrant and refugee communities. Funders need to take this into account when issuing grants. A community may need advocates who: (1) can get the mayor's ear to insist that the police chief make the department more accessible to immigrant and refugee victims of violence; (2) can work effectively with the health care system; (3) can help domestic violence service agencies develop the language capacity to help immigrants and refugees new to the community; and (4) can work effectively with VOLAGs. But while *together* these four actions can save lives, funding implementation of just one or two of them may have little or no impact at all, even if the funded advocates are effective in carrying out their discreet assignments. A holistic approach is essential.

It is worth noting, however, that language capacity is such a critical and overriding issue that even an organization that did nothing but pay for reliable translators to work with the police, courts, hospitals and shelters on domestic violence issues would be valuable.

Some program leaders recognize that they are not meeting the needs of immigrant and refugee victims of violence, but they simply do not have the resources to dramatically expand language interpretation and translation services, train colleagues in the judicial, health care and other systems, and provide the holistic set of services these victims need. Other program leaders need to learn that there are more services they could and should provide. A focus by funders on leadership development to share best practices in serving these populations would be invaluable.

The Imperative to Develop Community Leaders and Change Attitudes. Funders should recognize that developing community leaders who can help change social and community norms takes significant resources. If a community has a coherent plan to do so, or an organization with strong connections to the community has a program that is likely to work well there, funders should consider supporting these efforts even if they will not include casework to aid individual victims of violence.

By the same token, funders should recognize that some organizations seem to be effective in combating domestic violence in immigrant and refugee communities without an aggressive, overt effort to change the culture. Still, it is likely that these programs do more to help individual victims survive than to prevent violence.

Ask Questions About the Program's Strategy. Funders should know what the program's strategy is, and whether it makes sense in the context of what we know about what has worked—or not—in the past. Questions to ask include:

- Is the agency going to dedicate significant resources to changing the culture and practices of mainstream service providers such as the police, or not?
- Will the organization try aggressively to develop a cadre of survivor/advocates and, if so, are they willing to pay them?

- Is the agency a domestic violence service provider serving victims only, or does it provide a broader range of services in the community?
- Does the organization advertise the full range of services it provides?
- Does it have the financial resources to do well? (Or will have, depending on the level of the funder's generosity?)
- Is it going to openly and actively try to “change community norms” or not? If so, how?

Recommendations for Service Organizations

Service organizations should take into account all the factors that funders should, and ask themselves the same questions that funders should ask. In addition—and perhaps above all—they should be purposeful in determining what role to play in addressing domestic violence, thinking through *all* the roles they can play and determining what makes most sense for them and what will be most beneficial for the community.

Recommendations for Policy-Makers

At the federal level, the Office on Refugee Resettlement of the U.S. Department of Health and Human Services should work with VOLAGs to improve their sensitivity and response to IPV issues. Congress should continue to support the Violence Against Women Act and its provision to protect immigrant women and children. At the state and local level, policy-makers should ensure that police, courts, shelters, hospitals and social service agencies have (or have access to) reliable translators for as many languages as possible, to serve IPV victims. They should also ensure that personnel in those areas are trained (and ordered) to treat people from various cultural and national backgrounds with respect.

Section 4: Evaluation and Research

As Yoshihama reports in her literature review for this project, very few studies have focused exclusively on immigrants or refugees, as opposed to specific population groups identified by race or ethnicity (e.g., Latinas and Asian/Pacific Islanders, a broad category in itself). The vast majority of literature is descriptive, documenting the prevalence, scope, dynamics, risk protective factors, and consequences of IPV. Yoshihama also describes numerous limitations in the research, including aggregation (lumping various racial and ethnic groups together as one group); exclusion of large groups of immigrant and refugee populations; lack of attention to sociocultural context; and limited comparability with respect to such methodological aspects as sampling criteria, measures/instruments, data collection methods, and study framework. Yoshihama notes that it is delicate and difficult to strike a balance between standardized instruments, which enhance data comparability across studies, and the use of community-specific instruments that ensure greater sociocultural relevance. She adds that the high cost of multilingual research projects, requiring studies in multiple languages and managing translatability issues, is a major barrier to researchers who are interested in conducting studies of IPV in immigrant and refugee communities.



Research projects—projects that avoid the problems cited by Yoshihama—are needed to provide more information about the incidence of IPV in specific communities and effective responses that enhance victim safety and empowerment. Research must incorporate measures that prioritize victim safety and protect confidentiality.

Researchers can only be useful, however, if they have good data to work with. Researchers would have much more material to work with if service providers conducted more self-evaluation.

Many programs serving immigrant and refugee IPV victims incorporate some form of evaluation of their services. Programs that rely on several funding sources must report sheer numbers and respond to a variety of performance measures that vary with the funding provider. Some programs use a more informal process that involves exit interviews, completion of surveys, or periodic meetings with persons who received services to obtain suggestions for improvements.

Most programs wish to enhance their forms of evaluation in order to improve services to IPV victims and to provide more accurate documentation of their work. Some programs wish to conduct more strength-based evaluation to focus on what works for IPV victims and to follow up over a longer period of time.

The service programs need resources and assistance in developing evaluation systems that measure the quality of services and their impact on victims, while preserving victim confidentiality and trust. Funders thus need to both request that programs conduct self-evaluation, and help ensure the resources are there to get the job done. Funders should ask organizations to not only keep track of obvious indicators (number of people served, outcomes in individual cases), but also to evaluate themselves with respect to language competency, effectiveness of efforts to improve relations with mainstream service providers, leadership development within the community, and related issues discussed above. Documenting organizational processes and supporting formative research are also important.

Section 5: Conclusion

In examining the real-world experiences of domestic violence service providers, it is reasonable to conclude that everything is important, but an organization can be highly effective without doing everything.

Certainly, every community needs effective, accessible mainstream domestic violence services. Service organizations need to develop trust with women in their communities. Strong survivor activists can be invaluable in reaching victims and promoting lasting change. Improving social and community norms about intimate partner violence is one of the most effective ways to make women safer long-term.

In practice, resources are limited and domestic violence agencies are forced to prioritize, making difficult choices about what kinds of services and outreach they will offer. But funders can help alleviate their most difficult choices by recognizing the challenges involved in serving immigrant and refugee communities, and making grants wisely and in ways that help agencies overcome the obstacles associated with serving some of our most vulnerable victims of intimate partner violence.

Finally, it is critical for funders and policy-makers to recognize that the success of service organizations is limited by surrounding circumstances—Federal immigration law, the sensitivity of VOLAGs to domestic violence issues, the attitude and resources that law enforcers, courts and hospitals bring to dealing with IPV in immigrant and refugee communities. Federal, State and local policy-makers should take firm action to improve the legal and practical climate for IPV victims in these communities. Funders can support such changes on those issues through public education efforts, or give resources to service organizations to undertake such education themselves.

Appendix A:

Legal Structure and Financial Assistance Relating to Immigrants and Refugees

By Michael W. Runner, *director of Legal Programs, Family Violence Prevention Fund*

A vast and complex maze of laws, regulations and support systems both challenge and support IPV victims in immigrant and refugee communities. People in these communities share the commonalities of birth outside the United States and many of the difficulties that arise when persons migrate to new countries. Critical differences between the two communities, however, distinguish immigrants' and refugees' experiences with domestic violence and their access to supports and services. An understanding of these differences depends, in part, on information about the underlying legal structure and processes for the entry of refugees and immigrants into the United States.

Description and Status of Refugees

By the end of 2005, the estimated refugee population worldwide was 13 million, the lowest level in 25 years; 8.7 million of these refugees were under the care of the United Nations High Commissioner for Refugees (UNHCR).¹³ The U.S. Immigration and Nationality Act (INA) defines a refugee as a person who is outside (and in some instances within) his or her country and who is unable or unwilling to return because of persecution or a well-founded fear of persecution on account of race, religion, nationality, membership in a particular social group, or political opinion. This definition conforms with the definition used in the United Nations Convention and Protocol relating to the status of refugees. The INA includes a separate provision for granting of asylum on a case-by-case basis to persons who are physically present in the United States or at a land border or port of entry and who meet the definition of refugee.¹⁴

Upon referrals from the UNHCR, the U.S. State Department handles the overseas processing and admission of refugees to the United States from abroad; the U.S. Citizenship and Immigration Services (USCIS) of the Department of Homeland Security (DHS) makes final determinations about eligibility for admission. The USCIS determines whether an individual qualifies for refugee status and is otherwise admissible under U.S. immigration law. The INA sets forth various grounds of inadmissibility, which include health-related grounds, security-related grounds, public charge (i.e., indigence), and lack of proper documentation. Some inadmissibility grounds (public charge, lack of proper documentation) are not applicable to refugees. Others (except security-related grounds) can be waived by the U.S. Attorney General.¹⁵

13 Proposed Refugee Admissions for Fiscal Year 2007, Report to the Congress by the President of the United States, U.S. Department of State, p 11, available at www.wrapsonet.org/LinkClick.aspx?fileticket=bgxSKUZ8KGM%3d&tabid=180&mid=605&language=en-US.

14 Bruno A. Refugee Admissions and Resettlement Policy, Congressional Research Service, The Library of Congress (updated Jan. 25, 2006), pp. 4–5, available at www.wrapsonet.org/LinkClick.aspx?fileticket=dR%2fcVscHXNc%3d&tabid=180&mid=605&language=en-US. The INA definition of a refugee excludes any person who participated in the persecution of another.

15 *ibid.* at pp. 9–10.

Despite annual admission ceilings of 70,000 since 2000, the actual numbers of refugees admitted to the United States decreased dramatically in the years after the terrorist attacks of September 11, 2001. Only 27,110 refugees were admitted to the United States in 2002; this number had increased to 53,813 in 2005. Annual admissions of refugees between 1998 and 2001 ranged from a low of 69,304 (2001) to a high of 85,525 (1999). A system of priorities—distinct from whether a person qualifies for refugee status but reflective of the urgency of a person’s resettlement needs—guides State Department processing.¹⁶ The stated U.S. goal is to provide an opportunity for U.S. resettlement to at least 50 percent of all UNHCR referrals, depending on availability of funds. In calendar year 2005, the United States resettled more than 61 percent of the UNHCR-referred refugees who were resettled in third countries.¹⁷

Unlike immigrants (see discussion below), refugees cannot choose a particular country, or a specific region of that country, in which they will resettle. Most refugees flee their home countries to host—frequently neighboring—countries. When conditions in home countries do not permit repatriation and the host countries cannot or will not permit local integration, refugees in urgent need of protection are resettled to third countries, such as the United States. Thus, for most refugees who are permitted to enter the United States, this is their third country of relocation. Both refugees and asylees (those granted asylum) may apply for legal permanent resident status one year after receiving admission to the United States.¹⁸

Resettlement Assistance for Refugees

In contrast to immigrants who choose to enter the United States, refugees are admitted on humanitarian grounds and need not demonstrate economic self-sufficiency (see discussion below). The Office of Refugee Resettlement (ORR) within the U.S. Department of Health and Human Service (HHS) administers an initial transitional assistance program for temporarily dependent refugees. ORR supports the refugee cash assistance (RCA) and refugee medical assistance (RMA) programs administered by the states. RMA benefits are based on a state’s Medicaid program, and RCA payments are now based on the state’s Temporary Assistance for Needy Families (TANF) payment to a family unit of the same size. Before the 1996 Welfare Reform Act (and subsequent amendments) imposed time limitations,¹⁹ refugees who otherwise met the requirements of federal public assistance programs were immediately and indefinitely eligible to participate in them, just like U.S. citizens.²⁰

Refugees also receive resettlement assistance from national voluntary resettlement agencies (VOLAGs) that work through a network of local affiliates throughout the country to meet refugees’ immediate needs for limited-term financial assistance, housing

16 *ibid.* at pp. 5–8. The annual Fiscal Year (beginning October 1) admission ceilings from 2002 through 2007 were 70,000 refugees but actual admissions were far lower. Persons who are treated as refugees through a grant of asylum are excluded from these limits. See Note 9, *supra*, at p.15.

17 Proposed Refugee Admissions, *supra* Note 9, at pp.12–13.

18 Bruno at pp. 4–5. A legal permanent resident holds what is commonly known as a “green card.” There is no annual limit on these applications by refugees.

19 Refugees and asylees are eligible for SSI benefits and Medicaid for seven years after arrival, and for five years under TANF. Refugee/asylee treatment is accorded to Cuban/Haitian entrants, certain aliens whose deportation/removal is withheld for humanitarian purposes, Vietnam-born Amerasians fathered by U.S. citizens, and victims of human trafficking. See Wasem RE. *Noncitizen Eligibility for Major Federal Public Assistance Programs: Policies and Legislation*, Congressional Research Service, The Library of Congress (updated Mar. 17, 2004), pp. 4–5, available at www.immigrationforum.org/documents/CRS/PublicAssistance_CRS_3-17-04.pdf.

20 *ibid.* at pp. 12–13.

and basic health services.²¹ VOLAGs provide assistance and services to refugees for the first 30 days after their arrival in the United States. Services may include cultural orientation, counseling, English language training, and job skills training and placement. VOLAGs either provide these services directly or arrange for them to be provided by local government agencies or social service organizations that include faith- and community-based entities.²²

Description and Status of Immigrants

In contrast to refugees, immigrants may choose to migrate to a particular country and select a region of that country in which to resettle. Strict U.S. immigration quotas (each with a numerical limit) established by U.S. immigration law restrict the number of immigrants who may enter this country annually with processing of documentation by the USCIS.²³ Persons who receive priority immigration status as potential legal permanent residents (LPRs or green card holders) include foreign nationals who have: (1) a close family relationship with a U.S. citizen or legal permanent resident; (2) specified job skills; (3) residence in countries with relatively low levels of immigration to the United States; or (4) refugee or asylee status (see discussion above). In 2007, 1,052,415 immigrants applied for LPR status. Of that number, 431,368 were new arrivals to the United States. Females comprised 55 percent of these new LPRs, and 58 percent of the new LPR applicants were married.²⁴

The INA sets forth numerous grounds for prohibiting the entry of foreign-born persons into the United States (referred to as “grounds for inadmissibility”).²⁵ The significant grounds that control the numbers of legal immigrants relate to health, security, indigence (referred to as “public charge”), and lack of proper documentation. A person who emigrates to the United States without proper documentation (i.e., a green card) or who overstays a temporary visitor or student visa, for example, would be inadmissible as a legal immigrant. Likewise, unlike a refugee who is eligible for government services, an immigrant seeking status as a lawful permanent resident (LPR or holder of a “green card”) must establish that he or she will not become a “public charge” on the United States through receipt of certain cash or public benefits. Consequently, many immigrants who enter the United States without proper documentation or overstay their visas have no avenues to convert to legal status after arrival. If they are discovered and deported from the United States, additional grounds for inadmissibility under the INA will preclude their return for three to 10 years.

Despite the risks, which in some instances include life-threatening travel, many immigrants choose to enter the United States without proper documentation and processing. Underlying challenges in their home countries, such as severe economic pressures and in some instances domestic or sexual violence with limited legal or practical recourse, may add layers of compulsion to their decisions to migrate. According to estimates by the Pew

21 In fiscal year 2008, the U.S. State Department contracted with 10 national VOLAGs with some 350 local offices across the United States. See *Fact Sheet, Bureau of Population, Refugees, and Migration*, U.S. Department of State (Dec. 18, 2007).

22 *Fact Sheet, Voluntary Resettlement Agencies*, California Department of Social Services (Jan. 2008), available at www.dss.ca.gov/net.gov/RefugeeProgram/Res/pdf/FactSheets/VOLAGs_FactSheet.pdf.

23 Persons who qualify for legal permanent resident status and already live in the United States, including refugees, certain temporary workers, foreign students, family members, and certain undocumented immigrants, file an application with the USCIS for “adjustment of status” to a lawful permanent resident.

24 Jefferys K and Monger R. *U.S. Legal Permanent Residents: 2007, Annual Flow Report*, Department of Homeland Security, Office of Immigration Statistics (March 2008), available at www.dhs.gov/xlibrary/assets/statistics/publications/LPR_FR_2007.pdf.

25 8 U.S.C. §1182.

Hispanic Center in March 2006, based on current population surveys, approximately 11.5 million to 12 million undocumented immigrants reside in the United States, accounting for about 30 percent of the U.S. foreign-born population. Since 2000 the undocumented immigrant population has increased more than 500,000 persons per year.²⁶

Because of work by the Family Violence Prevention Fund, the National Network to End Violence Against Immigrant Women, and others, the Violence Against Women Act (VAWA) now provides protections for IPV victims who are immigrants. Generally, U.S. citizens and LPRs file an immigrant visa petition with the USCIS on behalf of a spouse or child, so that these family members may emigrate to or remain in the United States. The petitioner controls when or if the petition is filed. Some violent or abusive U.S. citizens and LPRs misuse their control of this process, however, by threatening to report spouses to immigration authorities if the victims report the violence they are experiencing. As a result, many immigrant IPV victims are afraid to report abuse to police or other authorities. Under the amendments to VAWA, IPV victims who are or were married to a U.S. citizen or LPR may be able independently to petition legal residency without their abusers' cooperation or knowledge.²⁷ A key goal of VAWA's immigration protections is to cut off the ability of abusers to blackmail victims with threats of deportation, and thereby avoid prosecution. An additional federal law permits victims of human trafficking who cooperate with law enforcement to secure documented immigration status.²⁸

Resettlement Assistance for Immigrants

Immigrants to the United States do not receive the resettlement assistance provided to refugees and asylees. In general, documented immigrants who are legal permanent residents (LPRs) become eligible for the full range of public assistance benefits only after 10 years' employment, documented by Social Security or other records. LPRs who entered the United States after August 22, 1996, are barred from TANF and Medicaid for five years, after which their coverage becomes a state option, and generally they are ineligible for Supplemental Security Income (SSI) until they become naturalized citizens. LPRs also may not obtain food stamps for five years after entry to the United States, with exceptions for LPR children and certain recipients of disability assistance who are eligible immediately. Most states have not exercised their option to bar LPRs from TANF or Medicaid.²⁹ Complicated rules and regulations of public benefits programs mean that immigrants urgently need support in order to determine whether their individual circumstances make them eligible for these benefits.

Federal legislation in 1996 barred undocumented immigrants from eligibility for food stamps, TANF, and other major federal public benefits, except emergency medical care (through Medicaid). Immigrant victims of domestic violence who receive VAWA immigration relief become eligible for food stamps and potentially additional benefits depending on their circumstances. Trafficking victims who receive VAWA immigration relief become eligible for food stamps, TANF, and Medicaid similarly to the program benefits received by asylees or refugees.³⁰

26 Passel, JS. *The Size and Characteristics of the Unauthorized Migrant Population in the U.S.*, Pew Hispanic Center (March 7, 2006), available at www.pewtrusts.org/uploadedFiles/www.pewtrusts.org/Reports/Hispanics_in_America/PHC_Immigration_0306.pdf. The CPS, a monthly survey of about 50,000 households conducted jointly by the U.S. Bureau of Labor Statistics and the Census Bureau.

27 INA, §204(a), codified in 8 U.S.C §1154(a).

28 Victims of Trafficking and Violence Protection Act of 2000 (P.L. 106-386) (Oct. 28, 2000).

29 See Wasem, supra, note 16 at pp. 2-5.

30 *ibid.* at pp.17-18. For a basic description of refugee eligibility for public benefit programs, see text of note 15.

Appendix B:

Literature on Intimate Partner Violence in Immigrant and Refugee Communities: Review and Recommendations

A Report Prepared by the Family Violence Prevention Fund for the Robert Wood Johnson Foundation, July 2008 by Mieko Yoshihama, Ph.D., L.M.S.W., A.C.S.W., Associate Professor, University of Michigan School of Social Work

Introduction

Violence against women is an issue that cannot wait. A brief look at the statistics makes it clear. At least one out of every three women is likely to be beaten, coerced into sex or otherwise abused in her lifetime. Through the practice of prenatal sex selection, countless others are denied the right even to exist. No country, no culture, no woman young or old is immune to this scourge. Far too often, the crimes go unpunished, the perpetrators walk free. (*Remarks by United Nations Secretary-General Ban Ki-moon to the Commission on the Status of Women, New York, February 25, 2008*)

Violence against women is prevalent across the globe, cutting across national, racial, ethnic, and sociocultural boundaries. The prevalence of violence against women in general, and intimate partner violence specifically (also known as domestic violence), has been extensively documented.¹⁻³ Violence against women takes many forms, hinders women's social participation and compromises their well-being. Violence against women is supported by, and simultaneously reinforces, women's lower status and male domination in society. Intimate partner violence (IPV) is the most prevalent form of violence against women. Although variations in research methodologies challenge the comparability of findings across studies, estimates from population-based studies indicate that between 10 percent and 40 percent of women experience IPV sometime in their lifetimes. Some estimates are as high as 50 percent or more.

This report focuses on IPV experienced by immigrants and refugees who now reside in the United States. Immigrants to the United States come from a wide range of countries; the largest numbers come from Mexico, China, the Philippines and India.⁴ In terms of refugee populations, the largest numbers come from Cambodia, Columbia, Cuba, Ethiopia, Haiti, Liberia, Iran, Sudan, Somalia, Ukraine, Russia, and Vietnam.⁵ Reflecting that the vast majority of cases of IPV are perpetrated against women and that the literature focuses almost exclusively on IPV in heterosexual relationships, this report discusses IPV perpetrated by men against women, unless otherwise specified.

The National Violence Against Women Survey estimated that approximately 1.5 million women in the United States are raped and/or physically assaulted by an intimate partner annually.⁶ IPV is a major threat to the health of people; *Healthy People 2010*, issued by the U.S. Department of Health and Human Services, includes an objective pertaining specifically to the reduction of IPV: *Objective 15-34: Reduce the rate of physical assault by current or former intimate partners with a target rate of 3.3 physical assaults per 1,000 persons aged 12 years and older from the baseline rate of 4.4.*

As foreign-born individuals currently make up 12.6 percent of the U.S. population and are a steadily growing group (they were 7.9% of the population in 1990 and 11.1% in 2000),^{4,7} addressing IPV in immigrant/refugee communities is an urgent national health agenda. A higher proportion of immigrants/refugees and their U.S.-born children under age 18 live in poverty (16.9% compared with 11.4% for natives and their children), and a much higher proportion of foreign-born individuals lack health insurance (33.8% compared with 13.0% for native-born individuals).⁷ These socioeconomic disparities make initiatives to address IPV in immigrant/refugee communities even more compelling and urgent.

This report will provide an overview of the current literature on IPV in immigrant/refugee communities in the United States. It should be noted that very few studies have focused exclusively on immigrants or refugees; most studies focus on specific population groups, such as Latinas and Asian/Pacific Islanders (API) that are known to include a high proportion of foreign-born individuals. Many Latina and Asian ethnic groups have a foreign-born rate of over 60 percent, compared with the national average of 12.6 percent.⁷⁻⁹ Descriptions of racial/ethnic groups (e.g., Latino/a, Hispanic, Asian, Asian/Pacific Islander, Black, African American, White, non-Hispanic White, Anglo, Caucasian) vary among authors, each representing a historical and political standpoint. In reporting findings from previous studies, original terminologies used by authors are retained where possible.

1. Overview

Despite the large and growing body of literature on IPV in the United States in general, the literature on IPV in immigrant/refugee communities remains limited. The current literature search and review uncovered over 400 publications, and there has been an increase in the number of publications during the last decade. The increase in number, however, does not necessarily mean an increase in quality. While there are studies that include immigrants/refugees in the sample intentionally and strategically, a large proportion of the publications “happened to” include immigrants/refugees. In the case of the latter, and in the case of the former to a lesser degree, the researchers seldom made any methodological or logistical arrangements—such as modifications to standardized instruments in order to increase their sociocultural relevance to the study populations—to ensure the validity of data collected or the results of analyses.

Methodological Issues

The vast majority of the literature on IPV in immigrant/refugee communities is of a descriptive nature, documenting the prevalence, scope, dynamics, risk and protective factors and consequences of IPV. The sociocultural, sociohistorical, and sociopolitical contexts and factors that affect various aspects of IPV are also addressed in many cases. When statistical analyses are conducted, the analytical approaches most commonly employed are correlational ones. Use of nonprobability samples is also common. There exists a very limited body of literature pertaining to program evaluation.

Aggregation (e.g., lumping people of Latina/o descent or those of API descent into one broad racial category, regardless of ethnicity, immigration status, or acculturation levels) is also prevalent. Aggregation hampers the identification of within-group variations by ethnicity, immigration status, or generational positions, which can be considerable. Because of enormous diversity in the sociocultural, sociohistorical, and sociopolitical contexts across immigrant/refugee population groups, developing and implementing a valid study is a major challenge. The balance between the use of standardized instruments, which help data comparability across studies and the use of community-specific instruments to ensure sociocultural relevance, is a delicate and difficult one to strike.

Furthermore, the high cost of multilingual research projects is a major barrier to researchers who are interested in conducting studies of IPV in immigrant/refugee communities. In addition to cost, the translatability of certain concepts poses challenges in conducting studies in multiple languages.

Ethical and Safety Concerns

Any research investigation must consider the safety and well-being of participants of paramount importance. Studies addressing a sensitive topic, such as IPV, require additional considerations to minimize potential harm associated with participation in such research projects. For example, for a woman in an abusive relationship, merely being asked to participate in a study of IPV may trigger her partner's suspicions that she might have disclosed his violence to others. Another critical ethical concern involves how to ensure informed consent to participate, especially when respondents have limited linguistic proficiency and/or limited understanding of their rights (e.g., rights to refuse participation). This is of particular concern when a study is conducted in an agency setting, where prospective respondents may feel obligated to participate for fear of negative consequences if they choose not to, or out of desire to please or show appreciation to service providers. The burden on community agencies that are asked to assist with research projects, such as personnel resources required to help with participant recruitment, can be substantial. Also prevalent is "hit-and-run research practice," where researchers "access subjects" and collect data, but do little to disseminate or use the study findings to promote needed changes at organizational, community, and/or societal levels. There is scant attention paid to safety and ethical issues in the literature on IPV in general, and that on immigrant/refugee communities is not an exception.

Uneven Attention

A relatively larger proportion of the literature addresses immigrant population groups compared with refugee groups. Among immigrants, a larger number of studies focus on Latina/Hispanic population groups, followed by API groups. Among studies of Latina/Hispanic population groups, the most frequently studied are those of Mexican descent. Studies of APIs most commonly focus on South Asians, especially Indians. A far smaller number of studies address other population groups, such as Arabs, Africans, Caribbeans, and Europeans.

The literature focuses almost exclusively on IPV perpetrated by adult men against adult women, with the following notable exceptions:

- Dating violence/IPV against adolescents/youth¹⁰⁻¹⁴
- IPV against women in same-sex relationships¹⁵⁻²²
- IPV against men in same-sex relationships^{15, 17, 18, 23-25}

2. Prevalence of IPV in Immigrant/Refugee Populations

While over half a dozen national population-based studies have assessed and reported prevalence estimates of IPV for Latinas, only a few have provided prevalence data for other immigrant/refugee population groups (Table 1). One such study, the National Violence Against Women Survey of 1995, found the following estimates for lifetime physical IPV: 21.2 percent for Latina women; 12.8 percent for API women; 26.8 percent for African-American women; 30.7 percent for American Indian/Alaskan women; 27.0 percent for women of mixed race; and 21.3 percent for White women.⁶

Table 1. Studies of IPV Prevalence in Latina and Asian/Pacific Islander Communities

Authors	Data Coll. Method	Sample		Measures	Physical Violence		Sexual Violence		Physical and/or Sexual Violence			
		N	Characteristics		Lifetime	Past year	Lifetime	Past year	Lifetime	Past year		
Both Latina and Asian/Pacific Islanders												
Black & Breiding, 2008 [BRFSS Survey]	T-RDD	P	N ^A	988	Hispanic women	4 PSV Qs in BRFSS Survey					20.5%	
				156	Asian women							9.7%
				8,375	White women							26.8%
				903	Black women							29.2%
				16,005	8,000 women; 8,005 men							
Tiaden & Thoennes, 2000 [NIJ VAW Survey]	T	P	N	628	Hispanic women	Adopted CTS	21.2%			7.9%	23.4%	
				133	API women		12.8%			3.8%	15.0%	
				780	African-Amer women		26.3%			7.4%	29.1%	
				88	Amer Indian/Alaskan Native		30.7%			15.9%	37.5%	
				397	Mixed race		27.0%			8.1%	30.2%	
		6,452	White			21.3%			7.7%	24.8%		
Latina												
Straus & Smith, 1990 [1985 NIJ Family Violence Resurvey]	T	P	N		Respondents of 1985 NFV Resurvey	CTS						
				721	Hispanic				17.3%			
				4,052	White				10.8%			
Sorenson & Telles, 1991	F	P	R		ECA ^B Study Los Angeles sample	"Have you ever hit or thrown things at your spouse/partner? if yes, did you ever do so first?; if so, more than once?" ^C						
				1,243	Mexican American <men & women>		20.0%					
				705	born in Mexico		12.8%					
				538	born in US		30.9%					
				1,149	White men & women		21.6%					
Kantor, Jasinski, Aldarondo, 1994 [NIJ Alcohol & Family Violence Survey]	F	P	N	743	Individuals living as a couple	CTS						
				105	Puerto Rican				20.4%			
				327	Mexican				10.5%			
				175	Mexican American				17.9%			
				136	Cuban				2.5%			
		1,025	Anglo			9.9%						
Jasinski, Asdigian, Kaufman Kantor, 1997 [NIJ Alcohol & Family Violence Survey]	F	P	N		Individuals living as a couple	CTS						
				702	Hispanic				12.3%			
				812	Anglo				10.5%			

Table 1. Studies of IPV Prevalence in Latina and Asian/Pacific Islander Communities (continued)

Authors	Data Coll. Method	Sample		Measures	Physical Violence		Sexual Violence		Physical and/or Sexual Violence				
		N	Characteristics		Lifetime	Past year	Lifetime	Past year	Lifetime	Past year			
Latina (continued)													
Jasinski, 2001 [Ntl Survey of Families & HHS (NSFH1 & 2)]	F	P	N	individuals 19+, married or cohabiting	3Qs ^D								
						240	Hispanic/Latino	11.4–13.8%					
						235	African American	14.9–9.7%					
						3,473	Caucasian	9.0–6.6%					
Caetano, Cunradi, Clark & Schafer, 2000 [1990 Ntl Alcohol Survey NAS]	F	P	N	Individuals 18+ married & cohabiting	CTS + 1 SV Q (forced sex)								
						527	Hispanic couples					17.0%	
						358	Black couples					22.9%	
				555	White couples						11.5%		
Field & Caetano, 2003 cited in Field & Caetano, 2004 [2000 NAS]	F	P	N	Racially "intact" couples; 72% of surviving couples from 1995 NAS sample	adapted CTS								
						387	Hispanic	20.6%					
						232	Black	19.9%					
						406	White	7.8%					
Lipsky & Caetano, 2007, Ntl Survey on Drug Use & Health [NSDUH]	F-CAPI	P	N	married or cohabiting women 18–49 in this study	1 Q "How many times during the past 12 months did your spouse or partner hit or threaten to hit you?"								
						7,924				5.1%			
						nr	Hispanic			6.7%			
						nr	Black			11.0%			
				nr	White						4.0%		
Lown & Vega, 2001a [Mexican American Prevalence and Services Survey]	F-CAPI	P	R	Latina female 18–59 y/o, Fresno Co, Calif.	1PV (push, hit w/ fist, use knife or gun, try to choke or burn) & 1 SV (force to have sex against will)								
						1,155 ^E			9.5%		4.0%		10.8%
Lown & Vega, 2001b [Mexican American Prevalence and Services Survey]	F-CAPI	P	R	Latina female 18–59 y/o, Fresno Co, Calif.	1PV (push, hit w/ fist, use knife or gun, try to choke or burn) & 1 SV (force to have sex against will)								
						1,155 ^E			10.7%				
						58.3%	Mexico-born			7.1%			
				41.7%	US-born			15.8%					
McFarlane, Groff, O'Brien, & Watson, 2005	F	NP	R	women 18–44 y/o, spoke E or S, at 5 public clinics	adopted March of Dimes Assault Screening Protocol (those positively screened were asked to complete SAVAMS & DAS)								
						7,443			5.8%				
						4,955	Hispanic			5.3%			
						1,884	African American			6.0%			
				604	White			8.9%					

Table 1. Studies of IPV Prevalence in Latina and Asian/Pacific Islander Communities (continued)

Authors	Data Coll. Method	Sample		Measures	Physical Violence		Sexual Violence		Physical and/or Sexual Violence		
		N	Characteristics		Lifetime	Past year	Lifetime	Past year	Lifetime	Past year	
Latina (continued)											
Denham, Frasier, Hooten et al., 2007	SA or OA ^F	R	NP	Female employees 18+ y/o at 12 (blue-collar) work sites in rural North Carolina	"Did a partner or ex-partner ever push, shove, hit, slap, kick or otherwise physically hurt you?"; "Did a partner/ex-partner yell at you, put you down, yell at you in public or make you feel bad about yourself?"						
						119	19.5%				
						95	15.9%				
						24	33.3%				
						499	25.2%				
						594	31.8%				
Ingram, 2007	T-RDD	R ⁶	P	men & women	Modified CTS; 16 items y-n response (not clear if SV is included)	12,039	57.2%	16.2%			
						1973	50.6%	18.7%			
						9982	58.5%	15.7%			
Hazen & Soriano 2007	F	R	P	Latina women 18–45 y/o, w/ contact w/ intimate partner last 12 mos., unduplicated cases @ com. health care system in San Diego, Calif.	CTS2, PMWI-SF						
						126	48.4%	25.4%	29.4%	21.4%	
						117	22.2%	12.8%	12.0%	5.1%	
						49	24.5%	14.3%	20.4%	18.4%	
Asian/Pacific Islanders											
Yick, 2000	T	P	R	Chinese <133 men, 129 women>	CTS ^c	18.1%	6.8%				
Hoagland & Rosen, 1990	F	NP	R	Filipina, undocumented	physical, emotional, or sexual abuse				20% ^H		
Yoshihama, 1999, 2001; Yoshihama & Gillespie, 2002; Yoshihama & Horrocks, 2003; past-year rates are unpublished	F	P	R	Japanese	Expanded CTS ⁱ and 11 sexual violence items	39.8–51.7%	12.8–14.7%	20.3–29.9%	6.2–8.5%	54.5%	19.0%
						Age adjusted ^d	57.4%	35.2%			
Song 1996	F ^L	NP	R	Korean	Multiple items ^m ; sexual violence was assessed by one item: "My husband/partner forced me to have sex with him."	26.5–33.6%	7%				
								22.0%	60.0%		
Kim & Sung, 2000	T	NP	R	Korean	CTS		18.0%				

Table 1. Studies of IPV Prevalence in Latina and Asian/Pacific Islander Communities (continued)

Authors	Data Coll. Method	Sample		Measures				Physical Violence		Sexual Violence		Physical and/or Sexual Violence			
		N	Characteristics	Lifetime		Past year		Lifetime		Past year		Lifetime		Past year	
Asian/Pacific Islanders (continued)															
Lee, 2007	SA	NP	R	136	Korean women	CTS2				29.4%					
Raj & Silverman, 2002	SA	NP	R	160	South Asian	CTS2		30.4%		26.6%			40.8%		36.9%
Hurwitz, Gupta, Liu, Silverman & Raj, 2006	SA	NP	R	208	South Asian	Adopted from MA Behavioral Risk Factor Surveillance System							21.2%		14.9%

Data collection method: CAPL=Computer Assisted Personal Interviews; F=Face-to-face interviews; T=Telephone interviews; T-RDD=Random Digit Dialing telephone interviews; OA=Orally-administered questionnaires; SA=Self-administered questionnaires

Sample: P=Probability sample; NP=Non-probability sample; N=National sample; R=Regional/Local sample; nr=Not reported

Measures: AAS=Abuse Assessment Screen; BRFS Survey=Behavioral Risk Factor Surveillance System Survey; CTS=Conflict Tactics Scale; CTS2=Conflict Tactics Scale 2; DAS=Danger Assessment Screen; ISA=Index of Spousal Abuse; PMWI-SF=Psychological Maltreatment of Women Inventory-Short Form; SAAWVS=Severity of Violence Against Women Scales; PV=Physical Violence; SV=Sexual Violence; PSV=Physical and/or Sexual Violence

- A. 16 states and 2 territories
- B. Epidemiologic Catchment Area Study
- C. Respondents were both female and male; the prevalence was not reported separately for women and men.
- D. 3 Qs used in NSFH: 1 "When you have a serious disagreement with your husband/wife/partner how often do you: end up hitting or throwing things at each other?"; 2 "Sometimes arguments between partners become physical. During the last year, has this happened in arguments between you and your husband/wife?"; 3 if Rs indicated yes to (1) or (2), "During the past year, how many fights with your h/w/p resulted in YOU (or h/w/p) hitting, shoving, or throwing things at him/her?"
- E. Weighted sample size is 1,188
- F. Self-administration with some (most Spanish-speaking) respondents, and face-to-face oral administration with others
- G. 10 non-random sites and 10 comparison sites matched on sociodemographic characteristics (as part of a study to evaluate the impact of CCRs)
- H. Including emotional violence
- I. 31 types of physical violence, including all 9 items of the physical aggression subscale of the Conflict Tactics Scale (modified, original 9 items split into 17 items). Additional forms of physical and sexual violence were drawn from studies in Japan and the United States.
- J. Based on the Kaplan-Meier estimator, which took into consideration the probability that some women who have not been abused at the time of the interview may experience an intimate partner's violence at a later time
- K. Based on the 17 types of physical violence included in the CTS physical aggression subscale (original 9 items split into 17 items)
- L. Augmented by group administration of written questionnaires
- M. Including: Low (yell, swear, destroy property, throw an object); Moderate (threaten to hit with an object, threaten to hit with fist, hit with a closed fist); Somewhat severe (slap, hit with an object, threaten with a knife, threaten to kill); Moderately Severe (threaten to kill himself, threaten with a gun, forced to have sex); Severe (squeeze or pinch, choke, bum, broke bone, stab); Very Severe (attempt to kill)

A recent analysis of the Behavioral Risk Factor Surveillance System (BRFSS) Survey in 16 states and two territories reported the following estimates of lifetime physical and/or sexual IPV: 20.5 percent for Hispanic women; 9.7 percent for Asian women; 29.2 percent for Black women; and 26.8 percent for White women.²⁶ These studies indicate somewhat or considerably lower IPV rates for Latina and Asian women when compared to other racial/ethnic groups. Virtually no population-based prevalence estimates are available for immigrant/refugee population groups other than Latina and Asian.

Other national population-based studies have reported somewhat inconsistent findings, with some reporting a higher rate of IPV in the previous year among Latinas/Hispanics than Whites,^{27–29} and others, a lower past-year rate in Latinas/Hispanics.^{30, 31} For rates of IPV ever experienced, different studies have found both higher³² and lower³³ rates for Latina/Hispanics than for White women, with others reporting comparable rates for the two groups.³⁴

Although studies using aggregated racial groups have found higher rates of domestic violence among non-Whites³⁵ and Mexican Americans²⁷ than Whites, studies that disaggregated subgroups often uncovered differences among ethnic subgroups and/or across generational positions within an ethnic group. For example, the National Alcohol and Family Violence Survey found a higher rate of domestic violence among Puerto Rican Americans than among Cuban Americans, and also found that the rate was significantly lower among first-generation Mexican immigrants than among their U.S.-born Mexican American counterparts.³⁶

These findings clearly underscore the importance of considering within-group differences among immigrant populations and warn against aggregation. It should also be noted that when other factors, such as socioeconomic status and partners' substance abuse, are taken into consideration in multivariate analyses, differences by race/ethnicity tend to disappear or decrease.^{36, 37} Thus, available data appear to indicate that IPV is *not* more prevalent, and in fact, is probably less prevalent, among immigrant/refugee population groups compared to other groups.

IPV-Related Homicide

Immigrants (foreign-born individuals) of Hispanic and Asian/other descent are at a higher risk of homicide in general (not limited to IPV-related homicide) than U.S.-born persons.³⁸ And although no population-based studies have provided rates of IPV-related homicide by immigration status, homicide reviews and analyses of reported homicide cases have consistently documented an overrepresentation of immigrant/refugee women among victims. For example, 31 percent (16 out of 51 cases) of women killed in domestic violence-related deaths from 1993 to 1997 in California's Santa Clara County were Asian, although Asians comprised only 17.5 percent of the county's population.³⁹ Of women and children killed in IPV-related homicides in Massachusetts in 1991, 13 percent were Asian, although Asians represented only 2.4 percent of the state's population.⁴⁰ In domestic violence-related homicides in 2000 in Hawaii five of the seven women killed were of Filipina descent⁴¹ (staff of the Domestic Violence Clearinghouse and Legal Hotline, Honolulu, HI, personal communication, April 3, 2002; also see the *Fact Sheet on Domestic Violence in Asian Communities* compiled by the Asian & Pacific Islander Institute on Domestic Violence). This is a disproportionately high rate given that Filipinos represent only 12.3 percent of the total population of Hawaii. The Washington State fatality reviews also found a higher rate of IPV-related homicides among immigrants.⁴²

i www.apiahf.org/apidvinstitute/PDF/Fact_Sheet.pdf

In light of the comparable or even lower prevalence of IPV among immigrants/refugees discussed above, the higher IPV-related homicide rates in these groups appear to indicate failure and/or inadequate response by existing systems and institutions (e.g., law enforcement and courts).

Immigration Status, Generational Position, and Acculturation

One research question that has been investigated by several groups of researchers is whether IPV is more prevalent among foreign-born individuals as compared with U.S.-born counterparts. Others have investigated the association between immigration status or acculturation levels and the prevalence of IPV.

For Latinas, some studies found a higher rate of physical IPV among U.S.-born Mexican Americans^{36,43} or U.S.-born Latinas⁴⁴ than among foreign-born counterparts. Findings concerning the relationship between acculturation levels and IPV risk are inconsistent. Some studies designated three to five levels of acculturation and found the “highest acculturation group” to be at higher risk of IPV,⁴⁵ and others found the “medium acculturation group”⁴⁶ or both the middle and high acculturation groups to be at higher risk.⁴⁷ In other studies, no significant association was found between acculturation levels and IPV risk.⁴⁸

For Asian/Pacific Islanders, Yoshihama’s study of Japanese women in Los Angeles found *no* significant generational differences in the risk of experiencing physical/sexual IPV.^{49,50} Raj and Silverman (2002) also found *no* association between the respondent’s experience of IPV and country of birth, citizenship status, or level of acculturation.⁵¹

Thus, the relationship between immigration status or acculturation levels and the likelihood of experiencing IPV is, at best, *inconclusive*. This challenges a widely held assumption that IPV is more prevalent among (recent) “un-accultured” immigrants compared to U.S.-born individuals or those immigrants who have been in the United States longer (thus “acculturated”).

Methodological Issues

The current review of studies of IPV prevalence in immigrant/refugee communities identified a number of methodological issues, including:

- **Exclusion:** The language(s) used in data collection can lead to the exclusion of large segments of immigrant/refugee populations. Studies have often been conducted only in English, excluding non-English-speaking individuals (e.g., recent immigrants). Although recent national surveys have used both English- and Spanish-speaking interviewers, immigrants who speak other languages remain excluded from study participation.
- **Inattention:** Even if studies include substantial numbers of immigrants/refugees in their samples (e.g., Latina or Asian individuals), researchers might not conduct analyses by race/ethnicity or report study results by race/ethnicity.
- **Aggregation:** A large proportion of researchers aggregate various ethnic groups. For example, lumping API ethnic groups (e.g., Chinese, Filipino, Indian, Japanese, Korean, Tongan, Vietnamese) together as one group. Aggregation may also take the form of not differentiating immigration status or generational position within a particular ethnic group.
- **Lack of attention to sociocultural context:** Despite a vast volume of literature documenting the various ways in which sociocultural factors affect the manifestations

of IPV, the majority of studies employ a standardized instrument that has been developed and normed based on the experiences of mainstream population groups. Although the use of standardized instruments can assist with the comparability of findings, the lack of an instrument's validity with a particular group may ultimately compromise the quality of the data. Yoshihama's study (2001) documented that the inclusion of socioculturally relevant items resulted in higher reported rates of IPV, which suggests that the use of standardized instruments is likely to result in underestimation of the prevalence of IPV.⁵²

- **Limited comparability:** In addition, studies vary considerably with respect to such methodological aspects as sampling criteria (e.g., age, marital status), measures/instruments, data collection methods, and study framework (e.g., whether the study is introduced as focused on IPV, safety, health, stress, or conflict). Such variations challenge the comparability of study findings. Furthermore, the effects of sampling and self-selection bias, as well as the degrees to which respondents are willing to disclose their experience of IPV, remain unknown.

3. IPV Dynamics, Risk Factors, and Consequences

Immigration Status and Systems as Tools of Control

Although IPV cuts across racial, ethnic, and sociocultural boundaries, there are certain socioculturally rooted ways in which IPV manifests itself. One notable aspect of IPV against immigrant women is the partner's use of a woman's immigration status, a vulnerability exacerbated by current U.S. immigration policies. In a provision of the Immigration Marriage Fraud Amendments of 1986 (8 U.S.C. § 1186a), a foreign spouse of a U.S. citizen is granted conditional residency status for two years, requiring the U.S. citizen to petition on behalf of his/her foreign spouse in order for the latter to obtain permanent residency. This policy provides partners (who may have a propensity toward intimidation) a virtual license to abuse.^{53, 54} Studies have documented numerous examples of how abusive partners use women's immigration status to instill fear in them and control them. For example, a partner may threaten to divorce his wife, or not petition for her permanent residency. Fear of losing legal status or of facing deportation could prevent a woman in this situation from seeking outside help.⁵⁵⁻⁶¹ And undocumented immigrant women face the heightened fear of being reported to the immigration authority.^{55, 62} The Immigrant Power & Control Wheelⁱⁱ provides a good overview of multiple ways in which immigration status can be used as part of a system of power and control.

In addition to immigration status, disparities in other areas, such as English proficiency and knowledge of U.S. laws and systems, can place immigrant/refugee women in a vulnerable position. Aided largely by such disparities, abusive partners may use the system to reinforce their abuse. For example, when a police officer arrives at the scene, the English-speaking partner may talk the police officer into believing that it was the immigrant/refugee woman who perpetrated the violence.

Although not intended to be exhaustive, the following types of marriages/relationships involve more pronounced disparities in economic and social resources between the couple, such as English proficiency, formal education, knowledge of U.S. social systems, and available personal networks:

ii www.endingviolence.org/files/uploads/ImmigrantWomenPCwheel.pdf

- Marriages to U.S. military personnel: Women who immigrate to the United States through their marriage or engagement to U.S. military personnel.⁶³
- Marriages through international marriage brokers or dating services: An increasing number of men in the United States utilize picture/mail-order bride services from such parts of the world as Asia and Eastern Europe.^{53, 59, 64–66}
- International marriages, typically arranged by family networks, where women residing in their country of origin marry men (usually of the same ethnic background) who have been living in the United States: Within many immigrant and refugee communities, a practice of marrying foreign-born women of the same ethnic and/or cultural background is common. Bachelors (and sometimes married men, as well) often return to their country of origin for the specific purpose of finding a bride.^{67–70}

Whether commercially arranged or not, these relationships involving uneven social and economic resources can make foreign-born women vulnerable to their partners' power and control. In particular, under the current immigration policies, the fact that their immigration status is dependent on their marriage to a U.S. citizen or resident places them in a very vulnerable position. Furthermore, many of these types of marriages are predicated upon the stereotypical views of women from these countries as subservient and passive. Many foreign-born brides enter the United States not knowing their rights (and are often purposefully kept from knowing their rights), isolated (and often intentionally deprived of opportunities to make social connections), and financially dependent (and often purposefully kept from becoming financially independent).

Risk and Protective Factors

Many studies of risk and protective factors of IPV use nonprobability samples and rely primarily on correlational analyses. As a result, no causality can be inferred. In fact, many factors found to be associated with a higher risk of IPV (e.g., being separated or divorced, low income, women's substance abuse) may actually be consequences of having experienced IPV. Thus, the following summary of risk and protective factors found in the literature must be interpreted with caution.

A number of sociodemographic characteristics have been identified as risk factors, although findings vary depending on whether the outcome variable is based on lifetime or past-year experience of IPV. For example, while young age is frequently found as a risk factor in studies of past-year IPV,^{31, 44, 71, 72} older age is found to be associated with increased risk of lifetime IPV.^{43, 73} This is not surprising because the older the woman, the longer she is exposed to the risk.

With respect to socioeconomic status, while some studies have found low income or financial strain to be associated with a higher risk of IPV,^{27, 31, 74, 75} others have not found a significant association between IPV risk and socioeconomic status. Other risk factors identified include being separated or divorced^{43, 44} and urban residence.^{27, 31, 71}

Frequently, partners' use of substances, especially heavy alcohol consumption, has been identified as a risk factor for IPV.^{44, 76–80} Relatively fewer protective factors have been identified; several studies have found the availability of social support to be a protective factor.^{33, 71}

While understanding risk and protective factors is important, because risk factors are not necessarily causes, addressing these correlational factors alone in prevention programs is unlikely to help prevent IPV.

Consequences of IPV

In contrast to a wide and extensive body of research that exists on the health and social consequences of IPV in the general U.S. female population over the last two decades, a far smaller number of studies have examined these consequences in immigrants/refugees. The literature on the effects of IPV on immigrants/refugees has begun to emerge and expand only recently. Studies of the health status of immigrant/refugee battered women indicates the general negative impact of IPV on physical health;^{81, 82} mental health, such as depression, posttraumatic stress, and anxiety symptoms and disorders;^{49, 50, 82-88} substance abuse;⁸⁹ and reproductive/sexual health, such as miscarriage and unwanted pregnancies.^{60, 82, 90}

A number of studies have found a dose-response relationship between IPV severity and the severity of health problems.^{49, 86, 91} Torres and Han (2000) found that the experience of forced sex (not physical abuse, nonphysical abuse, life changes, acculturation, or social support) was the only factor significantly associated with Posttraumatic Stress Disorder (PTSD) scores.⁸³ In another study, Yoshihama and Horrocks found that forced sex perpetrated by a partner did not independently contribute to increased posttraumatic stress symptom counts in the presence of other types of victimization. In this study, it was IPV-related injuries and fear for their lives that were associated with women's increased posttraumatic stress symptoms.⁴⁹

Due to methodological variations across studies, it is difficult to ascertain whether the prevalence of health problems among immigrant/refugee women is comparable to that of the general female population when both experience IPV. One study that compared rates of mental health problems found that abused Latina women were less likely than abused White women to be diagnosed with PTSD or an anxiety disorder.⁸³ Another study documented a higher rate of unmet mental health needs among Hispanic battered women.⁹² In addition to prevalence, symptom manifestations may vary by race/ethnicity, immigration status, and generational position.⁸⁶ More research is needed to enhance our understanding of health consequences and other effects of IPV among immigrants/refugees.

4. Knowledge, Attitudes and Beliefs of General Community

In general, community-based studies, as well as review articles, have found a lack, or low level, of awareness about IPV among immigrants/refugees (e.g., IPV is not seen as a problem in their community;^{59, 93, 94} IPV is recognized, but only as a family/private issue;^{95, 96} or community members condone IPV and/or do not consider various abusive or controlling acts to be IPV.^{93, 97, 98} In a study conducted by the Family Violence Prevention Fund utilizing a random sample of men and women, Asian-American men and women and Latino men were less likely to define a husband's shoving or face-smacking as domestic violence when compared to Caucasian men and women.⁹⁹ However, other studies found that some immigrant/refugee groups were more likely to recognize IPV and/or less likely to approve of IPV. For example, a study of multi-ethnic populations in California found that foreign-born individuals of Latino/a descent, and Korean, Vietnamese and other Asian descent saw various acts depicted in a vignette as wrong more frequently than native-born respondents¹⁰⁰ (e.g., "A husband told his wife that he did not want her to visit her family that night and that he would not allow it. Then he slapped her."). A study by Kantor and colleagues³⁶ found a wide variation by race/ethnicity in the proportion of respondents approving of a husband slapping his wife: Puerto Rican (18.8%); Mexican born in Mexico (7.7%); U.S.-born Mexican American (5.4%); Cuban (2.1%); and Anglo (13.6%). Given inconsistent findings, it is

premature to conclude that immigrants and refugees tend to under-recognize incidents of IPV or are more likely to tolerate IPV.

A number of studies have identified types of behavior exhibited by community members as exerting a strong influence on battered women's coping and help-seeking behaviors (e.g., gossiping and making fun of victims;^{24, 96} blame, hostility, and criticism for exposing IPV to those outside the family/ethnic community⁷⁰). A recent study of Ethiopian women in Seattle describes:⁷⁰

If the victims call the police or speak out about their abuse, they may face loss of support or direct intimidation from the community...For refugee and immigrant women whose only social support comes from other Ethiopians, community disapproval or sanction may be too much to bear. (p. 930)

As many immigrant/refugee battered women rely on support from family, friends and fellow community members (to be discussed in the Help-Seeking Section below), intervention and prevention programs must address the knowledge, attitudes, beliefs, and behaviors of community members and incorporate strategies aimed at changing community and social norms.

5. Sociocultural and Sociopolitical Context

Although not exhaustive or mutually exclusive, the following are general issues and factors that affect immigrant/refugee women's experiences with IPV in the United States. Understanding these factors is indispensable to the development of socioculturally effective intervention and prevention programs. In fact a considerable proportion of the literature on sociocultural issues has been written by practitioners and advocates. These issues have varying degrees of salience to specific immigrant/refugee subgroups depending on their specific circumstances, and thus, must not be generalized. Acknowledging enormous across- and within-group variations is critically important.

As an ecological framework suggests, there are dynamic and interactive influences among factors on individual, interpersonal, familial, organizational, community and policy levels.^{101,102} Thus, the attitudes and behaviors of an immigrant/refugee batterer, survivor, or community bystander are continuously shaping, and being shaped by, sociocultural and sociopolitical contexts. In order to organize many intersecting factors, this report will discuss them in a rather linear fashion (e.g., cultural practices, values, and norms in one section, and the impact of racism and xenophobia in a separate section). Nevertheless, these factors interact with, are influenced by, and reinforce each other. For example, the immigration and refugee settlement process and the experience of racism and other forms of discrimination are likely to reinforce certain cultural values and practices among immigrants and refugees.

Cultural Practices, Values, and Norms

The majority of the literature on IPV among immigrants/refugees discusses cultural values and practices that are unique and/or salient to particular ethnic/cultural groups. The ways these values and practices impact how IPV manifests itself, and how individuals, families, community members, and organizations respond to it are also analyzed. Caution must be exercised, however, not to essentialize culture as a (or the) cause of IPV. Rather, it is critical to view selected cultural values and practices as one of the factors that may influence various aspects of IPV in immigrant/refugee communities (e.g., manifestations, consequences and individual and community reactions).

Hierarchical and patriarchal family structure. It is important to recognize that patriarchal values and practices are found in almost all societies and cultures, including the contemporary United States. For immigrants and refugees, patriarchal aspects of family relationships may be intensified for various reasons (see the Cultural Freezing and Community Denial Section for more details). There is a large volume of literature that points to the hierarchical and patriarchal nature of families in many immigrant/refugee population groups, where roles and powers are ascribed based primarily on gender and age; in general, the man is regarded as the head of the household, and women are expected to defer to men.^{59, 67, 69, 95, 96, 103–125} These rigid gender-role expectations are likely to contribute to the justification of men’s violence against women who do not conform to such expectations.

The literature on IPV among Latina populations makes frequent reference to *machismo*, the man’s role as the head of the household who is expected to care for and protect the family unit.^{112, 126} Although the term is often associated with a stereotype of Latino families as highly patriarchal, as many authors caution, *machismo* also connotes ideas of honor, pride, courage, and responsibility to the family.¹²⁷ It is important not to essentialize cultures and mistake them for explanations of IPV.

Although domestic violence is typically conceptualized in the United States as violence perpetrated by one intimate partner against the other, it is important to take into account the important role that extended family members play in the lives of immigrants/refugees when designing intervention and prevention programs. Extended families play an important role in many immigrant/refugee families. It is not uncommon for a couple to live with the husband’s or sometimes the wife’s parents and other family members. The presence of extended family can provide resources and support of various kinds (e.g., help with childcare), diffuse tension between the couple, and offer comfort and advice in times of need. However, extended family members can also contribute to or exacerbate the husband’s controlling and abusive behavior. Studies of API populations reveal that it is not uncommon for parents-in-law (and other extended family members) to perpetrate violence against their daughters-in-law directly or indirectly.^{96, 113, 125, 128–131}

Family, face saving, faith, and fate. In many immigrant/refugee population groups, the family is regarded as the unit of central importance.^{67, 106, 108, 112, 114, 115, 117, 119, 132–134} There is strong pressure to keep the family together,^{59, 67, 96, 109, 114, 119} and this strong sense of familialism can hinder battered women’s willingness to escape from, disclose, or report their partners’ abuse.

Another factor that has been identified as guiding the behavior of many immigrants and refugees is the value of saving face. There is strong pressure to avoid shaming the family, which is likely to hinder women’s efforts to seek outside help for “family” problems.^{95, 96, 108, 113, 119, 121} Ayyub’s work with South Asian women illustrates the shame that divorce brings not only to women but also to families:⁶⁷

No price the women will pay would be greater than the sum they would bring on the family if they chose to end their marriage. (p. 243)

Although it may hinder help-seeking, the strong sense of familialism, on the other hand, can provide battered women with a sense of belonging, and support and care from family members.

Also, belief in fate has been identified as playing a significant role in immigrant/refugee women’s reactions to IPV.^{132, 135, 136} Women may accept their partners’ violence as fate and believe (or be led to believe) that they have little control over it.

Religion and faith are also important to many immigrants and refugees. For example, *Marianismo* (i.e., belief in the Virgin Mary) emphasizes certain ideals of femininity and motherhood, such as purity, humility, modesty, acceptance of fate, and self-sacrifice.¹³² These expectations may lead women to believe that they should endure partners' violence, and accept and/or forgive their behavior.

While it is important to recognize that these factors and values contribute to the pressure not to seek help, to endure and accept IPV, they also need to be viewed as sources of strength for many women in responding to and coping with challenges in their lives. Again, it is critical to recognize that these factors are not necessarily unique to immigrants/refugees, but are rather heightened due to current and historical sociopolitical circumstances (see the Cultural Freezing and Community Denial Section below for more details).

Trauma, Loss, Isolation, and Disruption in Social Capital

Immigration is associated with many changes and stressors, including disruption in the social support system, language barriers, and a lack of familiarity with the U.S. social system, which in turn are likely to intensify a sense of isolation and loneliness. Studies of IPV in immigrants/refugees have consistently documented a sense of isolation;^{61,}⁹⁶ a smaller social network and/or a shift from extended family to a nuclear family structure;^{61, 70, 119, 137} and a lower level of social support satisfaction than others.^{49, 50} It is important to note that isolation due to immigration/migration is often intensified by abusive partners' tactics of control, surveillance, and threat.

It is not uncommon for refugee women to have experienced sexual assault and other forms of violence against women during their journeys on land and at sea, as well as within refugee camps.¹³⁸ Some immigrant women also have faced a range of sexual assault, harassment, and exploitation during border-crossing.⁵⁵ The experience of trauma by many refugees from war-torn countries before and during their escape may desensitize them to suffering, and some, or many, may not consider IPV serious in comparison to their war-related ordeals.^{70, 96} The impact of torture, maltreatment in political camps, and trauma during refugee/immigration processes on the perpetration and experience of IPV is a neglected area of research.

Institutionalized Racism and Xenophobia

Impact of policies. Ongoing experiences with racist and discriminatory practices contribute to stress for many immigrant/refugee families. Although these stressors *do not cause* men to abuse their partners, they are likely to affect how the perpetrator, the survivor, their families, and community members respond to IPV. On an individual level, experiences with racism and discrimination affect the willingness of survivors to seek assistance from outside agencies. Many immigrant/refugee battered women are reluctant to report their partners' violence to the authorities because they are afraid that they and/or their partners will be treated with insensitivity, hostility, and/or discrimination.

There are many policies that have profound impacts on the vulnerability of immigrant/refugee women. (See [Appendix A](#) for a discussion of legal structures relating to U.S. immigrants and refugees.) The impact of U.S. immigration policies and welfare policies deserves a brief mention. As discussed in the Immigration Status and Systems as Tools of Control Section, certain provisions of U.S. immigration policies, such as the Immigration Marriage Fraud Amendments of 1986 (8 U.S.C. § 1186a), place immigrant women at risk of exploitation by U.S. citizens or permanent residents. The Personal

Responsibility and Work Opportunity Reconciliation Act of 1996 significantly reduced benefits to immigrants, which substantially limited the availability of financial resources for immigrant battered women.

Not only do racism and xenophobia contribute to the lack of resources and choices available to immigrant/refugee battered women, but experiences with racism and discrimination can lead to cultural freezing and community denial (to be discussed in more detail below).

Political activism on behalf of battered immigrant/refugee women. Due in large part to strong grassroots lobbying efforts, the Immigration Act of 1990 (Pub.L. 101-649) and the Violence Against Women Act (Title IV of the Violent Crime Control and Law Enforcement Act of 1994, Pub.L. 103-322, AKA Crime Bill) were enacted, which provided a number of avenues of legal recourse for battered immigrant women, including a waiver for failure to meet the requirements for permanent residency status and right to self-petition for residency status.¹³⁹ The reauthorizations of the Violence Against Women Act (VAWA) in 2000 and 2005 expanded the scope of individuals eligible for relief, eased the evidentiary requirements, and expanded access to public benefits.^{140, 141} As of 2006 a total of 42,000 self-petitions had been approved since the program began, and 10,000 had been denied, according to a staff member of Citizenship and Immigration Services of the U.S. Department of Homeland Security. This number alone is a testament not only to the previously unmet needs of battered immigrant women, but also to the effectiveness of the advocates who have worked tirelessly to bring about legal reform.

Cultural Freezing and Community Denial

The experiences of immigration and resettlement may trigger or exacerbate what is known as *cultural freezing*, the development and imposition of rigid values and normative behavioral expectations from one's country of origin, such as the affirmation of male control as head of the household and the expectation of submissiveness in women.¹⁰⁹ As such, the images of values and normative behaviors of the country of origin are often distorted, idealized, romanticized, and/or stereotyped. It is important to recognize that this process of distortion and/or idealization does not happen in isolation from other social forces, such as racism, xenophobia, and anti-immigrant/refugee sentiments.

In a society like the United States where pressure to assimilate is high, immigrants/refugees may feel threatened that "their" culture is being dissipated. What was familiar to them in their country of origin may not hold up in the new country. For example, while many men experience downward occupational and/or social mobility in the new country in which they are living, many women begin working and their occupational and/or social participation tends to increase. This shift can threaten the previously held family dynamics. In addition, school-age children generally acquire English proficiency and knowledge of U.S. systems faster than their parents, which may threaten the authority parents used to enjoy in their country of origin. In response to these threats, it is not uncommon for immigrants/refugees to attempt to (re)create what they consider to be their ideal of family in their culture or country of origin.

Although both men and women engage in such idealization, because men are the ones who generally used to enjoy higher status and more privileges in their country of origin, they have more to lose, and thus have a vested interest in keeping the idealized family structure where they assume authority, power, and control. Of course, whereas the desire to be in control may affect men in general, the process of immigration/refugee

resettlement is likely to exacerbate this tendency. If an immigrant/refugee man feels that his worth is being diminished or denied in the new social context of the United States, this heightened sense of vulnerability can lead to an increasing sense of need for control, and some men may resort to violence to establish or restore control. Women, on the other hand, may feel increasing pressure to protect their partners from potentially emasculating situations. While they may enjoy changes and opportunities in the new country, women may feel pressured to acquiesce to the needs and demands of their partners more than before immigration/resettlement.

Historically and contemporarily, immigrants and refugees have experienced overt and covert discrimination, exploitation, violence, and harassment. Such experiences may desensitize community members to the seriousness of IPV in their own community.^{121, 142} In the face of historical and contemporary discrimination against immigrant/refugee groups, the survival of the community is often considered the priority; coupled with patriarchal ideology, women's suffering is not seen as a serious and urgent problem.¹⁴³ Because acknowledging IPV as a problem is viewed as detrimental to the collective survival of the community, there is strong pressure to maintain a positive image of their community and remain silent about the problem of IPV.^{59, 121, 142, 144, 145} Those who violate these expectations may experience silencing, criticism, and sometimes even death threats. Nilda Rimonte, a founding director of the Center for the Pacific Asian Family—the nation's first shelter for API battered women—describes one such reaction of community members:¹¹⁸

After *Newsweek* quoted me as stating that there was a problem of wife-abuse in the Asian community, I received many irate phone calls from Asians angered by my exposure of the community's "underbelly." (p. 1313)

Cultural freezing and community denial are complex processes, shaped by societal and structural factors. Intervention and prevention programs must take into consideration these complex processes of immigration/resettlement, including cultural freezing, and an increased sense of vulnerability and pressure. At the same time, these potentially difficult or crisis-laden times can serve as opportunities for change.

6. Women's Help-Seeking and Individual and Agency Responses

Aversion to Contacting Formal Institutions, Preference for Informal Sources of Support

Consistent with the literature on help-seeking among the general U.S. female population, studies have consistently found that only a small proportion of battered immigrant/refugee women seek assistance from outside agencies.^{51, 61, 113, 121, 137, 138, 146, 147} In a study of Latina battered women by Santiago and Morash, only 12 percent of respondents said that they would seek help from people within institutional settings, while 73 percent said it was appropriate to seek the help of family members.¹⁴⁶ Dutton and colleagues documented that less than 10 percent of Latina battered women sought help from domestic violence programs.⁶¹ Although a somewhat larger proportion of battered immigrant/refugee women seek health care, not all of them disclose their experience of IPV to health care workers.^{61, 148}

In light of this, a finding of a more frequent use of the police among Latina and African-American women in some studies is somewhat contradictory.^{147, 149, 150} However, other studies did not find a higher use of police among Latinas.^{151, 152} Studies have not

systematically differentiated the use of police out of preference from that due to a lack of alternative resources to which to turn. In other words, higher use of the police among Latinas may not reflect preference, but may be the last resort in the absence of other viable resources.

As previously discussed, immigration and resettlement are often associated with disruptions in immigrants' and refugees' social support networks. Over 90 percent of Vietnamese women interviewed in Tran's study had only zero to two people as sources of support.¹¹⁹ In Yoshihama's study, which examined four generations of women of Japanese descent in Los Angeles, first-generation respondents (immigrants from Japan) had the smallest number of individuals who provided social support, and they were the least satisfied with the available social support.⁴⁹ South Asian women in Boston had fewer family members residing in the area, and South Asian and Hispanic women in a northeastern city had fewer family members residing in the United States compared with African-American women.¹³⁷ Despite limited availability, abused immigrant/refugee women rely heavily on the individuals in their social network for support.^{61, 75, 130, 137, 146, 147, 153}

Problematic Responses: Imposition of Values and Expectations and Lack of Sociocultural Competencies

Seeking help does not necessarily result in receiving the help that is desired.^{61, 121, 134, 137} Individuals to whom a battered immigrant/refugee woman has turned to for help may be well-meaning; however, they may impose their values and beliefs, deny or minimize her suffering, or worse, blame her rather than hold her abusive partner accountable. In addition, mainstream organizations may lack sociocultural understanding and/or may have discriminatory or insensitive attitudes toward immigrants/refugees.

In a study of Latina women in the Washington, D.C. area, only 20 percent said that the first person to whom they spoke about IPV told them that "what happened to them [partners' perpetration of violence] was wrong."⁶¹ In the same study, only 13.7 percent said they were offered shelter, and another 11.6 percent were helped to find shelter/legal services. Only half of the women who sought help from either formal or informal sources found the assistance they received to be helpful.¹⁴⁶

The importance of clergy has been discussed in a number of studies as well;^{25, 134,}¹⁴⁷ however, studies tend to find a low usage of clergy and faith-based assistance. For example, in one study only 3.3 percent to 5.7 percent of battered Latina women had used religious-based assistance;⁶¹ in another study, 9.6 percent.⁷⁵ Studies point to women's fears of not being understood or of not receiving the support desired, and instead, being blamed or encouraged to endure abuse by clergy and faith-based organizations.^{25, 134}

It is clear that strengthening mainstream agencies' capacity to respond to the needs of immigrant/refugee battered women is critical. In addition, given the importance of informal help sources in the lives of battered immigrant/refugee women, changing community members' attitudes and social norms is critical not only to lessening victim-blaming and promoting help-seeking, but ultimately, to preventing IPV.

7. Evaluation of Intervention and Prevention Programs

One of the scarcest areas of the literature on IPV in immigrant/refugee communities is that on intervention and prevention programs. This is not to say that immigrant/refugee communities are devoid of programs addressing IPV. On the contrary, immigrant/refugee women's groups and community-based organizations have developed and implemented

a wide range of innovative and socioculturally effective programs throughout the nation. The accompanying report, synthesizing the insights and recommendations gained from key informant interviews, provides information about these programs and points to principles and essential components of the programs addressing IPV in immigrant/refugee communities. Just as little published work exists that describes intervention and prevention programs addressing IPV in immigrant/refugee communities, publications on evaluation of such programs remain limited, with some notable exceptions.

Systemwide efforts: Documenting Our Work, a project of the National Resource Center on Domestic Violence, is one example of a system- and nationwide attempt to document and evaluate the activities of IPV programs. Although this project does not focus on immigrants/refugees, it includes assessment of not only shelter-based programs, but also non-shelter-based activities such as community outreach and education. A similar initiative has been conducted by the Asian & Pacific Islander Institute on Domestic Violence; their Data Project was designed to document the scope of program activities (e.g., unduplicated number of women and children served, number of community outreach and education hours provided).¹⁵⁴

Individual organizational efforts. Though it is rare for a nonresearch-based program's evaluation to be published in an academic or mainstream literature outlet, individual organizations sometimes disseminate the results of their evaluations in the form of a report, monograph, or brochure. Data on program activities (e.g., the number of individuals served, types of services rendered) are also routinely collected for the purpose of reporting to funding sources. Although these types of data have been rarely used for program evaluation thus far, they can be used to assess the impact of program activities.

Research-based efforts. Several, mostly research-based programs, have been systematically evaluated, including:

- A randomized controlled trial of three types of services for pregnant women. Although not targeting the Latina population specifically or exclusively, 96 percent of participants were Spanish-speaking women.¹⁵⁵
- Evaluation of the effectiveness of protection orders and telephone intervention aimed at increasing “safety-promoting behavior” of abused women. Although not targeting the Latina population specifically or exclusively, approximately 40 percent of participants were Latina.¹⁵⁶⁻¹⁵⁸
- ACCESS's Arab Domestic Violence Prevention Program: a media campaign aimed at increasing the local Arab American community's knowledge about IPV, safety tips, and available resources, along with workshops for community members at large.⁹⁷ Prior to the campaign, not one case of IPV was identified at the health clinic that is part of the Cultural Community Health Center, whereas post-campaign, “70 domestic violence clients have been identified and assisted in the health center.” (p. 211)
- The Shanti Project: a community-based universal IPV prevention program implemented through a communications campaign and local reinforcing activities in the Southeastern Michigan Gujarati community.¹⁵⁹⁻¹⁶¹

In addition, with support from targeted funding administered by federal agencies, such as the Centers for Disease Control and Prevention (CDC)—e.g., Domestic Violence Prevention Enhancement and Leadership Through Alliances (DELTA) and research funding for IPV prevention—a number of primary/universal IPV prevention programs have been established in immigrant/refugee communities. For example, in the state of Michigan alone, three out of four DELTA-funded projects work primarily with

immigrant/refugee communities: LA VIDA for Latina communities,¹⁶² ACCESS for Arab communities, and New Visions for API communities.¹⁶³ DELTA-funded prevention programs across 13 states have been engaged in ongoing evaluation of their activities.

8. Implications and Recommendations for Future Research

Combined Efforts of Research and Intervention and Prevention

Studies must address the methodological limitations of previous studies, such as exclusion, inattention, aggregation, and lack of sociocultural relevance. For the purposes of developing, implementing, and evaluating socioculturally effective programs to address IPV in immigrant/refugee communities, the following types of research efforts appear to be of prime importance and urgency:

- Community-based studies of IPV across various sociocultural groups, which allow for:
 - Across-group comparison (through the use of core, standardized instruments)
 - Group-specific investigation (through the inclusion of socioculturally relevant concepts and questions)
- Research efforts with broader and multiple goals to not only obtain data for knowledge and theory development, but also serve as:
 - Formative research that informs program development
 - Program evaluation
 - Capacity building of local residents (including survivors and advocates) and organizations
- Systematic evaluation of:
 - Innovative, community-based intervention programs
 - Community-based primary universal prevention projects aimed at changing social and community norms

In order to maximize the advocates' and practitioners' expertise and minimize their burden, a systematic and funded collaboration between researchers and community programs/agencies is critical. It may be helpful to create a consortium in several localities, each of which involves several immigrant/refugee IPV programs. In each locality, multiple programs, which serve different population groups, can engage in evaluation of their own programs while sharing resources, technical assistance, and core research methodologies (e.g., standardized questions could be asked in all communities, with each community adding community- or program-specific questions).

Capacity Building

In order to promote sustainable community efforts to prevent IPV, programs should incorporate ongoing mechanisms for capacity building, not only of community organizations and their staff and volunteers, but also of survivors and other individuals affected by IPV. With respect to capacity building of researchers, an increase in knowledge and skills in research methodologies is urgently needed to enhance our understanding of IPV in immigrant/refugee communities in general, and of promising practice models in particular. Beyond research skills, what is indispensable yet currently seriously neglected is careful attention to ethical and safety issues, and collaborative and empowering practice on the part of researchers

on behalf of immigrant/refugee communities whose members have experienced multiple challenges and repeated marginalization.

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This literature review documented rich and expanding efforts, despite methodological challenges and limited resources, to examine and elucidate complex and diverse realities of IPV in immigrant and refugee communities. Efforts to address IPV in immigrant and refugee communities reflect purposeful, tenacious organizing and advocacy led by immigrant and refugee women and their allies. The Violence Against Women Act, with specific provisions for battered immigrant women, is just one of the many examples of their accomplishments.

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