

RESEARCH BRIEF



BRIDGING THE GAPS

**Addressing refugee and immigrant women's
experiences with domestic violence
and sexual assault**

ACKNOWLEDGMENTS

The Bridging the Gaps project was led by Karin Wachter, PhD, Assistant Professor at Arizona State University, School of Social Work, and Jessica Dalpe, LMSW, US Programs Women's Protection and Empowerment Technical Advisor at the International Rescue Committee. This research would not have been possible without the unwavering commitment of IRC field staff - special thanks to the research team and language interpreters on location for their time and efforts. Above all, sincere thanks to the research participants who shared their valuable time, experiences, and expertise with tremendous candor and insight.

This project was supported by Grant No. 2016-SI-AX-0004 awarded by the Office on Violence Against Women, U.S. Department of Justice. The opinions, findings, conclusions, and recommendations expressed in this publication/program exhibition are those of the authors and do not necessarily reflect the views of the Department of Justice, Office on Violence Against Women.

TO CITE THIS BRIEF:

Wachter, K. & Dalpe, J. (2018). Bridging the Gaps: *Addressing refugee and immigrant women's experiences with domestic violence and sexual assault*. New York, NY: International Rescue Committee.

The United States (U.S.) resettlement program provides an opportunity for new beginnings to refugees forced to flee their homes because of war or persecution. With the aim of promoting both self-sufficiency and a successful transition, a network of agencies and community partners provides a wide range of services to refugees resettling to the U.S. Resettlement agencies begin by receiving individuals and families at the airport and helping them to settle in, and then expand their services to include assisting new arrivals to enroll children in school, secure employment, and connect to healthcare and other resources¹. However, additional needs emerge beyond the immediate priorities involved with resettling in a new country.

Violence against women and girls persists throughout the world². The threat of violence against women perpetrated by known and unknown persons increases during armed conflict and forced migration³. The physical, psychological, social, economic, and other consequences of domestic violence⁴ (DV) and non-partner sexual assault (SA) can endure over time and complicate resettlement processes in ways that may not be readily apparent to direct service providers. Despite the promises of new beginnings, women who resettle may confront new or ongoing abuse after arriving to the U.S., without the necessary support and skills they need to navigate new systems.

Gaps in knowledge remain regarding the services and support related to DV and SA that women need and want after arriving to the U.S. These knowledge gaps include questions such as: how and from whom do women request help; what happens when women seek help; what factors influence how women access services and support; and how do services account for the experiences with DV and SA of refugee and immigrant women?

This brief highlights results from a multi-methods study that sought to address some of these knowledge gaps. Key findings inform recommendations for practitioners and agencies situated within the refugee resettlement and DV/SA service sectors in the U.S., as well as policy makers, donors, and other stakeholders.

THE RESEARCH

Building on previous research⁵, and with funding from the Office on Violence against Women, the International Rescue Committee (IRC) and an external researcher at Arizona State University implemented the Bridging the Gaps project to study service and support needs of refugee and immigrant women who have experienced DV/SA. The study was conducted in a metropolitan area in the southern region of the U.S from December 2016 through April 2018. Two study arms formed the basis of the project.

Through 2016, the IRC office located where the study took place resettled over 1,000 refugees each year, and served an additional 2,500 refugees, immigrants, and asylees. Due to changes in resettlement policy at the national level, refugee arrivals have significantly decreased since 2017.

¹ Office of Refugee Resettlement: www.acf.hhs.gov/orr/refugees

² World Health Organization: www.who.int/news-room/fact-sheets/detail/violence-against-women

³ See GBV Responders Network: www.gbvresponders.org/research-learning/completed-research stalking and psychological harm by a current or former intimate partner. Center for Disease Control: www.bit.ly/2kBF0yV

⁴ Domestic violence, or intimate partner violence, refers to physical violence, sexual violence,

⁵ Bridge to Safety Evaluation: www.gbvresponders.org/wp-content/uploads/2015/10/Bridge-to-Safety-Final-Evaluation-Report.pdf

STUDY ARM ONE

The first study arm involved analyzing data the IRC staff collected through routine screening and response services with newly arrived adult female clients (n= 113). The screening process involved informed consent procedures followed by the administration of three screening measures: (1) pre- and post-arrival experiences of DV/SA⁶, (2) current emotional distress (RHS-15)⁷, and (3) pre-resettlement experiences of torture⁸. Additional items captured referrals offered and accepted by clients who screened positive for DV/SA, torture, and/or emotional distress.

Key Findings

From October 2016 through April 2018, the IRC office worked with 215 adult women new arrivals who resettled from 18 different countries. During that period, 113 women participated in the screening process within an average of 60 days after arrival to the U.S.⁹ Staff conducted screenings in private and with a trained interpreter, as needed. Women who participated in the screening originated from 14 countries: Afghanistan, Bhutan, Burma, Burundi, Colombia, Democratic Republic of Congo (DRC), Eritrea, Ethiopia, Iran, Iraq, Nepal, Pakistan, Somalia, and Syria. The majority of women originated from the DRC and Bhutan. The average age of the women at the time of the screening was 33 years old (range: 19 to 64 years old).

	Positive Screen	Negative Screen
Controlling behavior (pre-arrival)	13 (12%)	100 (88%)
Controlling behavior (post-arrival)	6 (5%)	107 (95%)
Physical violence (pre-arrival)	16 (14%)	97 (86%)
Physical violence (post-arrival)	3 (3%)	110 (97%)
Sexual violence (pre-arrival)	9 (8%)	104 (92%)
Sexual violence (post-arrival)	0 (0%)	113 (100%)

Twenty-nine women (26%) screened positive and 84 women (74%) screened negative for DV and/or SA. Outcomes from the DV/SA screening indicated that the majority of disclosures related to experiences women had before arrival to the U.S. However, of the positive screens, 24% (7/29) were of experiences of DV after arrival to the U.S.

⁶ Wachter, K. & Donahue, K. (2015). *Bridge to Safety: An evaluation of a pilot intervention to screen for and respond to domestic violence and sexual assault with refugee women in the U.S.* New York, NY: International Rescue Committee.

⁷ © 2011 Pathways to Wellness: Integrating Refugee Health and Well-Being.

⁸ Torture Victims Relief Act of 1998, Pub. L. No. 105-320, (1998).

⁹ Ninety women participated in screening within an average of 23 days (range: 0 - 93) post-arrival to the U.S., and 21 women engaged in screening over 100 days after arrival (range: 122 - 721).

SCREENING MEASURES INCLUDED:

1 Bridge to Safety Screener

A five-item evidence-based, culturally adapted screener for DV/SA. Screenings were determined to be positive if a woman responded 'yes' to any of the first four questions, related to controlling behavior, physical violence, and sexual violence.

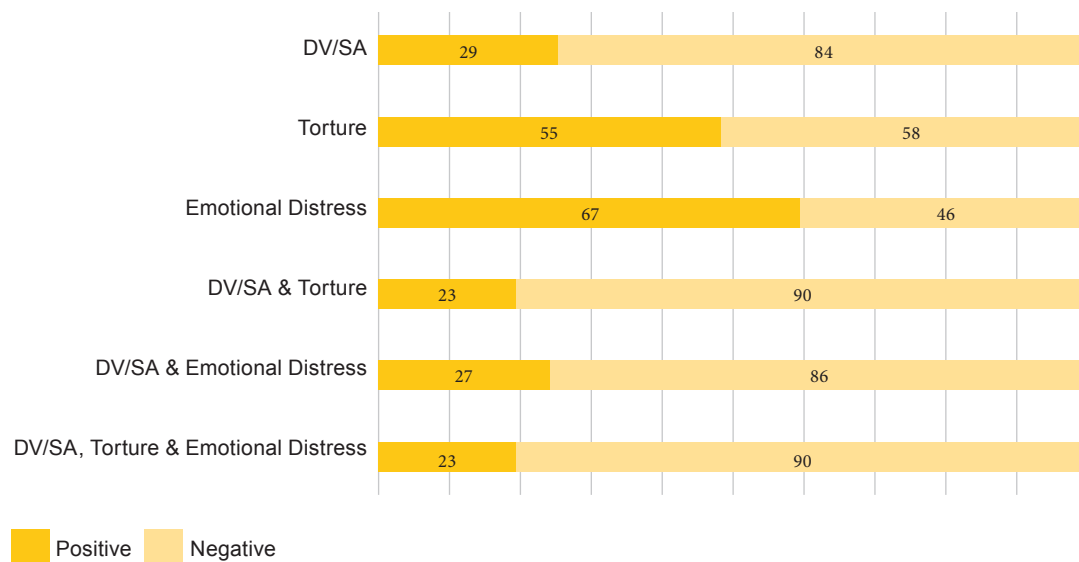
2 Refugee Health Screener 15 (RHS-15)

A 15-item validated screening for emotional distress. Screenings were determined to be positive by reaching or surpassing a pre-determined score on the items or indicating a severe level of distress through a visual aid.

3 Torture Screener

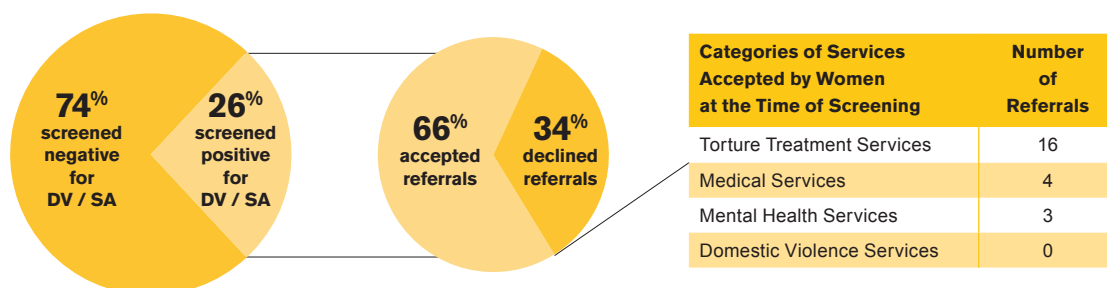
A four-item screening for eligibility for services provided under the U.S. definition of survivor of torture. Screenings were determined to be positive if a woman responded 'yes' to any of the four questions.

Figure 1: Screening Outcomes for DV/SA, Torture, and Emotional Distress



Of the 113 women screened, 29 women screened positive for DV/SA (26%); 55 screened positive for experiences of torture as primary or secondary survivors (49%); and 67 screened positive for emotional distress (59%). Women also screened positive across multiple screening categories. Twenty-three women screened positive for DV/SA and torture (20%); 27 screened positive for DV/SA and emotional distress (24%); and 23 women screened positive for DV/SA, torture, and emotional distress (20%).

Figure 2: DV/SA Screening Outcomes and Referrals Accepted/Declined



Of the women who disclosed DV and/or SA during screening, 66% (19/29) accepted referrals to services at the time of screening. When a woman screened positive for DV/SA, a caseworker would engage her in a discussion regarding her service needs and the service options available in the local community. Services in the area where the research took place included a medical clinic and torture treatment center that provided mental health services for survivors of torture. Mental health services, and DV services including shelter, advocacy, and counseling were also available. Of the 19 women who accepted referrals to services, three accepted referrals to multiple service providers while the remaining 16 women accepted referrals to only one service provider. In total, staff offered 23 referrals to 19 women, the overwhelming majority of which were for torture treatment services.

STUDY ARM TWO

The second study arm involved conducting qualitative interviews, as well as focus groups with three participant groups. Group A was comprised of female clients who had resettled to the U.S. and screened positive for DV and/or SA during the routine programming described above, or had otherwise disclosed information to agency staff (n= 10). Group B included female clients who had resettled to the U.S. and had either not disclosed DV/SA, or had not participated in screening (n= 25). Group C was comprised of representatives from organizations serving refugees, immigrants, and/or U.S.-born survivors of DV/SA, as well as other stakeholders at the local or state level (n= 53). Each individual provided verbal consent to participate.

Table 2. Arm Two Participant Demographics

	Group A (n= 10)	Group B (n= 25)	Group C (n= 53)
REGION OF ORIGIN			
South and Southeast Asia	-	8	4
Central and East Africa	8	17	10
West and North Africa	-	-	5
Eastern Europe	-	-	2
Middle East	2	-	1
Central America and Caribbean	-	-	4
North America	-	-	27
GENDER			
Female	10	25	43
Male	-	-	10
AGE			
18 – 29	2	8	16
30 – 39	3	7	24
≥ 40	5	10	13
TIME IN U.S.*			
< 12 months	4	5	-
12 – 24 months	6	13	-
> 2 years	-	4	-
*missing data for Group B (n = 22)			

Key Findings

A multi-step qualitative analysis process produced four interrelated themes that reflect the key findings.

(1) Women have formidable service and support needs related to DV/SA

Participants provided insights into the desired services and support needed to address the consequences for DV/SA on women's health, mental health, and overall wellbeing. Participants described their difficulty with managing stress, worry, depression, forgetfulness, insomnia, nightmares, heart palpitations, loss of appetite and weight, and intrusive thoughts. At least two of the Group A participants were living with acute physical health problems because of the violence they had endured. Across study groups, participants described women expressing a desire for an authority figure to intervene directly with the abusive partner in attempt to stop the violence. Participants described these authority figures as a trusted family or community member, or a service provider, such as their refugee resettlement case manager in the U.S. Service providers indicated that when women disclosed experiencing DV, they were less inclined to accept a referral and more interested in having that particular staff person help them, often requesting that they speak with their husband.

All participant groups highlighted the extent to which finances are a universal concern for women resettling to the U.S., particularly those threatened with DV. Financial assistance—particularly for housing—emerged as both a salient service need as well as a factor impeding women from seeking help (see below).

(2) Access to immediate and extended family shapes whether and how women seek help

When confronted with DV primarily in the past (pre-resettlement), women described turning to their families for assistance, typically to request refuge following violent episodes and to request family members to intervene directly with the abusive partner. Women described considerable variation in the willingness of families to intervene, with actions occurring on a continuum from providing passive support to actively identifying solutions. Some families passively provided temporary respite shelter and then actively sent women back to their abusers against their will. Some families were also reported to have physically and/or emotionally abused the women while sheltering them. Regardless, having family to turn to was a key factor in helping women weigh options and, for some, to ultimately separate from an abusive partner. The point at which families felt their efforts had failed and they lost hope that the abusive spouse would change seemed to signal to women that they could leave in good conscience with the blessing of their family. In the absence of family support, women perceived having few, if any, viable alternatives. Therefore, women lacking family support may be more likely to resign themselves to living with acute suffering primarily out of concern for the well-being of their children. Resettlement-related separation from family may thus compound existing barriers to women seeking help for the abuse they are experiencing in their home. Even for women with family in the U.S., service options are also limited, as family members may not have the necessary information to advise them appropriately in this context.

(3) A myriad of factors limit women's access to support and services

Gaps in information. Participants indicated not knowing what service options were available in the U.S. for women experiencing abuse. Women indicated knowing where they could turn for help in their countries of origin and while displaced (prior to resettling to the U.S.), frequently mentioning the presence of women's rights organizations and women's programs. They posed questions over the course of the discussions such as, "Where is the women's center here?" and "Where can a woman who is suffering in America go for help?" Women assumed there were professional DV services in the U.S., but indicated not knowing anything about the service options and processes. In the context of feeling uninformed, Group B participants noted three possible pathways for women in abusive relationships; women might turn to a trusted family member or friend, a resettlement agency, or to the police.

Silence. The silence surrounding women's experiences and suffering clearly emerged as a factor shaping women's access to support and services. Women described keeping quiet at all phases of their experiences—from when they entered the relationship and the abuse began, living over time with the abuse, and even after they left the abusive relationship. For some, the silence also reflected entrenched social and familial norms that equated suffering to being a woman. For others, staying silent was a strategy for keeping themselves safe and financially stable as they navigated daily life with abusive partners. In particular, for those without family, staying silent appeared to reflect the lack of options available to them.

Economic factors. Financial concerns and women's economic vulnerability acted as distinct barriers to women seeking help both pre- and post-arrival to the U.S. Participants expressed having significant fear of losing the financial support their husbands provided. Women perceived separating from their husbands as setting into motion a chain of events that would render them financially destitute and unable to pay for housing or provide for their children, culminating in the U.S. government taking their children away. Not being able to pay for housing was particularly distressing, especially for women who did not work outside of the home, speak English, drive, or know how to navigate the public transportation system.

Family and community dynamics. In addition to prioritizing the well-being of their children, women's decisions to seek help and/or separate from abusive spouses reflected their desire to fulfill family and community expectations, and to uphold the interests of immediate and extended family. Women heavily weighed the importance of these relationships and commitments in their decision-making. Participants explained how community members would often apply pressure and invoke religious doctrine to convince women to persevere, have faith, and keep the family intact. Women described the backlash they could expect from family and community members overseas as well as in the U.S. if they were to call the police to report DV. One focus group described calling the police to report DV as an indication that a woman was willing to destroy her husband. Women discussed the substantial financial implications for a woman's family, who would be responsible for paying back any dowry given at the time of marriage were she to separate from her husband. Women felt responsible for possible threats levied against their families in retaliation for a woman leaving and her family not reimbursing the dowry.

Communication and trust. The ability of women to communicate their concerns to institutions and individuals they trusted was instrumental in accessing formal services. Participants discussed the fact that men typically arrived to the U.S. with more education and better English language skills than did women, exacerbating dependencies and putting women at a considerable disadvantage in comparison to their male partners. Service providers in Group C discussed their perceptions that women needed someone they could talk to in order for their healing to progress, but that finding someone who speaks their language and is not part of their community (and therefore more trustworthy) was the "hardest part". Other service providers lamented the complexity, especially in smaller counties, of obtaining protective orders and other legal procedures, making it nearly impossible for non-fluent English speakers to decipher the process.

4) Complex factors shape service provision for refugee and immigrant women who have experienced DV/SA

“We weren’t ready.” DV service providers spoke to the fact that the mainstream service sector was not set up to address the particular needs of refugees and immigrants, both documented and undocumented. In essence, providers indicated that DV programming and services had not evolved to reflect the demographic changes in population that have occurred both in the metropolitan area and across the state where the research took place. Staff employed by mainstream DV agencies did not reflect the ethno-cultural identities of those residing in the areas where their organizations operated, nor did they have the necessary language skills on staff to engage with non-English speakers, including on crisis hotlines. Participants spoke to the complex processes involved for women to seek help and/or go into shelter, and how those complexities compounded every step women new to the U.S. take in search of freedom from the violence they experienced at home. Resettlement agency staff also reflected not feeling ready or prepared to respond to women’s requests for help on both the individual and organizational levels. Resettlement staff expressed a sense of helplessness in their attempts to conduct meaningful direct practice with women who had experienced multiple traumas, because of a lack of training, supervision, organizational support, and time to engage meaningfully with clients who disclosed. Participants expressed an imperative for resettlement agencies to build up knowledge and skills across staff to address the scope of need among their clients.

“Lives are at stake because there is no place to go.” DV service providers spoke to the demand for services – shelter services in particular – outweighing the capacity of large mainstream organizations. As one representative from the DV sector aptly described, “We constantly say no because we’re constantly full. And that makes our day very long because we’re navigating with partner agencies, but then they too are getting full. We are running out of space and so what’s going to happen is this train wreck is going to crash and there’s going to be lives at stake because there is no place to go.” The same provider indicated that their organization received as many as 30 requests for safe haven for women and children per day, three to five of which came from immigrant communities. Resettlement agency staff who struggled to find options for immigrant and refugee clients in need of immediate assistance expressed the perception that “there is never space” when needed. Agency staff expressed feeling discouraged and a sense of hopelessness around the viability of collaboration and referrals. This perception reflected an “ethical conundrum” shared among resettlement agency staff to encourage clients to disclose DV but feeling that they did not have enough concrete resources to offer them in response.

“Time is not on their side.” Challenges associated with time emerged as a salient theme across DV and resettlement service providers. DV providers explained how the time involved with processes women undergo to seek help, go into shelter, and ultimately transition out of shelter was considerably longer for women new to the country. In light of the short-term nature of many DV programs (e.g., three months), time was a daunting challenge confronting refugee and immigrant women, particularly those without legal status. Participants made a compelling case for re-envisioning housing programs to reflect the length of time immigrant and refugee women needed to make it through each step of the process without becoming overwhelmed to the point of paralysis. Resettlement service providers discussed juggling the multitude of tasks on behalf of refugee and immigrant clients within strict deadlines, limiting the staff’s ability to “connect with clients in a deeper way”. As one resettlement agency staff described feeling, “I have so much time pressure with all these other services that I need to deliver on time...If I have time, I’ll remind this woman of her rights, but I need to make sure she gets a social [security card] first.” Service providers working outside of resettlement also noted the impact of time constraints within the resettlement service sector to address clients’ desires to “have someone to talk to” and needs for “additional support to navigate the social environment or get the resources they need”.

RECOMMENDATIONS

The following recommendations address principal needs identified over the course of this study. The recommendations are rooted in the research findings, suggestions made by study participants, and the complex realities shaping this work. The seven recommendations reflect three levels of intervention, thereby addressing direct practice, organizational responses, and structural interventions. Each recommendation targets a broad audience of providers including domestic violence / sexual assault (DV/SA), refugee resettlement, social service, legal, and community-based organizations, unless otherwise noted. Although the research findings are specific to the context in which the study took place, the intent of the recommendations is to apply to a broader audience of service providers, policy makers, and donors.

DIRECT PRACTICE

1. Improve refugee and immigrant women's access to and utilization of DV / SA services.

- Improve women's knowledge of locally available DV/SA services in tangible and useful ways so that they can explain the available services in their own words and know how to access them on their own terms.
- Connect refugee and immigrant survivors with specific caseworkers and advocates from the DV/SA service sectors who can provide services.
- Normalize talking about women's well-being in post-arrival orientations, screening initiatives, regular resettlement case management, and in informal and formal interactions across all resettlement services with women, men, and youth beyond the initial resettlement period.
- Provide professional language interpretation services to women who disclose experiences with DV/SA and want to pursue referrals.

2. Expand programming and opportunities for women to build skills and gain viable employment.

- Ensure employment services account for women's specific needs, experiences, and barriers, and facilitate access to childcare, transportation, and bank accounts.
- Expand educational opportunities for women related to speaking and writing in English, numeracy, financial literacy, banking, navigating transportation, as well as technical training and professional development.
- Develop long-term programming with families and community stakeholders to address changing gender norms and expectations, especially during the first two years of resettlement.

3. Explore approaches to safely managing women's requests for direct intervention with partners who use violence.

- Establish working groups of DV/SA, social service, and refugee resettlement practitioners as well as representatives of refugee and immigrant communities to explore further women's requests for direct intervention, and how to respond safely and meaningfully.
- Explore and assess local, culturally appropriate, and evidence-based approaches for engaging men as allies against the use of violence against women.

ORGANIZATIONAL RESPONSES

4. Training and staff development.

- Create regular and ongoing opportunities for reciprocal training opportunities between DV/SA and resettlement agencies, ensuring DV/SA service providers understand issues relevant to immigrant and refugee groups¹⁰ and that resettlement staff are aware of the principles of empathic response to DV/SA¹¹. These trainings should occur at regular intervals (bi-annually or yearly).
- Provide opportunities for resettlement staff tasked with specific responsibilities regarding DV/SA screening and response to pursue in-depth, ongoing training and supervision to build technical skills and prevent staff secondary traumatic stress and burnout¹².
- Ensure all interpreters and case aides receive training on the principles of professional interpretation¹³, including confidentiality and managing secondary trauma, recognizing that they are often from and part of the communities they serve.

5. Reinforce existing coordination and collaboration between resettlement, DV/SA, mental health, legal service, and other community-based organizations.

- Continue to expand and strengthen coordination mechanisms at the state and local levels in the U.S. between and within organizations through activities such as conferences, joint coalition meetings, and the drafting of standard operating procedures for referrals and information sharing among providers.
- Pursue joint funding opportunities to facilitate collaboration between resettlement and DV/SA agencies, and other mental health, legal service, and community-based organizations.

STRUCTURAL INTERVENTIONS

6. Explore familiar entry-points for immigrant and refugee women to access support and services.

- Identify opportunities to build community-based social networks to connect women with peer and professional support services, as per their needs and requests.
- Explore possibilities to develop women's centers, either stand alone or within existing infrastructures that can serve as the go-to service center for immigrant and refugee women experiencing DV and/or suffering from long-term consequences of DV and sexual violence.

7. Improve access to services for immigrant and refugee women and expand time frame for service provision.

- Conduct regular needs assessments in the geographical areas in which DV/SA organizations operate to identify evolving needs.
- Allocate more resources to transportation and language interpretation in resettlement and DV/SA organizational budgets to facilitate access to resources critical to women's safety and well-being.
- Develop sustainable solutions for long-term supportive housing for survivors and their children in collaboration with local housing authorities, taking into account the particular barriers refugee and immigrant women face in achieving financial stability.

¹⁰ For more resources, visit the VAWnet page on DV in immigrant communities: www.bit.ly/2sXhvGG

¹¹ For more resources, visit Simmons College's online DV training: www.sites.google.com/a/simmons.edu/dv-training/home

¹² For more resources, visit the Headington Institute: www.headington-institute.org

¹³ For more resources, see the International Medical Interpreters Association's Standards of Practice: www.imiaweb.org/standards/standards.asp



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