

Immigrant Women's Health

Problems and Solutions

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Jossey-Bass Publishers • San Francisco

of control in a relationship and can be considered a form of non-physical abuse.

Women's organizations, health care professionals, and international organizations, such as the United Nations, have shifted the debate on domestic violence to a public arena, arguing that violence in the family has psychological, physical, health, and social consequences not only for the woman, but for other family members as well.

In general, there are not enough services that effectively address the full range of problems associated with domestic violence. The situation is worse for immigrant and refugee women because of their unique psychosocial and cultural needs. Available services must become more culturally competent in order to be effective resources for immigrant women. Health care practitioners need to be especially sensitive to both the presentation and the needs of immigrant women who may have been abused.

Prevalence of Violence

While the status of women may be lower in many other countries, U.S. society is particularly violent (Acerno, Resnick, and Kilpatrick, 1997). Most studies have found that domestic violence cuts across racial and ethnic lines, varies by socioeconomic status of the partner, and is linked with alcohol use (Bachman and Saltzman, 1994; Acerno, Resnick, and Kilpatrick, 1997; Barnett and Fagan, 1993). Unfortunately, reliable prevalence rates of domestic violence in immigrant and refugee women are unavailable. The National Crime and Victimization Survey indicates that women of all races and ethnic groups are about equally vulnerable to attacks by intimate partners (U.S. Department of Justice, 1995). It is estimated that 5 to 10 percent of women who present to emergency departments are recent victims of domestic violence (Abbott and others, 1995).

Anecdotal data make comparisons or generalizations extremely difficult. For example, the significant increase in the number of shelters that serve API women either suggests an increasing prevalence of domestic violence in this population (Abraham, 1995; Kanuha, 1994) or reflects the growing API population (U.S. Bureau of the Census, 1994). Nonetheless, shelter providers and

Domestic Violence

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The family is a major source of protection and support for most people, particularly in times of crisis (Doherty and Campbell, 1988; Gurin, 1985). Unfortunately for some, however, it may be a source of stress, violence, and abuse (Straus and Gelles, 1988). Individuals are more likely to be abused physically and verbally within the confines of the family than anywhere else in society (Gelles and Cornell, 1990). Estimates are that one out of four women in the United States will experience violence at the hands of her household partner during her lifetime (Schornstein, 1997).

Domestic violence is defined as any violence within the patient-defined family—physical, sexual, verbal, and psychological—that poses a threat to a woman's mental and physical well-being. Most studies of domestic violence focus on wife/spouse/partner abuse. However, in-laws also may play a significant role, as in the case of wife abuse and bride burning in India (Fernandez, 1997). Therefore, the definition of domestic violence needs to include abuse by all family members. In addition, accidental injuries that occur in the course of nonphysical events (such as a quarrel) must be considered in the context of abuse. Injuries resulting from pushing, shoving, or holding, even if there was no intent to injure, may indicate a potentially violent household. For immigrant women, legal or civil rights violations, which may range from withholding a passport to coercive threats, including turning someone in to the Immigration and Naturalization Service, may signal a woman's lack

clinicians have argued that the prevalence of domestic violence is likely to be higher in immigrant and refugee communities due to migration-related stressors, the redefinition of familial roles, frustrations in seeking employment, the loss of status associated with downward mobility, and the resulting shame and loss of face.

Obstacles to Obtaining Care

The U.S. Bureau of Population, Refugees, and Migration (1997) notes that refugee women are vulnerable to violence, such as threats, assault, and rape, at every stage of their flight, and this is compounded by violence within the family. As a result, these women suffer from high rates of posttraumatic stress disorder and depression (Frye and D'Avanzo, 1994; Chung and Kagawa-Singer, 1993). Inability to communicate with service providers, fear of discrimination, and cultural norms that prescribe self-sacrifice and modesty about their bodies (True and Guillermo, 1996; Luquisen, Groessl, and Puttkammer, 1995), compounded by lack of understanding of Western medicine, ignorance of their medical and legal rights, and fear that seeking government assistance may lead to deportation (Mayeno and Hirota, 1994) impede their ability to obtain help. Help seeking may be intimidating for women in lesbian relationships, because of the censure that exists regarding homosexual practices (Marin, 1997; Kanuha, 1990). In addition, managed care systems may not allow sufficient time for interaction between health care practitioners and patients, making establishment of rapport and elucidation of a history even more difficult. Health care providers and the health care system must be especially culturally sensitive to victims who do seek help (Campbell and Campbell, 1996; True and Guillermo, 1996).

Culture, Gender Roles, and Meanings of Abuse

It has been argued that asking women about domestic abuse is in itself an intervention (Heise, 1994). Studies have indicated that the identification of domestic violence is higher if women are explicitly asked whether they are being abused (Olson and others, 1996; Quillian, 1996; Poirier, 1997). However, whether this is true

for immigrant women is unknown. Most immigrant and refugee women from Asia, Africa, and Latin America are from traditional societies with restrictive gender roles (Chin, 1994; Song-Kim, 1992). Traditional gender role socialization allows men to criticize, chastise, and strike women for whom they have responsibility (Yim, 1978). This is considered acceptable behavior in those cultures. Immigrant and refugee women sometimes live in larger households where resources are shared by extended family members. In these cases, the perpetrator may be an older male sibling, or an adult who serves as guardian and has the power and control or is the main economic provider in the family. Thus, in response to a pointed closed-ended question from an interviewer such as, "Were you beaten by your spouse?" a respondent might answer no since the perpetrator of violence was not her spouse but someone else in the household, whom she feels she cannot betray. Women who are beaten and shouted at may not recognize their experiences as abuse.

Although there are literal translations for the word *abuse* or *assault* in some languages, it may not be used in relation to domestic violence. Women may use other terms to describe their experiences of abuse and battering (Marin, 1997).

Role of Tradition

In contrast to Western culture, which highly values individualism, immigrant and refugee women often come from traditional cultures, where a woman seldom is given any private, individual space. Immigrants from Africa, Asia, and Latin America often live with their extended families and extended kinship networks, where the family's well-being takes precedence over an individual's rights (Pereira, 1997). Women especially are socialized to be self-sacrificing and to consider the rights of the family as a whole over their own.

The probability that an immigrant or refugee woman will disclose an experience of violence often is minimized when the abuser accompanies her wherever she goes because of religious principles or traditions, not allowing her to move freely in public, treating her as though she is shy and wary, or even providing

translation services for her benefit. In such situations, neither the health care provider nor the patient is likely to be able to discuss possibilities of abuse.

In addition, immigrant and refugee women who are socialized in traditional gender roles may not be willing to confide their problems to male health care practitioners or to people outside their own race or ethnic group. It is highly inappropriate to ask the family member who accompanies the woman whether there is abuse in the family; that is tantamount to asking the husband whether he abuses his wife.

Legal Barriers

Immigrant and refugee women may not want to disclose that they are living with violence at home when their immigrant status is dependent on their marriage (Takagi, 1991; Narayan, 1997). Many immigrants are not aware that the Violence Against Women Act (1994) allows victims of domestic violence, even if undocumented, to seek lawful permanent residence status through self-petitioning or suspension of deportation. A memorandum issued by the Immigration and Naturalization Service (Orloff and Kelly, 1995) allows women to seek political asylum in the United States for problems related to gender persecution (Orloff and Kelly, 1995; Schornstein, 1997), although providing proof of the need for asylum often is a cumbersome and involved process (Schornstein, 1997). Immigrant women may recognize the inconsistencies between recent legal provisions and the general tone of the national discourse on immigration reform and therefore may not reveal their victimization due to fear of deportation. Barriers to accessing resources, which may have increased with welfare and immigration reform, may deny immigrant women an opportunity for identification, protection, and possible asylum.

Western Model of Services

The Western model of intervention is individually oriented. Immigrants from Asia, Africa, and Latin America have a strong familial and collective sense of self (Hsu, 1985). The individually oriented method of interceding in cases of domestic violence usu-

ally is to provide choices that encourage women to leave the abusive situation. However, making that choice implies having viable options for a better life and knowledge of the consequences of those choices. For a woman who is socialized into the traditional ideals of being a good wife and mother, which include the sacrifice of personal freedom and autonomy, leaving her husband and family often is not a viable option (Agger, 1992; Dasgupta and Warrior, 1996). Issues of shame and embarrassment add to the reticence of both patient and provider in broaching the subject of domestic violence. Women also fear retaliation and increased abuse if they attempt to disclose the violence or leave the abusive situation, adding to the difficulty in eliciting a history of abuse.

Marriage brings many immigrant and refugee women a certain social standing and acceptance in their own ethnic or cultural milieu. Divorce and separation are not viewed positively, even if women are attempting to leave abusive situations. Further, many immigrant women do not have extramarital support systems. If a woman chooses to leave with her children, she must learn to negotiate the system to acquire housing, employment, and child care, tasks for which she is often ill prepared, especially in an alien society and culture.

Given the role and importance of the family and social networks for immigrant and refugee women, a more effective model of intervention and prevention needs to encompass the client-defined family. Unfortunately, this may be difficult given the structure of medical insurance and benefits; most insurance coverage targets the individual and does not include a client- or patient-defined family.

Although abused women suffer from mental health problems, such as depression and posttraumatic stress disorder (Houskamp and Foy, 1991; Cascardi and O'Leary, 1992), they may be reluctant to seek assistance due to feelings of shame and guilt (Crites, 1987, 1991). They may approach the health care practitioner only after they have failed in their efforts to elicit the support of other family members or community and religious leaders.

Some have discussed the negative attitude of health care institutions and providers toward victims of domestic violence (Kanuha, 1994). Women who do not leave their abusive situations are viewed as passive by U.S. health care providers. These women

believe that breaking up the family is neither economically nor socially beneficial for themselves or their children (Browne, 1993), and their familial and collective sense of belonging precludes them from leaving the abusive situation. Thus, their so-called inaction or passivity is in fact a survival tactic in which the women are trying to do the best for their families, even at the risk of continued abuse.

Consequences of Mandatory Reporting

Certain states require health practitioners to report suspected cases of domestic violence, and there may be penalties for failure to do so (Hyman, Schillinger, and Lo, 1995). Although mandatory reporting to law enforcement has been common for injuries resulting from or related to firearms or other dangerous weapons, extending it to suspected abuse of adult women may undermine basic principles of patient autonomy in decision making. Although it might seem that mandatory reporting would lead to recognition and criminalization of domestic violence, thereby punishing the abuser, the criminal justice system has little, if any, way to protect women from the repetitive behavior of their abusers without permanent incarceration of perpetrators. Negative repercussions, such as the threat or occurrence of retaliatory violence (Hart, 1993), may further discourage abused women from revealing domestic violence to health care providers (Hyman, Schillinger, and Lo, 1995).

Even after health care professionals report a case to local authorities, the woman may not perceive herself as being abused. Many immigrant and refugee women come from war-torn areas where they have witnessed political, economic, and social strife. They mistrust government and its various arms, so the consequences of the reporting (such as visits from police) and the perceived threat of deportation may result in more tension within the family, and possibly more abuse of the women. If men who are not lawful residents are deported as a result of reporting through this mandate, women must face the added burden of breaking up their families and sharing the custody of the children across international lines (Crites, 1987). In the light of these potential conse-

quences, it is important that the decision to make a report to the police or governmental authorities be made by the woman.

Women must be given sufficient time, resources, support, and information about available legal protections in order to reassure them that disclosure of violence to health personnel will be confidential, will be directed toward the woman's safety, and will facilitate communication with police when they deem that an appropriate step in changing their life situation.

The Case of Kiranjit Ahluwalia

Many of the issues discussed are poignantly illustrated in the much-publicized case of Kiranjit Ahluwalia, an immigrant Indian woman in England who lived in an abusive situation for ten years (Ahluwalia and Gupta, 1997). Tired of the battering, she allegedly set fire to her abuser, her husband, who subsequently died from the burns. Kiranjit was accused, convicted of manslaughter in the first degree, and remanded to jail. In the hearing and conviction, the prosecution contended that she was culpable since during the ten years of her marriage, she had made no attempts to leave the abusive situation or to get help from social workers. It was further contended that the act of setting her husband on fire was deliberate and intentional, and therefore punishable.

Her case was subsequently reopened and defended by the Southall Black Sisterhood, a women's organization. Her culturally sensitive lawyers and psychologists gathered evidence to show that Kiranjit belonged to a culture that was dominated by the concept of family shame, and family honor, or *izzat*. She also was afraid that she would not be given custody of her children in case of a divorce and thus did not even consider seeking help from social workers, neighbors, or anyone else outside her own family. The defense argued that Kiranjit had developed battered woman's syndrome, in which her consciousness became injured to the consequences of her actions. After considering the cultural context, the judge ruled to acquit Ahluwalia.

This case illustrates the role of tradition in hindering immigrant women from accessing services. It highlights the initial cultural insensitivity of the Western system of care and justice in

interceding with cases of domestic violence and shows how a more culturally sensitive understanding finally led to Ahluwalia's acquittal.

Screening Issues

Health care providers of all types must be trained to screen for domestic violence and to be culturally competent when eliciting a history of abuse from immigrant women. Use of standardized protocols in some hospitals has been shown to increase the accurate identification of physical abuse of women by their husbands, boyfriends, or other intimates (McLeer and Anwar, 1987). Such protocols have been required by the Joint Commission on Accreditation of Healthcare Organizations since 1992.

In screening the immigrant woman, the first task is to establish appropriate translation services that do not depend on family members or friends. This is critical to gain the trust of the patient and to be able to reassure her of the confidential nature of the questioning. Translation can be challenging in settings where few immigrants of a specific language group are seen. It also can be difficult to find private time with a patient who is a victim of battering. It is not uncommon for batterers to insist on remaining with the victim the entire time, to relate the history, and to assume a "protective stance" in the presence of the providers. When the index of suspicion is high, potential victims must be removed from all family company long enough to get unfiltered information. This situation can require a great deal of resourcefulness on the part of the clinician and staff. Training staff ensures that a mechanism for separating suspected victims is in place.

Providers should use routine screening questions that first orient women to the context of violence ("violence is common") and then elicit closed-ended responses (Acierno, Resnick, and Kilpatrick, 1997). These questions should be thought of as another "vital sign." A number of screening protocols for domestic violence have been developed (American College of Emergency Physicians, 1995; American Medical Association, 1992a; Dutton, Mitchell, and Haywood, 1996; Furbee, Sikora, Williams, and Derk, 1998). The protocol used by George Washington University Medical Center is shown in Exhibit 10.1.

Exhibit 10.1. Screening Protocol for Domestic Violence.

Introduction

1. These days many people are exposed to violence in some form.
2. Violence is a health risk and can result in physical and emotional problems.
3. It is our routine procedure to ask adult patients about their exposure to violence.
4. If you are a violence victim, we can better help you if we know it.

Questions:

1. In the past 12 months, has anyone threatened you with or actually used a knife or gun to scare or hurt you?
Last 12 months? Yes No
If "yes" to 12 months, last 1 month? Yes No
2. In the past 12 months, has anyone choked, kicked, bitten or punched you?
Last 12 months? Yes No
If "yes" to 12 months, last 1 month? Yes No
3. In the past 12 months, has anyone slapped, pushed, grabbed or shoved you?
Last 12 months? Yes No
If "yes" to 12 months, last 1 month? Yes No
4. In the past 12 months, has anyone forced or coerced you to have sex?
Last 12 months? Yes No
If "yes" to 12 months, last 1 month? Yes No
5. In the past 12 months, have you been afraid that a current or former intimate partner would hurt you physically?
Last 12 months? Yes No
If "yes" to 12 months, last 1 month? Yes No
- If "yes" to any of 1-5, then ask:
6. What is your relationship with the person who has hurt you?
___ Current or former intimate partner
___ Other family member
___ Acquaintance or friend
___ Co-worker
___ Stranger
___ Other (specify)
7. Have the police been notified within the last month about any of these experiences?

Source: Dutton, Mitchell, and Haywood, 1996. Used with permission.

In addition to acute injuries that should raise suspicion of domestic violence enough to prompt immediate questioning (see Exhibit 10.2), domestic violence can be a frequent cause of other somatic complaints, including headache and migraine, abdominal pain, chronic pain, and sleep disruptions. Behavioral problems include anxiety and depression, suicidality, posttraumatic stress disorder, and substance and eating disorders (Kilpatrick, Resnick, and Acierno, 1997).

Thus, multiple clues may guide the provider to suspect that a patient is experiencing violence in her home. Specialists from different disciplines may see patients with varying patterns of presentation. Many of the sequelae of domestic violence result in loss of work time and loss of productivity, at great cost to businesses and society (Dunham and Leetch, 1996; McAfee, 1994).

Conclusion

It is imperative that domestic violence in the immigrant and refugee population be understood and addressed from a culturally relevant, sensitive, and competent perspective. Health care

providers of all types are integral to the provision of care of women and families in domestic violence situations. Team rather than individual care models provide the advantage of case management and improve communication among all service providers. Providers need to understand the role and relationship of the perpetrator and the victim within a cultural context. Written clinical screening protocols should be implemented at all health facilities. Providers must be cognizant of the laws related to domestic violence and their ramifications for women who seek assistance. In addition, health care providers should advocate for victims and participate in training members of the criminal justice system about domestic violence and the repetitive behavior of perpetrators. Culturally competent health care involves understanding the meaning of abuse within the victim's cultural framework, the role of tradition, the legal system, and the specific circumstances of each immigrant woman. The Fourth International Women's Conference (Beijing) concluded that violence is harmful for women and that strict cultural relativism no longer is applicable to domestic violence.

Exhibit 10.2. Medical Clues Raising the Suspicion of Domestic Violence.

Central patterns of injuries

Contusions or injuries on the head, neck, abdomen, or face

Injuries suggestive of combative posture (injuries to palms of hands, extensor aspect or ulnar side of forearm, boxer's fractures)

Type or extent of injury inconsistent with the patient's history of injury

Substantial delay from time of injury to time of care seeking

Injuries occurring during pregnancy

A pattern of repeated visits to the emergency department

Evidence of alcohol or drug use

Arrival in the emergency department for suicide attempt or gesture

Sexual assaults and partner rape

Source: Adapted from American College of Emergency Physicians, 1995, and American Medical Association, 1992a.