Published in final edited form as:

Race Soc Probl. 2018 December ; 10(4): 348–365. doi:10.1007/s12552-018-9247-z.

Multilevel Risk and Protective Factors for Intimate Partner Violence Among African, Asian, and Latina Immigrant and Refugee Women: Perceptions of Effective Safety Planning Interventions

BUSHRA SABRI, PhD,

John Hopkins University School of Nursing, Community Public Health Nursing

NKIRU NNAWULEZI, PhD,

University of Maryland, Baltimore County, Department of Psychology

VERONICA P.S. NJIE-CARR, PhD,

University of Maryland School of Nursing, Department of Organizational Systems Adult Health

JILL MESSING, PhD,

School of Social Work, Arizona State University

ALLISON WARD-LASHER, MSW,

School of Social Work, Arizona State University

CARMEN ALVAREZ, PhD, and

John Hopkins University School of Nursing, Community Public Health Nursing

JACQUELYN C. CAMPBELL, PhD

John Hopkins University School of Nursing, Community Public Health Nursing

Abstract

Immigrant and refugee women are at high risk for intimate partner violence (IPV) and intimate partner homicide (IPH). Given the growing number of immigrants and refugees in the US and the concerns about IPV and IPH among immigrant and refugee groups, this paper aims to identify survivors and practitioners' perceptions of a) common and culturally specific risk and protective factors for IPV and IPH for immigrant and refugee women and b) areas of safety planning interventions for survivors who are at risk for severe or lethal violence by an intimate partner. Qualitative data for this multi-site study were collected from women and practitioners residing in seven geographically diverse US locations. Eighty-three in-depth interviews were conducted with adult immigrant and refugee survivors of IPV, who identified as Asian ($n=30$), Latina ($n=30$), and African ($n=23$). Additionally, nine focus groups and five key informant interviews were conducted with practitioners ($n=62$) who serve immigrant and refugee survivors of IPV. Results revealed multilevel risk and protective factors for IPV/IPH found at the societal-level (e.g., patriarchal cultural norms), relationship-level (e.g., partner abusive behaviors), and individual-level (e.g.,

acculturation in the US). These findings can inform the development of culturally responsive risk assessment and safety planning interventions across legal, social service, and healthcare settings.

Keywords

immigrant; intimate partner violence; safety; refugee

Immigrant and/or refugee (IMR) women are at high risk for victimization by intimate partner violence (IPV) and severe IPV including intimate partner homicide (IPH) (Frye, Hosein, Waltermayer, Blaney, & Wilt, 2005; Runner, Yoshihama, & Novick, 2009). IMR populations are growing in the United States (US), accounting for 13.3% of the US population in 2014 (Ziegler & Camarota, 2015); approximately half of immigrants are women (American Immigration Council, 2014). A study of homicides of women in New York City (1990 to 1999) found foreign-born status to be the strongest risk factor for homicide of a female by a male intimate partner (Frye et al., 2005). With the growing number of IMR in the US and concerns about disproportionate impact of IPV and IPH on health and safety of IMR women, there is need for culturally tailored or responsive risk assessment and safety planning interventions for at-risk groups of immigrant and refugee survivors of IPV, yet limited research has examined risk factors for future re-assault, severe re-assault, or homicide among IMR women in abusive relationships (Messing et al., 2013). The purpose of this multi-site study was to examine the perception of IMR survivors and advocates working with this population with regard to (a) the factors that increase risk for re-assault, severe re-assault, and homicide (i.e., risk factors) and factors that enhance safety (i.e., protective factors) and b) specific safety planning intervention strategies.

IPV among IMR women is influenced by complex factors operating at multiple levels in women's lives that may either pose a risk or protect them from IPV. While risk factors increase the likelihood that survivors will experience threats to their safety, protective factors decrease or buffer against the risk of IPV and enhance women's capacity to effectively address violence and the related health and safety risks (World Health Organization/London School of Hygiene and Tropical Medicine, 2010). The socio-ecological model (Bronfenbrenner, 1979) provides a useful structure by which to identify and organize risk and protective factors of IPV at the macrosystem (societal), exosystem (community), microsystem (relationship) and individual (survivor) levels (Heise, 1998; Pinnewala, 2009; Sabri, 2014). Combining the socioecological model with the Sanctions and Sanctuary Framework (Counts, Brown, & Campbell, 1999; Koenig, Stephenson, Ahmed, et al, 2006) provides a cultural overlay to each system within the ecological model. The Sanctions and Sanctuary Perspective accounts for variations among cultures in terms of the amount, frequency, and severity of IPV, in what is condoned or condemned, in the sanctions that allow or forbid IPV (e.g., laws and norms) and in the availability of sanctuary for IPV survivors (e.g., shelter). Women who are unable to access sanctuary (e.g. through divorce restrictions and/or living with husband's extended family) and/or who live in communities where sanctions against IPV do not exist or are not applied may be more likely to remain with their abusive partners. The adequacy of sanctions (i.e., policies, laws and regulations) against IPV for IMR women at the macrosystem and exosystem level of the socio-ecological

model can play a significant role in addressing IPV in IMR communities. Policies and programs that protect IMR survivors regardless of their immigration status, can prevent IPV among IMR women.

Using these frameworks and drawing from previous research, it is possible to theorize risk and protective factors faced by IMR survivors of IPV. At the macrosystem level, IMR women face traditional gender norms and cultural beliefs that accept violence against women (Heise, 1998; Krug, Mercy, Dahlberg, & Zwi, 2002; Stith, Smith, Penn, Ward & Tritt, 2004). Attitudes condoning violence and traditional sex role ideology both increase risk for IPV (Stith, Smith, Penn, Ward & Tritt, 2004), perhaps enhancing the risk faced by IMR women. A partner who threatens to report an immigrant woman to authorities, such as child protective services or immigration and customs enforcement, is more likely to severely re-assault his partner, indicating that harnessing macro-level institutions is a strategy for abuse in IMR women's relationships (Messing et al., 2013).

At the exosystem level, which includes community structures such as neighborhoods, social networks, and community-level social institutions (Pinnewala, 2009), community members or social networks that support the use of violence against women can pose a risk to women's safety. Immigrant women report higher perceived social and legal risk to leaving an abusive partner than non-immigrant women (Amanor-Boadu et al., 2012). Further, abused immigrant women are likely to report more social isolation than non-immigrant abused women (Amanor-Boadu et al., 2012). Adeyinka and colleagues (2013) found that African women from some West African countries who sought support from community and religious leaders after experiencing abuse, reported dissatisfaction with the responses received because of blame based on gender roles and social expectations. Similar reports were found in a study by Tonsing (2016) among abused South Asian women. In limited contradictory cases, community member or leader engagement in concerns of violence against women could be perceived as protective (Shalabi, Mitchell, & Andersson, 2015). For example, Shalabi and colleagues (2015) reported that Arab community leaders and religious leaders contributed toward supporting abuse victims by providing funds, resources, and related services to transition them to a life of independence from the partner. Nonetheless, evidence supporting the role of communities conforming to gender norms and cultural expectations that place women at risk for abuse abound in the literature (Hyman et al., 2011; Stith et al., 2004; Tonsing, 2016).

The microsystem level includes close relationships such as in-laws, parental family, husband, and children. Microsystem level factors such as frequency or severity of abuse in an intimate partner relationship, forced sex, strangulation, and threats to kill have been found as risk factors for IPV, severe IPV, and IPH in existing literature on non-immigrant and immigrant populations (Campbell et al., 2003; Messing et al., 2013; Sabri, Campbell, & Dabby, 2016). Immigrant women who were primarily Latina were found to be at greater risk for severe violence if they were married, had no children in the home, and had no children with their abusive partner, indicating an increased importance placed on family structure (Messing et al., 2013). Immigrant women are more likely to report fear of their abusive partner and to report being more controlled by him (Amanor-Boadu et al., 2012). In India, a

mother-in-law may be complicit in abuse and homicide, extending microsystem-level factors to other family members (Sabri, Sanchez, & Campbell, 2014).

The individual level represents the personal history of a survivor (Pinnewala, 2009) and includes risk factors for IPV such as age, education, and income (CDC, 2016; National Center for Health Statistics, 2016; Stith, Smith, Penn, Ward & Tritt, 2004). Abusive partners can influence individual level risk factors as well. A partner who prevents an immigrant woman from getting a job, going to school, or learning English is more likely to severely re-assault her (Messing et al., 2013). Depression, alcohol use, and illicit drug use additionally increase risk for violence (Stith, Smith, Penn, Ward & Tritt, 2004). Individual level protective factors, such as self-esteem and spirituality, have been found to be associated with positive coping among survivors (Bemardes, Ray, & Harkins, 2009).

Heise's recent meta-analytical test of elements of the socio-ecological model among 481,205 women in 441 countries provided persuasive evidence of the importance of norms, particularly those related to male authority over female behavior and those justifying IPV, as well as the extent to which law and practice disadvantage women compared with men in accessing tangible resources (Heise & Kotsadam, 2015). However, there were moderator effects across ecological levels. For example, a girl's education was more strongly associated with reduced risk of IPV in countries where wife abuse is normative than where it is not. IPV was less prevalent in countries with a high proportion of women in the formal work force, but working for money increased a woman's risk in countries where few women work.

The Current Study

Risk and protective factors identified in the current literature on IPV in general may not be the same for IMR women. While some actions that women take, such as getting an order of protection or going to shelter have demonstrated decreases in moderate and severe re-assault (Messing et al., 2017), there is scant literature examining individual, microsystem, exosystem, and macrosystem characteristics that protect against abuse. Because of the difficulty inherent in studying prevention (e.g., Is it possible to know that a particular characteristic or action prevented violence?), previous research has primarily focused on risk factors for IPV and IPH, rather than protective factors. Examining both risk and protective factors may have the effect of improving risk-informed interventions, such as safety planning for survivors, and for developing culturally appropriate interventions that enhance the strengths and protective factors of women experiencing IPV (Campbell, 2001; Messing & Campbell, 2016). Understanding the actions that IMR women are taking to enhance their safety in relationships with abusive partners will assist in safety planning and in the development of survivor-defined culturally appropriate interventions that approach culture within a strengths-based model.

Most studies on IPV among IMR groups in the US have focused either on IMR groups from one world region or from one country of origin. Given that the US is home to many IMR women from diverse world regions, additional research is needed to identify culturally-specific strategies to best address IPV and meet the needs of diverse groups of IMR women

in the US. To address this gap in research, and because of the difficulty inherent in studying protective factors, this study used qualitative methods collected from IMR survivors across diverse world regions and practitioners who serve IMR survivors to identify multi-level perceived risk and protective factors for repeat and severe IPV and IPH as well as safety planning intervention strategies. Drawing on expertise from survivors and practitioners provide unique perspectives on the research aim and enhanced the study's trustworthiness.

Method

Study Setting

This study was conducted by a collaborative research team with contacts across the U.S. To examine risk and protective factors among IMR survivors, the research team contacted agencies (i.e. social services, health services) in Massachusetts, New York, Arizona, Virginia, Washington DC, Minnesota, and California that work with IMR individuals.

Recruitment Procedures

Participants were recruited using purposive and snowball sampling techniques since the purpose of the research was to examine risk and protective factors for survivors from specific cultural backgrounds. This type of sampling technique has been found to be helpful in recruitment of hard to reach populations (Faugier, 1997); especially given that the topic of IPV is taboo in some of the cultural groups. The focus on particular groups of immigrants was at the request of the funding source. We selected IMR survivors from Latin America, Asia, and Africa due to the high rates of IPV among these groups (Frye et al., 2005; Runner et al., 2009).

The research team had connections to community organizations serving these groups and relied on community partners who work with IMR women to assist with locating and recruiting IMR survivors. The partners were contacted via phone, email, and in-person visits and flyers were distributed among agencies serving IMR women. Our partners assisted with recruitment of practitioners from within their organizations as well as from other organizations in their network. Survivors were recruited using multiple strategies including flyers posted at organizations serving IMR survivors as well as locations where IMR women congregate (churches, events, and meetings), word of mouth, and meetings with community collaborators.

Survivors were eligible for an in-depth interview if they were over the age of 18, had experienced abuse in the past two years, and self-identified as an IMR from Asia, Latin America, or Africa. Practitioners were eligible for a key informant interview or a focus group if they had two or more years of experience serving Asian, African, or Latina IMR survivors or perpetrators of IPV. Practitioners were compensated \$40 for participation in focus groups/key informant interviews and survivors were compensated \$25 for participation in in-depth interviews and \$10 for travel. Practitioners were compensated at a higher rate than survivors primarily due to their professional expertise and/or their assistance with disseminating study information or recruiting survivors for in-depth interviews.

Participants

Eighty-three IMR survivors of IPV and 62 practitioners serving IMR survivors of IPV were eligible and consented to be interviewed. Survivors in this study represented six Asian cultural groups from India, Philippines, Pakistan, Laos, Thailand, and Hmong; nine Latina groups from Mexico, Jamaica, Dominican Republic, Puerto Rico, El Salvador, Honduras, Peru, Guatemala, and Colombia; and eight African groups from Democratic Republic of Congo, Rwanda, Burundi, Nigeria, Uganda, Somalia, Kenya and Ethiopia. Practitioners were from diverse backgrounds; some shared the countries of origin of the clients they worked with while others did not. Some practitioners were from the same organizations who assisted with recruitment of survivors. Others were experts in the community who had extensive experience serving survivors but were not currently providing direct services to survivors or had contact with survivors to help with recruitment.

Data Collection Procedures

Trained members from the research team conducted individual interviews and focus groups using a demographic sheet and semi-structured survivor interview or focus group/key informant interview guides. It was not feasible for some practitioners to travel from one state to the other to attend the focus group sessions. We, therefore, used key informant interviews for those practitioners who could not participate in focus groups due to geographical distance but whose input was critical because of their rich experience serving survivors. The survivors and practitioners were asked similar questions about risk and protective factors for IPV/IPH and the need for safety planning interventions. For instance, survivors were asked: *Are there any red flags or warning signs in your relationship that make you think that things may be getting more dangerous, like he might try to seriously hurt or even kill you?* Practitioners were asked: *Are there any red flags or warning signs in women's relationships with the abuser that make you think that things may be getting more dangerous for women you serve, like he might be trying to seriously hurt or even kill her?* The interviews with survivors more focused on their living situations, their perceptions of what was expected of them as women in their communities, their relationship experiences, perceived risks and protective factors for IPV/IPH in their relationships as well as among other survivors from their communities, how they kept themselves safe, and perspectives on services in the US including safety planning. The practitioners' guide focused on their use of risk assessments in practice, risk and protective factors for IPV/IPH they noticed in relationships of survivors they served, practices that increase safety, and services that would be useful for IMR survivors of IPV survivors.

The survivor interviews lasted approximately two hours to two and a half hours depending on if an interpreter was used; and the key informant interview or the focus group lasted approximately two hours. We interviewed the practitioners at agency locations. Survivors were given the option to decide on an interview location that they thought was safe and convenient (in some cases their own homes). All interviews were audio-recorded using digital recorders with interviewers also taking field notes. Data was transcribed in English by professional transcriptionists. All study procedures were approved by the institutional review boards at the home institutions of the study investigators.

The number of participants was adequate to reach data saturation in each group and each group of practitioners serving survivors. Saturation was reached when no new themes were identified from the data generated in the focus groups and individual interviews. Even though the sample size was determined *a priori*, it was based on previous work done by qualitative scholars who suggest that data saturation is an indication that data is redundant and no new information will be generated beyond what was already obtained (Hagaman & Wutich, 2006; Sandelowski, 1995). Hagaman and Wutich (2006) investigated sample size needs to reach data saturation in a multisite, cross-cultural study and found that less than 16 participants are adequate for homogenous groups and 20 to 40 participants for heterogeneous groups.

Data Analysis

The focus group and interview data were analyzed using a constructivist perspective and a hybrid process of deductive and inductive theoretical thematic analysis (Braun & Clarke, 2006). Thematic analysis is preferable when samples are predetermined before the study is implemented. Thematic analysis with a constructivist perspective seeks to theorize the structural, social and cultural contexts that drive the individual accounts that are shared with the researcher (Braun & Clark, 2006). The overarching codes and themes reflected contextual dimensions of practitioners and survivors' experiences. The socio-ecological framework guided the analysis to identify multilevel factors related to IPV at each level of the framework.

Survivors and practitioners were organized by three groups (e.g., African, Asian, Latina). There were two coders (primary and secondary) for each group. Before analysis, two trained research team members developed a coding framework informed by the socioecological model (e.g., individual, micro, exo, macro) and general risk and protective factors (e.g., abuser characteristics). The coders first read and familiarized themselves with the data from their assigned group. Following the initial reading, researchers independently coded using the coding framework based on the socioecological model. Coders simultaneously developed inductive codes as they arose which arose primarily when discussing cultural factors that contributed to risk. The codes were developed independently by two coders, and then brought to the larger group for discussion around inconsistencies and theme development. The research team contained experts on IMR survivors' experiences, and discussed how these data aligned with, and expanded upon, previous research. The team came to an agreement about the content and meaning of each code. All coders from across groups discussed the within- and between-group similarities and differences. Codes were then aggregated by each group into themes. Common- and culturally-specific risk and protective factors were developed (Figures 1 and 2). Themes were developed based on the aggregated and distinct codes across all ethnic groups. We reported results at each level of the ecological model. We established trustworthiness by maintaining an audit trail through detailed notes of research activities, recording notes of thoughts and experiences and regular debriefing sessions among team members for reflexivity, data triangulation by using two data sources (survivors and practitioners that provided input on survivors' experiences), and analytic triangulation with multiple coders on the team.

We integrated the perspectives of practitioners and survivors for data triangulation. Practitioner focus groups and key informant interviews provided rich data to the study because it was based on their several years of experience serving survivors. They were also able to draw connections and synthesize experiences across multiple survivors which provided some insight into factors occurring at higher levels of the ecological model. The survivor data was useful in exploring in-depth experiences of individual survivors, their perspectives and issues they faced.

Results

The in-depth interviews were conducted with IPV survivors who identified as Asian ($n=30$), Latina ($n=30$) or African ($n=23$) and were first- (i.e., foreign born) or second-generation IMR (i.e., those who were born in the US but had foreign-born parents). The survivors were on average 37.1 years old ($SD=10.9$). Except for the two second-generation immigrants, they had been in the US for an average of nine years ($SD=8.8$). Approximately 61.5% ($n=72$) of the participants reported being employed at the time of the interview; the remainder of the interviewees either were unemployed or did not specify their employment status. Most survivors were mothers (82.5%, $n=71$), with an average of 2.5 children (see Table 1). Nine focus groups were conducted with practitioners ($n=62$) serving Asian, Latina and African women IMR survivors and/or perpetrators of IPV. The number of participants in focus groups ranged from 5-9. In addition, 5 key informant interviews were conducted with practitioners serving IMR survivors generally ($n=1$), Latina survivors ($n=1$), African survivors ($n=1$), and Filipino survivors ($n=2$). The practitioners ranged in age from 19–75, with a mean age of 43.9 ($SD=13.6$). Demographic information on the participating practitioners can be found in Table 2.

Perceived common and culturally-specific risk and protective factors were identified and organized using different levels of the socio-ecological model: a) societal level, b) community-level, c) relationship-level, and d) individual-level (Figures 1 and 2). In the sections below, pseudo names were used to present participants' quotes.

Common Risk and Protective Factors of IPV/IPH at Different Levels (Figure 1)

Common factors at the societal-level.—Perceived risk factors at the societal-level that were common across IMR groups were patriarchal norms, expectation that women do not express disagreement and religion forcing women to stay in abusive relationships. The protective factors were laws and religion in the US and religion or faith used to address or cope with abuse.

Patriarchal cultural norms and the normalization of IPV. Almost all groups of participants (practitioners and survivors) highlighted the role of patriarchal cultural norms in abusive relationships and were critical of norms that contributed to violence against women. Most survivors described that their risk was increased because of the cultural emphasis on male authority and entitlement or ownership over women. The cultural expectations for women that increased risk for IPV included the low status of women, that women should not express disagreement or argue with their partner, that they should always please their

partner, and be respectful of him. This is illustrated in the following quotes by two survivors and two practitioners:

“In Africa they believe that even if your husband is treating you bad, he's your husband and he has a right” (Adake, Nigerian Survivor).

“Women are seen as property. It's okay to assume that a woman will take care of you automatically. I would take care of him—whenever and all the time. I had to be able to read his mind. When he needed me, I had to be there. Even if I didn't know that he needed me” (Dawb, Hmong Survivor).

Women who did not abide by strict gender roles and/or did not take primary responsibility for family care, were seen as rebelling against cultural norms. Because of this strict division of labor, women were also seen as responsible for keeping the family together; thus, they were blamed for marital conflict, increasing their risk of abuse.

“You have to accept the husband as he is in the community. When there is a problem in the household, the community, the society holds the woman more responsible for resolving the issues than the man. It is your responsibility to be a good wife, to make sure your house will work well, even if the problem doesn't come from her” (Noella, Great Lakes region, Focus Group Practitioner).

“I don't know a society that doesn't accept [violence against woman] certainly our does” (Isabella, Central American Focus Group Practitioner).

Religious doctrine and faith.: Religion was used as a tool to keep women in abusive relationships where scriptures tell women to submit to their husbands and save the marriage at all costs. For example, per details provided by Hmong practitioners in the focus group, in the Hmong religious belief system of Shamanism (which involves a person becoming a master of spirits and having access to and influence on the world of spirits), if a husband was believed to be transitioning into a full Shaman and was violent towards a partner, his behavior was normalized as part of the transition. Further, Hmong women are afraid to leave their abusive relationship because of the religious belief in re-incarnation. In Hmong culture, it is believed that if a husband's family leaves a woman, she may not get a proper burial, and therefore may not be re-incarnated. When one is not re-incarnated, his or her spirit goes to hell. The survivor's own family is afraid of taking charge of the burial due to the belief that some calamity will inflict on them if they bury the woman since the woman is husband's responsibility. The fear of not getting a proper funeral service and of community ostracizing prevented Hmong women from leaving their abusers.

Religion as a risk factor for IPV is reflected in the following quotes by a survivor and a practitioner:

“If ... your wife is involved with someone else ...if she 's not listening to you verbally, if he forbids her one time or two time and if she is not listening, at that time religion gives men permission to physically hit or slap his wife” (Sonali, Indian survivor).

“Some victims reach out to their faith community and if there is not a very progressive priest... will tell them: Well you need to do more for your marriage” (Zurine, Mexican Focus Group Practitioner). *“I heard mothers tell their daughters because of religion you have to stay with him”* (Melissa, Caribbean Focus Group Practitioner).

Survivors and practitioners also described how religion helped women address their abusive situations. For example, some survivors had an opportunity to share their problems with a priest in the church or imam in a mosque or with other congregants. An Indian survivor shared that members of a church made her realize that she was not in a safe environment and helped her create a safety plan. Ethiopian advocates shared that their church has abuser intervention services. In some cases, religious leaders reminded an abusive partner of his responsibilities toward his partner: *“The imam (religious leaders) will just explain to them (abusers) what the religion says, that they don’t own her blood. You have to treat her well. Now that you married... you ‘re responsible for her... You have to feed her, give her clothes. Be there for her”* (Casho, Somali Survivor). Survivors expressed how their beliefs and faith in religion helped them leave their abusive situations, stay safe, or cope with the abuse. For instance, Camila, a Central American survivor stated: *“I never give up...since I went to a Catholic school, I always have a lot of faith, and I put that in God’s hands”*.

Laws and regulations in the United States.: According to some survivors and practitioners, there was more freedom for women while they were in the US than in their home countries. Some participants believed that US has laws and regulations against IPV and violations of human rights, there are consequences for breaking these laws, and women have more access to social and legal resources. For instance, Priscilla, a Great Lakes Region survivor said: *“The good thing about America is that the laws are very important, and people follow the laws”*. Darna, a Filipino survivor shared: *“People here are more open... Divorce here is okay. It makes you feel less restricted in terms of being free, and also gives you more hope that you can survive”*.

According to Deepa, an Indian practitioner: *“You have to give (survivors) confidence that here in this country this is the law. In H1 visa if you have a domestic violence case, you can be deported”*.

However, the laws and regulations were also highlighted as limited in protecting survivors. For instance, Charo, a Caribbean practitioner mentioned the limitation of survivors who are able to get a restraining order: *“Restraining orders are great. You work in the court, but at the end of the day, it is a piece of paper that if a person doesn’t honor it then it means nothing. It can actually put sometimes [survivors] at more risk because now this person is mad”*.

According to Katrin, an Ethiopian practitioner, the US laws may not always protect survivors from homicides: *“[Men] blow... legal implication...they cannot live in this country. They...will be in prison, so... killing himself, and his wife, is no different for him, come all the way from Ethiopia and be in prison, he prefers to kill his wife, himself, because we... are a very proud society. We don’t want people to know that”*.

Common factors at the community level.: At the community level of the ecological model, risk and protective factors that were common across IMR groups related to kinds of support survivors received by formal and informal sources of help (Figure 1). In addition, participants shared their perceptions of how safety planning interventions could serve as a protective resource for women.

Informal sources of support.: Community support was commonly reported as a protective factor by both survivors and practitioners. Women received support from friends, co-workers, and neighbors. Examples of the kind of support received from friends and co-workers included emotional support, calling the authorities when needed, providing a place to stay or by helping survivors get to a shelter or a safe place. The help that women received from neighbors ranged from material support such as clothes or money, to calling the police when they heard or saw indications of abuse.

“You scream at me here and I don’t need to call the police. If my neighbor sees you mistreating me or a child or dog, it is not even me who has to announce it. It can be someone else”(Adelina, Mexican Survivor).

Formal Sources of Support.: Some survivors shared how formal sources of help such as talking to a psychotherapist or a doctor provided them courage to leave the abusive situation. Some women learned about IPV through *their healthcare provider* such as OB/GYN. Others reported having positive experiences with the healthcare providers such as noticing the bruises and asking about safety or connecting women to resources.

For some survivors, the police were a protective resource getting them to a safe place, and providing information about resources for help. *“Sometimes [police] will help. For example, if there had been some argument and I would be outside with the kids. The police would come, and they would remove him”*(Grace, Great Lakes Region Survivor). *“I have a policewoman I can call. My coping mechanism is my counseling groups and my church”* (Santa, Indian Survivor). For other survivors, differential treatment by the police and the court system was a barrier to addressing abuse.

“Police ...are here to protect us, but they are taking their own people’s side, instead of listening to you. They are making a false report. The child protection, too. I tell them what’s going on. I showed them pictures. They closed my case. There is no hope”(Rashmi, Indian survivor). Some survivors avoided contact with the police due to a general fear of law enforcement or due to fear of gossip in the community.

Community agencies or non-profits were very helpful in providing different forms of services to survivors such as obtaining a restraining order, providing shelter, food, classes for finding a job and referral to clinics and other services in the community. However, some gaps in formal services in the exosystem were highlighted, as reflected in the following quotes by practitioners:

“We don’t have a center that would offer what our community is used to, that they feel safe. [Shelter] is a demeaning place... Nobody wants to go to a shelter, but there is no alternative.

We don't have some kind of a place where women can go safely and have the cultural services and activities"(Aarti, Indian Focus Group Practitioner).

"Services are very limited, especially when it comes to shelter and housing ...when you add on top of that immigration status and language barriers and ability to access the resources. I feel like it's a triple barrier ...I've called [Domestic violence agency] hotline several times in the last couple of months with a couple of different people and shelters are full. [Survivors] are sent back to the homeless shelter system, which is not really an option. I feel like that's a serious barrier"(Valentina, Central American Practitioner).

Common factors at the relationship level.: Relationship level risk factors that were common across IMR groups were partners' abusive behaviors and characteristics, lack of support from in-laws and other family members and some women's own characteristics that placed them at risk. Protective factors that were common at the relationship level included presence of children in the family.

Partner's abusive behaviors and characteristics.: Specifically, all IMR survivors and practitioners mentioned partners' behaviors such as threats to kill her or her family, threats to take away children, threats to commit suicide, threats of deportation or control of passports/green cards, suspicion, jealousy, control and isolation, physical abuse, forced sex, choking or strangulation, verbal abuse, psychological abuse, and control of finances contributing to their risk for violence or severe IPV/IPH. These behaviors sometimes prevented survivors from seeking help. For example, a survivor shared her experience of partner mistreatment:

"One time I tried to call the police, he said that he will take the kid away from me, and I will never see him again, so I was scared to do that"(Aamiina, Somali Survivor). Another survivor shared that her partner's mistreatment got worse when she was going through divorce: *"As I was proceeding with the divorce, he got worse with me. He started withdrawing, verbally attacking me, and threatened me. He said that if anything ever happens, I could never go to him"*(Gitanjali, Indian survivor). One Indian survivor mentioned that she feared her partner because he told her horror stories, made her watch movies where a man kills his wife. He also spread rumors that she was mentally ill and trying to commit suicide. The implicit danger was that he may have killed her and tried to make it look like a suicide. Some IMR survivors from Philippine, Somalia and India talked about sudden change in behavior as a risk factor for severe IPV/IPH such as change from being abusive to being extra nice to the woman and asking her to go with him alone at some place. Other behaviors highlighted were abusing a woman during pregnancy or not caring about her pregnancy needs.

Almost all survivors from the three regions described traits such as mental health problems, personality disorder, inability to control anger, history of violence or assaulting others, witnessing domestic violence as a child or while growing up, unemployment, alcohol and drug problems, cheating or infidelity, access to weapons/guns or knives, prior criminal history, history of violation of protective order or gang membership as risk factors for severe violence/homicide. Some Asian and Latina survivors discussed that abusers who lie,

manipulate the system (e.g., police, CPS, court), and pretend to be a different person can be dangerous.

The warning signs related to partners' behaviors and characteristics are illustrated in the following quotes by practitioners:

"I worked with a woman who came in for a restraining order ...there were red flags going off in my head. Although he hasn't been violent towards her—or swerved while they were driving, or threatened to kill her in public...he has told her, "I will find you every time, and I probably will kill you." This is an individual who has access to money [and] his father is very powerful in the Dominican Republic" (Bimini, Caribbean Focus Group Practitioner).

"Sometimes it's good to see the record of the person because it happened in Alexandria. He killed his wife and his children. Finally, police identified that that person... was abusing weapon and a drug. Therefore, if there is a person... who has that kind of story, that's red flag for me" (Laura, Ethiopian Focus Group Practitioner).

Role of family.: In-laws' abuse and their significant role in instigation or support of partners' abuse were mentioned by the IMR survivors and practitioners from all the three regions. In-laws were reported to be involved in various forms of abuse such as keeping the property of a woman, not letting her communicate with her own parents, and restricting access to healthcare when needed. Family normalization and protection of partners' abuse worsened survivors' family situations. Residing with in-laws was highlighted as a risk factor by all the three Asian groups. In-law abuse and in-laws access to a weapon were mentioned as risk factors for IPV/IPH. For instance, a practitioner shared how a survivor's mother-in-law contributed to her abuse: *"[An abused woman] cannot trust her mother-in-law. I had one client telling me about something she was planning on doing and she told the mother-in-law. The mother-in-law called him at work, he got out of work, and he just beat her up"* (Alejandro, Caribbean Focus Group Practitioner). A Filipino survivor gave an example where her mother-in-law instigated her husband against her: *"His mom didn't like me... One time I heard his mom, like, "Maybe she only wants your money." That hurts me because I didn't come here because of his money. I came here because I love him and I wanted to marry him"* (Dalisay, Filipino Survivor).

The pressure from overall members of the family to stay in the abusive relationships appeared in interviews of survivors and practitioners from all the three regions: Asia, Latin America and Africa. For instance, a Somali survivor's parents pressured her to forgive and sent her back to the abuser. *One of my neighbors... was abused and she went to her parents to tell them what happened. The parents sent her back. "Go to your husband. He is married to you. You are supposed to be disciplined"* (Barkhaddo, Somali Focus Group Practitioner).

For other survivors, family members were a source of support in multiple ways such as providing emotional support (e.g., preventing a survivor from giving up and committing suicide), financial support, providing a safe place to stay, helping file a restraining order, talking to the abuser, or encouraging to be confident in breaking free from the abusive relationship.

Role of children.: Most survivors and practitioners described children as a source of strength which kept survivors going even during the worst abusive experiences. Some also expressed that irrespective of how bad their experiences have been, the best part was having children. Children helped them cope (e.g., not having suicidal thoughts for the sake of children), and at times took protective actions (e.g., disclosing to the neighbors or at school that the woman was being abused). *I know a lady... whose... husband was abusing her physically. She never reported.... but one day he was beating her in front of her children. One of her younger daughters just called 911. The police came... they deported him* (Maris, Ethiopian Focus Group Practitioner). Having children also motivated some survivors to leave the abusive relationship. However, according to a practitioner, presence of children can be a barrier to leaving the abuser. *To make the decision to leave, because you have all these children... you know you're in a bad situation, but you don't have any means to support them. I feel that that can be an issue, too, the number of kids that you have. You can get stuck there* (Claudia, Great Lakes Region Focus Group Practitioner).

Per one survivor and practitioner in the focus group from the Great Lakes region, being pregnant and having children was protective due to reasons such as partner not being comfortable abusing in front of children.

"At one point, God helped me. Eventually, I got pregnant. The time I had my first baby, I felt like I was catching a break a little bit. After three years, his family started accusing me of refusing to get pregnant again" (Medi, Great Lakes Region Survivor).

Common factors at the individual level.—Among factors at the individual level (i.e., women's individual level), Asian, Latina and African survivors and practitioners commonly highlighted some characteristics of survivors that placed them at risk for IPV/IPH.

Women's characteristics.: These characteristics included not having family in the US, having nowhere to go, being on a dependent visa, having an undocumented status, not being financially independent, lack of education, in the process of leaving the abuser, or coming back after leaving the abuser. For instance, a practitioner shared: *"If they [survivors] are not educated enough [they are at risk] ... have to know their rights [they are at risk]"* (Barkhado, Somali Focus Group Practitioner). Another practitioner shared: *"Not knowing resources affects her. You're isolated. You just don't know anyone"* (Eve, Hmong Focus Group Practitioner). A Caribbean survivor mentioned: *"Usually the men will abuse the women that are not educated, women that are not prepared, women that are not working- so women that are financially dependent on them"* (Teresa, Caribbean Survivor).

The reported indicators of dangerous abusive relationships were physical signs of bruises or bruises in non-visible areas, hospitalization because of wounds caused by the abuser, and not showing up at work or no longer connecting with family and friends. Survivors not wanting to disclose abuse to others for fear of the abuser going to jail and ignoring abuse in the relationship also were reported to place them at risk. Examples are illustrated in the following quotes:

"I think forgiveness is what has put me to that point. ..I kept on forgiving him, and saying, "Okay, he's the father of my kids. He made a mistake. Let me move on. Let me do the right thing" (Dembe, Ugandan Survivor).

"Isolation [of a woman] would be really big deal... [placing woman at risk]" (Mahalia, Filipino Focus Group Practitioner)

Other perceived risk factors for severe abuse/homicide were women having an affair with someone outside the relationship or having doors without locks so that the abuser could easily get hold of them.

Acculturation leading to knowledge, and access to resources.: Acculturation was highlighted as both risk and protective factor by both survivors and practitioners. Acculturation was reported to place women at risk when women's independence or empowerment intimidated men and made them violent.

Overall, survivors and practitioners believed that learning ways of life in the US reduced the risk for violence. Survivors being financially stable and independent (e.g., knowing how to drive, having own money, a place to live, a phone), having education, knowledge and access to resources were identified as protective factors against abuse by both survivors and practitioners.

"If you have been here a long time and you have become acculturated enough to have the knowledge of the legal system, knowledge of DSS...this knowledge is protective. It is easy to be in your own community where you're comfortable, where your language is spoken, and you're discriminated as soon as you put one toe out of it, so you stay in it, but someone else who has become a little bit more acculturated, that person can be judged. It can put them at more risk. They lose the supports that may have been protective before" (Sofia, Central American Focus Group Practitioner).

"I am fluent in English...I was able to advocate for myself and clarify my needs, and being able to understand what my needs are, and then getting those needs met. I have a privilege, I have education. I was married to a White man, so I gained some White privilege" (Houa, Hmong survivor).

Internal sources of strength.: Given the enormous challenges survivors experienced as wives and mothers; and as wives and mothers in a foreign country, participants repeatedly reported their innate abilities to cope, mustering the strength and resiliency to stay strong and care for their children and themselves. Survivors in the study identified multiple internal strengths such as being patient, resilient, a peacemaker, strong, determined and willing to stand up to whatever situation happened in life, knowing who to contact and how to access resources, not hesitating to ask for help, having a positive personality, being social, not being afraid easily, having a "fighting spirit", being calm, and wanting to be a role model for children. Other reported strengths were being optimistic or having hope and trying for progress in life. Recognition or realization of being in an abusive situation and taking steps to address abuse were also identified as internal strengths. Both survivors and practitioners shared examples of survivors' strengths during their abusive relationships:

“I believe that being a strong woman [have helped me survive]. I’m by myself. I do everything by myself” (Jasmine, Filipino Survivor). “My dad was really a very positive person. He passed away and I used to think he’s with me all the time, and he’s just giving me all the energy that I am going through and he’s there for me. That kept me going for a long time” (Rashmi, Indian Survivor).

“[Survivors] build a network of other survivors to keep them strong or be able to talk to people, talk to those who are similar. Peer support” (Mahalia, Filipino Focus Group Practitioner). “[The strength is Hmong women’s] ability to calm things down... we see this all the time when they show up to shelters, they’re not in that crisis mode” (Jong, Hmong Focus Group Practitioner).

Survivors’ use of safety strategies.: IMR survivors and practitioners reported several safety strategies that survivors use to protect themselves from the abuser—such as building safety circles, seeking help from family, friends, neighbors, community members, police, health care provider, accessing shelter services, and making an escape plan. Other reported strategies included always keeping the phone with emergency numbers, relocating to a new state, filing a restraining order, minimizing interaction with the abuser, not going out alone at night, and being in a place that was not known to the abuser. During the relationship, survivors reported using strategies such as keeping quiet and not talking back, not doing or saying anything to make the abuser angry, going along with what he said or following the rules, avoiding him, locking the doors, leaving the situation for few hours, going somewhere out when the abuser was upset until he became calm. Some survivors would look for self-help resources on the internet or resources such as immigration attorneys, social services in the community or call non-profit organizations. Some survivors also reported changing locks, placing motion lights outside the house, not leaving the house, having code words to talk to family members which meant emergency or had secret friends. Creating an escape plan by saving money and planning for the future was another highlighted safety strategy. Some women talked about hiding knives to protect themselves from the abuser. The following quotes illustrate safety planning strategies used by participants:

“My strategy was to keep my mouth shut. Whenever I spoke, it was more violent. If I did not speak, it was less violent” (Shruti, Indian survivor). “[I kept myself safe] by trying to please him, most of the time... I will apologize a lot to him...sometimes I didn’t even do anything, and I’m apologizing for something I didn’t do or create” (Earlena, Mexican Survivor)

“[Survivors] go into hiding. I had a cousin who...not only left Philippines but she just moved to a different state from where he thought she would be and did not tell anyone where she was for years” (Tala, Filipino, Practitioner, Key Informant Interview). “The safety strategy is] not crossing his path. Keep the children away from not crossing. Either give meals before or after... keep him calm” (Hema, Indian Focus Group Practitioner).

Culturally-Specific Risk and Protective Factors of IPV/IPH at Different Levels (Figure 2)

Culturally-specific factors at the societal level.—At the societal-level, some culturally-specific risk and protective factors were highlighted such as culturally-specific expectations for marriage and divorce and specific cultural beliefs or practices. For instance,

one Hmong advocate talked about the use of black magic by the male partner as a threat to harm through which women could get killed. Yet, the Western legal system would not provide women with a restraining order based on this threat. *“There are some forms of black magic that people can use to harm. If somebody harms your spirit, then you can be sick and die. The Western [society] don’t see that as a threat. It’s so hard for these women to file a restraining order and get granted. I’ve seen restraining orders getting dismissed because of that. They just don’t understand that part of the spirituality”* (Jong, Hmong Focus Group Practitioner).

Most survivors and practitioners described that the marriage practices in various cultures placed women at risk of IPV and IPH. This includes the arrangements made that commit women to marriage for life and the cultural stigma of divorce that keeps them in abusive relationships. While the details of these cultural practices varied, the overarching patriarchal cultural expectations remained consistent across cultures. For example, among Indian women, the importance of family honor or image – staying together and presenting a façade of contentment or happiness, was more important than her partner’s use of violence, thus demonstrating the commitment women have to their marriages and the responsibility that they feel to the image that they present to their community. An Indian practitioner shared: *“I told her [a survivor] that, “You should.... tell these things to your sisters...discuss with your dad...she always used to tell me that I have three daughters. If it goes out in the society, nobody will marry my daughters”* (Ruchi, Indian Focus Group Practitioner). A Somali practitioner stated: *“Some mothers...because of the stigma will just tell them, “Stay in the marriage. Figure out ways to fix this”* (Khadiija, Somali Focus Group practitioner).

Similar practices of forced or arranged marriages, dowry, bride price, or ‘mehr,’ are found across Indian, Hmong, and Somali cultures: *“Forcing the girl—a woman to marry a guy that she is not in love with [is abusive]”* (Hani, Somali Survivor). While the specific details of this risk were expressed somewhat differently by each group, the overarching theme of cultural marriage practices subordinating women were consistent. For example, Indian women spoke about risk for IPV if they were unable to bring enough dowry (payment to the husband’s family) to the marriage. *“She [Mother-in-law] used to tell me it’s shameful for a family that you...didn’t bring anything [dowry] with you. You didn’t give us anything”* (Rashmi, Indian survivor). A Hmong practitioner shared culturally specific risk factor related to the survivor leaving. *“When she leaves, if anything happens to her, his [husband’s] family is no longer responsible...That’s really...giving him permission [to kill] because now his family no longer has responsibility for her body”* (Hli, Hmong Focus Group Practitioner).

The Hmong and Somali practices include a payment to the wife’s family; Hmong women faced increased risk if the man who paid money for his wife believed that he owned her. In the Somali culture, polygamy or use of religion to justify having multiple wives is a risk factor for IPV. In addition, due to the Somali cultural norm where the husband must agree to a divorce, a woman is unable to break free from the abusive relationship and remarry. The following quotes illustrate the role of cultural expectations for marriage and divorce by survivors and practitioners:

“As a Filipina... you cannot divorce your husband. You have to do your chores as a woman. You have to take care of your husband. You have to cook for your husband. You have to please him even though sometimes it’s not right anymore... We are below men” (Rosamie, Filipino Survivor).

“[Community and family] don’t divorce. Instead, they tell you that’s how it goes in marriage. It’s up to you to work on it and make it better. You stay, thinking things will get better” (Bisette, Great Lakes Region Survivor).

“Women do not treat (divorced women) well in this society. They are not—invited to parties...even if they’re invited, as soon as they leave, they know that they’re going to be talked about” (Aarti, Indian Focus Group Practitioner).

Culturally-specific factors at the community level.: Lack of support from the community (e.g., community shaming and isolating a survivor for getting divorced or leaving the abusive relationship) was highlighted by some survivors and practitioners as a risk factor for IPV/IPH. For example, a practitioner shared: *“In our community... family breakdown is a big issue—It’s not supported by the community. It’s very hard on the woman when a family breaks and it’s her fault”* (Aynalem, Ethiopian Focus Group Practitioner). If a woman sought help, she was ostracized by the community: *“Sometimes when she [a survivor] talks and... calls the police... she will be the bad person. People will talk about her and say that she called the police for her husband. Nobody wants to say hi to her or want to be close to her because of it”* (Sumaya, Somali Focus Group Practitioner).

A Hmong survivor who was also a practitioner shared: *“Now that I’m a divorced woman—two-time divorced woman—in my community—people look down on me. They forget about me. They don’t invite me to functions. I’m isolated. In my professional community, I’m seen as a leader. I have to wear these two different hats and it’s really hard to, sometimes, find a good balance between the two”* (Chee, Hmong survivor).

For other survivors who had positive experiences with their communities, community support was protective. Community was highlighted as a resource for connectedness, supporting survivors in times of need by African survivors. Elders in the community resolved issues for African survivors such as threatening to call the police if an abusive partner did not stop using violence. *“There is a Burundian community called Baho. ...these are people...who ...help them to resolve their problems without involving the law enforcement”* (Rosie, Great Lakes Region Survivor).

Culturally-specific factors at the relationship and individual levels.: In cultures where the primary responsibility of keeping the family together is on women or emphasis is placed on chastity of women, abusive partners used these beliefs for their advantage. Threatening the survivor through social media or publicly humiliating them were specifically mentioned as abuser’s tactics by some African survivors. Some African survivors also talked about the husband or partner spreading rumors about them sleeping around and contracting AIDS. IMR women who married outside their cultures were also at a disadvantage. Some Asian survivors mentioned that a partner not being from the same race/ethnicity or being from a

White majority culture can be a risk factor for severe IPV/IPH. The abuser from White majority culture knows the system in the US and has support from his family and community which can place their IMR partner at risk. In contrast, his immigrant female partner has no support system in place in the US and is more vulnerable due to lack of knowledge and social isolation. For instance, an Indian survivor shared: *“He is white, Caucasian. He was born and brought up [here], so he knows the system. His parents have lived here, they know all the people. He knows everybody. They were able to change the judge, because I got a restraining order on him. [In-laws and him] would isolate my kids from me. He would just drive off with my kids for days and not come back... He would email everybody, my friends, my employers, neighbors, even my own family saying I have a mental illness”* (Simran, Indian survivor)

Other reported reasons of abuse or marital conflict were a preference for a male child (Indian and Caribbean survivors). Some survivors talked about the inability to get pregnant (Caribbean) or to give birth to a male child (Indian) as risk factors for abuse. In situations where acculturation is seen as a threat by the abuser can place survivors at risk.

Recommendations for Safety Planning Interventions

Survivors and practitioners provided suggestions for effective safety planning interventions for IMR women by formal sources of help (e.g., advocates serving survivors) in the community. These suggestions are summarized below:

- 1) A survivor centered approach, which places importance on women’s autonomy, priorities, on their ability to make informed choices, “open door for self-expression” and provide options;
- 2) Ensure access to a safe and secure place to get away from the abuser, provide transportation assistance to those who need to get to a safe place. Some perceived characteristics of a safe and secure place were a positive environment, accommodates the children, is culturally appropriate (e.g., provide appropriate food), and the survivors can stay there for a month to 6 months or longer if they need.
- 3) Educate survivors and link them to resources for survival. Some of the examples of the needs of resources shared were food, financial assistance/emergency loans that do not need identification from women, legal assistance, a sustainable job, education or short careers to eliminate their dependency on partners, English learning or driving classes, affordable housing, phones and financial assistance to go back to the home country to get away from the abuser. According to an Indian survivor, for instance, a safety plan should provide a safe place to move away from the abuser: *“[A safety plan should include] Giving that person a safe place to stay ...they should have a phone near them* (Astha, Indian Survivor). It was highlighted that recent immigrant survivors should be oriented on the American system, about laws and rights in the country, where to get resources, how to access public benefits and where to go when they need help. An important need was to have an advocate that could help survivors navigate systems such as immigration services, court services or getting a restraining order. Practitioners should provide survivors with a list of numbers to call, including information about advocates from the same cultural background, if survivors are in

danger. For instance, a survivor shared her needs for safety planning: *“I would prefer them to advise me, like, “There is a program here and there to help you, to prevent you from getting into bad shape—your partner might kill you” (Daus, Hmong Survivor).*

- 4) Empower survivors and build their self-esteem by promoting survivors' independence, self-confidence and self-worth;
- 5) Address emotional safety needs by providing access to a counselor/therapist. Women wanted someone they can always feel comfortable and safe to go to and get some advice. The counselor should emphasize the importance of choosing to be safe—providing concrete advice such as making sure they take all the documents when they leave the abusive partner;
- 6) Provide information about the 911 service since some survivors are probably unaware that the service exists including availability of service in different languages;
- 7) Connect survivors with support groups of other women going through similar situations. Some IMR survivors did not have family in the US and were lonely and isolated. Support groups could help them build their social support networks with other survivors who knew about the situation. It also offered women someone to call when there is a crisis.
- 8) Practitioners take time to build rapport and trust and emphasize privacy and confidentiality. Also, considered important was giving some time to survivors to process and share their story instead of rushing to get to the point.
- 9) Provide culturally sensitive safety planning to IMR survivors. According to the participants, the service providers working with IMR survivors must be aware of survivors' background, their culture and provide advice that fits what they want. Also, there is need for bilingual professionals to assist with safety planning of IMR survivors. A culturally-informed safety planning need was highlighted by a Hmong practitioner: *“In our community, the violence doesn't happen just from her partner,” but her family, her partner's family also. Then we have to do additional safety planning for her around the family” (Eve, Hmong Focus Group Practitioner).*
- 10) Make safety planning an ongoing process. Safety planning was not a short-term onetime event for survivors. It needed to be an ongoing process addressing not just immediate safety needs but also future safety needs. The strategies shared were doing wellness checks, calling survivors periodically to check on their progress, or sending services to women's homes to make sure everything is alright. *“Our safety planning needs to be ongoing, it needs to be dynamic and it's different for every survivor” (Acacia, Mexican Focus Group Practitioner).* Another practitioner shared: *“Our safety planning with our clients is pretty much at every stage. If you're going through the clan system, we safety plan. Once you're done with that, you're going to go through the court system, we safety plan. If you're going to file a restraining order, we safety plan” (Hli, Hmong Focus Group Practitioner).*
- 11) Talk to community leaders and the abuser. Some survivors highlighted the importance of educating the community and talking to community leaders for any abusive situation. Others

shared the importance of educating the abuser, counseling him when the woman is living separately, and make arrangements for him to attend classes on how to respect women.

Discussion

In this study, we found common and culturally specific risk and protective factors at multiple ecological levels that placed IMR women at perceived risk for re-assault, severe re-assault and homicide or protected them from re-assault, severe re-assault or homicide. While many of the risk and protective factors are similar to those found in previous research in US majority culture (e.g., physical abuse, jealousy, Campbell et al., 2003), others are specific to cultural norms or practices that the practitioners and survivors in our sample from their deep knowledge of IPV in their cultural context identified.

A patriarchal social structure with violence as a mechanism for the maintenance of power and control in intimate relationships is a principal theoretical foundation of research on gender based violence (Messing, Thaller, Ward-Lasher & Bagwell-Gray, 2015; Reed, Raj, Miller & Silverman, 2010). At the societal-level, this study found patriarchal cultural norms that relate to low social status of women, rigid gender role expectations, and normalization of violence against women as contributors of IPV among IMR women. A broad umbrella of “patriarchal ideology” that prescribes rules for women, places importance on male superiority, limits women’s rights, and views women as possessions was consistent across interviews, although it manifested itself differently in different cultures. For instance, women seen as property which is transferred to her husband through bride price in African cultures and dowry system in Indian culture. Previous research has noted that what is acceptable or unacceptable with regard to violence against women is inconsistent across cultures (Gustafson & Illuebbey, 2014; Kalunta-Crumpton, 2013) and part of that inconsistency is related to the extent of patriarchal norms in that society (Counts, Brown & Campbell, 1999).

Laws and regulations against IPV were mostly highlighted as protective for IMR women. US laws related to protective or no-contact orders, active police response to IPV, and strong actions on violation of protective orders (Dugan, Nagin, & Rosefield, 2003) are some examples of legal sanctions that could protect survivors from future revictimization. Previous research has demonstrated that, among Latinas, fear of deportation may keep them from reporting victimization to police; however, trust that the police will treat them fairly and not use excessive force is more important to crime reporting than fear of deportation (Messing, Becerra, Ward-Lasher & Androff, 2015). Providing information to survivors about criminal and civil legal options and their rights (as well as their abuser’s rights) within the US justice system may assist IMR survivors in reaching out to the police for support.

Cultural norms and fear of being ostracized prevent women from reporting to the police or accessing legal services (Horn, 2009; Shalabi et al., 2015). Thus, informal support networks may be more acceptable than seeking help from the police or legal sources due to experiences such as racial prejudice and discrimination. Some IMR survivors highlighted lack of support or inadequate support by resources in the community and indicated that this placed them at risk; others found enormous support from informal arenas such as elders and

church leaders in their communities, who readily supported and counselled them. The specific informal support that women access is important; similar to the findings of this research prior studies have found that religion can lead to women staying in abusive relationships or can be a coping mechanism to recover from abuse (Potter, 2007). Advocates can ensure that community leaders have appropriate information to assist women who disclose abuse to them.

Consistent with prior research, lack of support and social stigma can be barriers to help seeking among IMR women (Ahmad, Driver, McNally, & Stewart, 2009). We found that survivors who received support from counselors, police, health care providers, and victim advocates identified these sources of support as protective. However, unless practitioners are specifically trained and culturally appropriate, they may have limited knowledge of the cultural context and availability of resources for IMR women. Safety planning interventions must incorporate strategies on how to access safety nets and services without access to electronic communication. In addition, it is important to build survivors' confidence, self-esteem and empower them to garner a sense of independence for proactive steps towards addressing abuse. Furthermore, suggestions included taking time to build trust with the survivor, emphasizing privacy and confidentiality, and tailoring culturally sensitive, safety planning based on survivor's priorities. Training for practitioners that is held periodically could include updated information about resources and how to provide culturally-specific interventions to IMR survivors (O'Brien & Macy, 2016).

Similar to research among non-immigrant women, a partner's abusive behaviors – such as control, isolation, jealousy, severe physical abuse, and threats to kill – were identified as risk factors for re-assault, severe re-assault and homicide (Campbell et al., 2003). Unique to IMR survivors were threats of public humiliation; preference for a male child; the partners being from a different race, ethnicity, or tribe; and use of threats of deportation as means of control. IMR women are more vulnerable to IPV when they have uncertain or undocumented immigration status, lack of knowledge of the US system, and are far from their family. Fear of deportation, lack of English skills, and limited access to resources in the community lead to an inability to speak out against abuse and seek services (West, 2005).

An IMR woman's level of acculturation was identified as both a risk and protective factor. Acculturation or a woman perceived by the partner as behaving like an American can place her at risk when he sees it as a threat to his power in relationship (Kalunta-Crumpton, 2013). Yet acculturation can also serve a protective role because of women's knowledge of the available resources in the US and how to access them. Previous studies found an association between low levels of acculturation (e.g. separation level), related family stress, and decreased likelihood of actions to address IPV among immigrants (Paat, 2014; West, 2005). Use of personal strengths (e.g., being patient, optimistic), safety strategies, and seeking outside formal support protected women from future revictimization.

Despite the diversity of our sample in terms of countries of origin and cultural backgrounds, we found more similarities than differences in risk and protective factors for abuse and components to be included in safety planning interventions. It is, however, crucial to avoid a "one size fits all" approach and be culturally responsive to the unique needs of abused IMR

women in the US (Messing et al., 2015). How to best address cultural factors in caring for survivors of IPV, remains an area for further exploration. Even within a particular ethnic group, there is likely variation in degree of credence to gender norm expectations and tolerance of abuse. One strategy is to build on the positive aspects of cultural values and beliefs. For example, an HIV prevention intervention for Latinos used the common value of *machismo* to support safer sex behavior (Villarruel, Jemmott, & Jemmott, 2005). *Machismo* – refers not only to male chauvinism and dominance, but also being a provider and a protector for one's home. Condom use was encouraged as a way to protect oneself and partner. Similarly, service providers for survivors of IPV, can work with women to draw on what they believe are positive aspects of their respective cultures to guide their decision-making and actions for primary or secondary prevention of IPV.

IPV among IMR communities is influenced by living at the intersection of multiple forms of oppressions such as race, class, gender, and immigration status (West, 2005). Patriarchal cultural norms are overarching explanations for IPV; however, it is important to consider roles of multiple forms of oppressions related to being a minority and an immigrant, and how different factors at multiple contexts in women's lives contribute to IPV. Also important is not to classify IPV perpetrators in broad social terms with patriarchy as the only explanation (Dutton, 1994). IPV prevention efforts can be improved by focusing on specific characteristics of perpetrators of IPV and how these interact with culture (Dutton, 1994; Njie-Carr, 2014). This study provides important opportunities to strengthen policies, practice, and research. Specifically, survivors and providers expressed the importance of trusting relationships, so that over time survivors can feel comfortable discussing their IPV experiences. This provides opportunities for education and training for providers to be culturally sensitive to the needs of the IMR survivors. It also provides opportunities for long-term relationship building so IMR women's needs will be met holistically.

The role of health care providers in supporting survivors remains critical. Participants identified healthcare providers as a source of support. This reiterates the importance of providers not only routinely screening for IPV but also knowing how to appropriately respond. This study offers more information to help providers craft culturally appropriate and nonjudgmental ways of broaching the issue of IPV with a patient. In prior research, survivors highlighted the importance of being able to trust healthcare providers with IPV disclosure and to receive knowledgeable and nonjudgmental responses (Feder, Hutson, Ramsay, & Taket, 2006; Kelly, 2009).

This study provides information about factors in multiple levels of ecological contexts that must be considered in designing IPV prevention and intervention strategies for IMR women. Future studies can build on these findings by examining risk and protective factors for IPV and needs for safety planning interventions among other IMR groups of IPV survivors not included in this research. The findings can also be used in future research on designing and evaluating prevention and intervention strategies for IMR IPV survivors. Our findings could be considered in risk assessments and safety planning for IMR survivors in different settings (e.g., victim assistance programs, law enforcement agencies). Information on factors that can place IMR women at risk for future violence, as well as protective factors that may assist IMR women in guarding against future violence, can be used to design and implement

appropriate policies and measures to best cater to the needs of diverse groups of IMR survivors of IPV.

Given the critical role of structural societal factors in increasing vulnerabilities for IPV for women, it is important to ensure that structural interventions that include community and policy changes are integrated in IPV prevention and intervention efforts among IMR groups. Structural interventions may be more effective and sustainable; particularly, for IMR women with multiple structural challenges determined collectively or at the community level. While resources were available for IMR survivors, issues around survivors' eligibility to access resources regardless of their documentation status needs to be better disseminated. Part of these initiatives could be providing the information in multiple languages that represents most IMR populations as well as integrate it as part of all health and social service related women encounters. The strengths of the study include perspectives of diverse groups of IMR survivors and practitioners. A limitation was inclusion of only certain groups of IMR women and not IMR women from other regions of the world. However, factors such as gender inequality or patriarchy and immigration-related risk factors for IPV found in this study are most likely faced by IMR survivors of IPV from other regions. This research was based on self-report and is therefore limited by retrospective bias and participants' willingness to share information. Nonetheless, this study is an important contribution to the field on issues faced by IMR survivors of IPV in the US and their needs for services.

Acknowledgments

This work was supported by Eunice Kennedy Shriver National Institute for Child Health & Human Development (R01HD081179-01 AI); Dr. Sabri was supported by Eunice Kennedy Shriver National Institute for Child Health & Human Development (K99HD082350 and R00HD082350). The content is solely the responsibility of the authors and does not necessarily represent the official views of the National Institutes of Health.

References

- Adeyinka A, Chu T, Keatley E, & Rasmussen A (2013). Research on victim of intimate partner violence: Intimate partner violence among West African immigrants. *Journal of Aggression, Maltreatment, & Trauma*, 22, 109–126. doi: 10.1080/10926771.2013.719592
- Ahmad F, Driver N, McNally MJ, & Stewart DE (2009). "Why doesn't she seek help for partner abuse?" An exploratory study with South Asian immigrant women. *Social Science & Medicine*, 69(4), 613–622. doi:10.1016/j.socscimed.2009.06.011 [PubMed: 19576669]
- Akinsulure-Smith A, Chu T, Keatley E, & Rasmussen A (2013). Intimate partner violence among West African immigrants. *Journal of Aggression, Maltreatment & Trauma*, 22(2), 109–126. doi: 10.1080/10926771.2013.719592
- Amanor-Boadu Y, Messing JT, Stith SM, Anderson JR, O'Sullivan C, & Campbell JC (2012). Immigrant and non-immigrant women: Factors that predict leaving an abusive relationship. *Violence Against Women*, 18(5), 611–633 [PubMed: 22807500]
- American Immigration Council (2014). Immigrant women in the United States: A portrait of demographic diversity. Retrieved from <https://www.americanimmigrationcouncil.org/research/immigrant-women-united-states>
- Bernardes CM, Ray S, & Harkins D (2009). An exploratory study of resilience and coping strategies among portuguese-speaking immigrant women survivors of domestic violence. *American Journal of Psychological Research*, 5(1), 81–96.
- Braun V, & Clarke V (2006). Using thematic analysis in psychology. *Qualitative research in psychology*, 3(2), 77–101. doi: 10.1191/1478088706qp0630a

- Bronfenbrenner U (1979). The ecology of human development. Cambridge, MA: Harvard University Press.
- Campbell JC, Webster D, Koziol-McLain J, Block C, Campbell D, Curry MA, ... & Sharps P (2003). Risk factors for femicide in abusive relationships: Results from a multisite case control study. *American journal of public health*, 93(7), 1089–1097. [PubMed: 12835191]
- Campbell JC (2001). Safety planning based on lethality assessment for partners of batterers in intervention programs. *Journal of Aggression, Maltreatment & Trauma*, 5(2), 129–143.
- Centers for Disease Control and Prevention (2016). Surveillance for Violent Deaths - National Violent Death Reporting System, 17 States, 2013. Surveillance Summaries. Morbidity and Mortality Weekly Report, 65(10), 1–42. [PubMed: 26766396]
- Counts DA, Brown JK, & Campbell J (1999). To have and to hit: Cultural perspectives on wife beating. University of Illinois Press.
- Dugan L, Nagin DS, & Rosefield R (2003). Exposure reduction or retaliation? The effects of domestic violence resources on intimate partner homicide. *Law & Society Review*, 37(1), 169–198.
- Dutton DG (1994). Patriarchy and wife assault: The ecological fallacy. *Violence and victims*, 9(2), 167–182. [PubMed: 7696196]
- Faugier J (1997). Sampling hard to reach populations. *Journal of Advanced Nursing*, 26(4), 797.
- Feder GS, Hutson M, Ramsay J, & Taket AR (2006). Women exposed to intimate partner violence: Expectations and experiences when they encounter health care professionals: A metaanalysis of qualitative studies. *Archives of Internal Medicine*, 166, 22–37. [PubMed: 16401807]
- Frye V, Hosein V, Waltermaurer E, Blaney S, & Wilt S (2005). Femicide in New York City: 1990 to 1999. *Homicide Studies*, 9(3), 204–228.
- Gustafson DT, & Illuebbey V (2013). “Traditional discipline” or domestic violence: Participatory action research with Sudanese refugee community. *Journal of Cultural Diversity*, 20(2), 51–56.
- Hagaman AK, & Wutich A (2017). How many interviews are enough to identify metathemes in multisite and cross-cultural research? Another perspective on Guest, Bunce, and Johnson’s (2006) Landmark Study. *Field Methods*, 29(1), 23–41. doi: 10.1177/1525822X16640447
- Heise LL (1998). Violence against women an integrated, ecological framework. *Violence Against Women*, 4(3), 262–290. [PubMed: 12296014]
- Heise LL, & Kotsadam A (2015). Cross-national and multilevel correlates of partner violence: An analysis of data from population-based surveys. *Lancet Global Health* 3: e332–40 [PubMed: 26001577]
- Horn R (2009). Responses to intimate partner violence in KaKuna refugee camp: Refugee interactions with agency systems. *Social Science and Medicine*, 70, 160–168. [PubMed: 19846247]
- Hyman I, Mason r., Guruge S, Berman H, Kanagaratnam P, Manuel L (2011). Perceptions of factors contributing to intimate partner violence among Sri Lankan tamil immigrant women in Canada. *Health Care for Women International*, 32, 779–794. doi: 10.1080/07399332.2011.569220 [PubMed: 21834718]
- Kalunta-Crumpton A (2013). Intimate partner violence among immigrant Nigerian women in the United States: An analysis of internet commentaries on the murders of nine Nigerian women by their male spouses. *International Journal of Law, Crimine, and Justice*, 41, 213–232.
- Kelly UA (2009). I’m a mother first”: The influence of mothering in the decision-making processes of battered immigrant Latinowomen. *Research in Nursing & Health*, 32, 286–297. [PubMed: 19350663]
- Koenig MA, Stephenson R, Ahmed S, Jejeebhoy SJ, & Campbell JC (2006). Individual and contextual determinants of domestic violence in North India. *American Journal of Public Health*, 96, 132–38 [PubMed: 16317213]
- Krug EG, Mercy JA, Dahlberg LL, & Zwi AB (2002). The world report on violence and health. *The lancet*, 360(9339), 1083–1088.
- Mallorymm AB, Dharnidharka P, Deitz SL, Barros-Gomes P, Cafferky B, Stith SM, & Van K (2016). A meta-analysis of cross cultural risk markers for intimate partner violence. *Aggression and Violence Behavior*, 31, 116–126.

- Messing JT, Ward-Lasher A, Thaller J, & Bagwell-Gray ME (2015). The state of intimate partner of intimate partner violence intervention: Progress and continuing challenges. *Social Work*, 60(4), 305–313. doi:10.1093/sw/swv027.
- Messing JT, Amanor-Boadu Y, Cavanaugh CE, Glass NE, & Campbell JC (2013). Culturally competent intimate partner violence risk assessment: Adapting the danger assessment for immigrant women. *Social Work Research*, 37(3), 263–275. doi: 10.1093/swr/svt019
- Messing JT, Becerra D, Ward-Lasher A, & Androff DK (2015). Latinas' perceptions of law enforcement: Fear of deportation, crime reporting, and trust in the system. *Affilia*, 30(3), 328–340. doi: 10.1177/0886109915576520
- Messing JT & Campbell JC (2016). Informing collaborative interventions: Intimate partner violence risk assessment for front line police officers. *Policing: A Journal of Policy & Practice*, 10(4), 328–340.
- Messing JT, O'Sullivan C, Cavanaugh CE, Campbell JC (2017). Are abused women's protective actions associated with reduced threats, stalking, and violence perpetrated by their male intimate partners? *Violence Against Women*, 23(3), 263–286. [PubMed: 27118689]
- Messing JT, Ward-Lasher A, Thaller J, Bagwell-Gray M (2015). The state of intimate partner violence intervention: Progress and continuing challenges. *Social Work*, 60(4), 305–313. [PubMed: 26489351]
- National Center for Health Statistics (2016). *Health 2016. With Special Feature on Racial and Ethnic Disparities*. Hyattsville, MD: US Department of Health and Human Services.
- Njie-Carr V (2014). Violence experiences among HIV-infected women and perceptions of male perpetrators roles: A concurrent mixed method study. *Journal of Association of Nurses in AIDS Care*, 25(5), 376–391. doi: 10.1016/j.jana.2013.11.002
- O'Brien JE, & Macy RJ (2016). Culturally specific interventions for female survivors of gender-based violence. *Aggression and Violent Behavior*, 31, 48–60.
- Paat Y (2014). Risk and resilience of immigrant women in intimate partner violence. *Journal of Human Behavior in the Social Environment*, 24, 725–740. doi: 10.1080/10911359.2013.853018
- Reed E, Raj A, Miller E, & Silverman JG (2010). Losing the “gender” in gender-based violence: The missteps of research on dating and intimate partner violence. *Violence Against Women*, 16(3), 348–354. [PubMed: 20133922]
- Rosenthal L, & Levy SR (2010). Understanding women's risk for HIV infection using social dominance theory and the four bases of gendered power. *Psychology of Women Quarterly*, 34, 21–35. doi: 0361-6843/10
- Pinnewala P (2009). Good women, martyrs, and survivors: A theoretical framework for South Asian women's responses to partner violence. *Violence against women*, 75(1), 81–105. doi: 10.1177/1077801208328005
- Potter H (2007). Battered black women's use of religious services and spirituality for assistance in leaving abusive relationships. *Violence Against Women*, 13(3), 262–284. doi: 10.1177/1077801206297438 [PubMed: 17322271]
- Runner M, Yoshihama M, & Novick S (2009). Intimate partner violence in immigrant and refugee communities: Challenges, promising practices and recommendations. Retrieved from https://www.futureswithoutviolence.org/userfiles/file/ImmigrantWomen/IPV_Report_March_2009.pdf
- Sabri (2014). Domestic violence among South Asian women: An ecological perspective In Taylor M & Pooley JA (Eds). *Overcoming domestic violence: Creating a dialogue around vulnerable populations*. New York: Nova Science Publishers.
- Sabri B Campbell JC, & Dabby FC (2016). Gender differences in intimate partner homicides among ethnic subgroups of Asians. *Violence Against Women*, 22 (4), 432–453. [PubMed: 26391620]
- Sabri B, Sanchez MV, & Campbell JC (2015). Motives and characteristics of domestic violence homicides and suicides among women in India. *Health care for women international*, 36(7), 851–866. doi: 10.1080/07399332.2014.971954 [PubMed: 25383682]
- Sandelowski M (1995). Sample size in qualitative research. *Research in Nursing & Health*, 75(2), 179–183.

- Shalabi D, Mitchell S, Anderson N (2015). Review of gender violence among Arab immigrants in Canada: Key issues for prevention efforts. *Journal of Family Violence*, 30, 817–825. doi: 10.1007/s10896-015-9718-6.
- Stewart DE, Gagnon A, Merry LA, Dennis C (2012). Risk factors and health profiles of recent migrant women who experienced violence associated with pregnancy. *Journal of Women's Health*, 27(10), 1100–1106. doi: 10.1089/jwh.2011.3415
- Stith SM, Rosen KH, McCollum EE, & Thomsen CJ (2004). Treating intimate partner violence within intact couple relationships: Outcomes of multi-couple versus individual couple therapy. *Journal of Marital and Family Therapy*, 30(3), 305–318. [PubMed: 15293649]
- Stith SM, Smith DB, Penn CE, Ward DB, & Tritt D (2004). Intimate partner physical abuse perpetration and victimization risk factors: A meta-analytic review. *Aggression and violent behavior*, 10(1), 65–98. doi: 10.1016/j.avb.2003.09.001
- Tonsing JC (2016). Domestic violence: Intersection of culture, gender and context. *Journal of Immigrant and Minority Health*, 18(2), 442–446. doi: 10.1007/s10903-015-0193-1 [PubMed: 25774039]
- Villarruel AM, Jemmott LS, & Jemmott JB (2005). Designing a culturally based intervention to reduce HIV sexual risk for Latino adolescents. *Journal of the Association of Nurses in AIDS Care*, 16(2), 23–31 [PubMed: 16438123]
- West C (2005). The “political gag order” has been lifted: Violence in ethnically diverse families In Sokoloff NJ (with Pratt C; Eds.), *Domestic violence at the margins: Readings in race, class, gender, and culture*. Piscataway, NJ: Rutgers University Press
- World Health Organization London School of Hygiene and Tropical Medicine (2010). *Preventing intimate partner and sexual violence against women: Taking action and generating evidence*.
- Zeigler K, & Camarota SA (2015). *Immigrant Population Hits Record 42.1 Million in Second Quarter of 2015*. Center Immigration Studies, Washington, DC.

Figure 1.
An Ecological Framework for Common Risk and Protective Factors for Intimate Partner Violence Among Immigrant and Refugee Women

Figure 2.
An Ecological Framework for Culturally Specific Risk and Protective Factors for Intimate Partner Violence Among Immigrant and Refugee Women

Table 1

Sociodemographic Characteristics of Survivors

	Mean	Standard Deviation
Age	37.1	10.9
Number of Children	2.46	2.07
	%	N
Employment (Yes)	61.5	72
Race		
Asian ¹	42.9	28
Latina/Hispanic ²	11.1	30
Black/African ³	35.8	30

¹ Note: Asian ethnic groups included 28 foreign-born survivors from Philippines ($n=11$), India($n=8$), Pakistan($n=2$), Laos($n=8$), Thailand ($n=1$), & 2 Hmong US-born second generation immigrants;

² Latina ethnic groups were foreign-born from Mexico ($n=10$), Jamaica($n=1$), Dominican Republic($n=7$), Puerto Rico($n=1$), El Salvador($n=4$), Honduras($n=1$), Peru($n=1$), Guatemala($n=3$), and Colombia($n=1$);

³ African ethnic groups were from the Great Lakes Region of Africa including Democratic Republic of Congo($n=7$), Rwanda($n=3$), Burundi ($n=1$), Nigeria($n=1$), Uganda($n=1$), Somalia($n=7$), Kenya($n=1$) and Ethiopia ($n=2$).

Table 2

Sociodemographic Characteristics of Practitioners

	Mean	Standard Deviation
Age	43.9	13.67
	%	N
Race		
Asian ¹	32.4	33
Latina/Hispanic ²	28.5	28
Black/African ³	32.3	33
White/Caucasian	5.9	6
Multiracial	1.0	1
Professional Background		
Advocate/Provider	60.6	37
Upper Management ⁴	19.5	12
Other ⁵	19.2	12

¹ Asian ethnic groups included those who self-identified as Asian belonging to groups such as Hmong, Filipinos, Vietnamese, Thai, Indian, and Japanese American.

² Latina/Hispanic included those from Puerto Rico, Mexico, and regions in Caribbean, Central America and South America.

³ Black/African Americans included practitioners from countries such as Somalia, Uganda, Bosnia, Burundi, Kenya, Democratic Republic of Kenya and Ethiopia.

⁴ Upper management included those in positions such as Director, Associate Director or Assistant Director.

⁵ The “other” category included professions such as public prosecutor, social worker, pastor, cultural health navigator, and program specialist.