Navigating culture: An exploration of domestic violence and abuse resource provision to the Harrisonburg Iraqi Refugee Community

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Navigating Culture: An Exploration of Domestic Violence and Abuse Resource Provision to the
Harrisonburg Iraqi Refugee Community

An Honors College Project Presented to
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by Kaitlin Michelle Holland
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Introduction

In 2016 the number of people forcibly displaced worldwide reached more than 60 million; the largest number recorded since the end of World War II. Of these 60 million, 20 million are refugees, meaning that they have been displaced outside of their home countries due to war, conflict, or persecution (Nikolau, 2016). Internally displaced persons and asylum seekers make up the remaining 40 million forcibly displaced people. Refugees flee from their country of origin to a second country that offers them temporary asylum. Refugee resettlement involves the relocation of refugees from this secondary asylum country to a third country that offers permanent relocation and guarantees them rights similar to country nationals (United Nations High Commissioner for Refugees). Only about 1% of the total refugee population is recommended for resettlement each year. The United Nations High Commissioner for Refugees (UNHCR), which leads the search for durable solutions for refugees, recommends that the remaining 99% of refugees not eligible for resettlement either voluntarily return to their home country, or integrate into their country of first asylum (Adess et al., 2009).

The United States first started accepting refugees in the aftermath of World War II, resettling 250,000 displaced Europeans unable to return home after the end of the war. The Displaced Persons Act of 1948 allowed for an additional 400,000 displaced Europeans, and was the first official piece of legislation addressing refugees. In the decades following, the U.S. did not have a standardized resettlement process. Rather they passed individual laws allowing for specific groups to be resettled in the U.S. as the need arose, mostly resettling refugees from former Communist regimes in China, Cuba, Hungary, Korea, Poland, and Yugoslavia (Refugee Council USA).
Our modern standardized system of resettlement began after the fall of Vietnam in 1975. The U.S. formed an ad hoc Refugee Task Force with temporary funding that resettled over 100,000 refugees from Southeast Asia. The experience of a temporary program addressing such a large influx of refugees led Congress to pass the Refugee Act of 1980, which standardized the resettlement services provided to refugees and provided the legal basis for our ongoing refugee admissions program (Gilmore; Office of Refugee Resettlement; Refugee Council USA).

The U.S. has continued to resettle refugees in the years since, historically leading the world in the number of refugees resettled (United Nations High Commissioner for Refugees). The President and Congress set an admissions ceiling of refugees per fiscal year, determining the maximum number of resettlements allowed. The number of refugees admitted per fiscal year fluctuates with the admissions ceiling and is usually a reflection of the current political climate of the country. Although refugee admissions ceilings and policies are changing under President Trump, the U.S. has a rich history of integrating refugees into local communities. As such, about 3 million refugees have been resettled in the U.S. since 1980 (Krogstad & Radford, 2017).

Iraqi refugees are one such group that have been admitted since the passing of the Refugee Act of 1980. Resettlement began in the 1990’s when approximately 10,000 Iraqi refugees were admitted to the U.S. after the Gulf War. These refugees were mainly Kurds who were experiencing persecution due to their minority status in Iraq and Muslim Shi’a’s who participated in an uprising against Saddam Hussein in 1991 (Kobel, 2000). The biggest waves of Iraqi migration occurred during and after the Iraq War. Refugees began leaving the country in force after the 2006 bombing of the Al-Askari Mosque. The bombing resulted in an increase in sectarian and ethnic violence that displaced Iraqis across the country (Government...
Accountability Office). However, the U.S. did not resettle large numbers of Iraqi refugees until 2008; after increased pressure from advocacy groups and international reporting brought light to America’s role in the invasion and the plight of refugees. Iraqi migration continues today due to violence and insecurity related to the rise of the jihadist group “The Islamic State in Iraq and the Levant” (ISIL), though at much lower levels than during the Iraq War (Watson Institute for International and Public Affairs, 2016). As of 2014, the U.S. had resettled more than 110,000 refugees originally from Iraq (Bureau of Population, Refugees, and Migration, 2014).

The process of resettlement to the U.S. begins when refugees register with the UNHCR in their country of first asylum. Only those refugees that meet resettlement criteria are referred to the United States Refugee Admissions Program, or USRAP. The 11 eligibility criteria for Iraqi refugees are as follows:

1. Survivors of torture and violence, including sexual and gender-based violence
2. Members of minority groups and persons targeted due to their ethnicity or sect
3. Women at risk in country of asylum
4. Unaccompanied or separate children
5. Dependents of refugees living in resettlement countries
6. Elderly refugees
7. Refugees with medical needs
8. High profile cases
9. Iraqis who fled due to their association with the U.S. or other foreign institutions
10. Stateless persons
11. Refugees at risk for refoulment.
Once a refugee has received a referral, the Bureau of Population, Refugees, and Migration begins the process of intake interviews in the refugee’s asylum country. These interviews are to confirm that a refugee’s persecution claim is well founded. Then medical clearance, security checks, and placement with a voluntary agency, or VOLAG, in the U.S. are all required before travel plans are made (Adess et al., 2009).

Besides asylee or refugee status, some Iraqis are eligible to come to the U.S. through Special Immigrant Visas, or SIVS. The SIV program was created to assist Iraqi nationals who worked with the U.S. military during the war in Iraq. There are two types of SIV programs. The first SIV program is for Iraqis who were employed by/on the behalf of the U.S. government. The program was active from 2008 to 2014, and for every year of its existence allowed for 5,000 SIVs to be issued to Iraqi employees and contractors that were being threatened due to their assistance to the U.S. during the war. The second SIV program applies to Iraqi/Afghan Translators and Interpreters and began in 2006. This currently active program allows for the issuance of 50 SIVs a year and does not require a proof of threat due to service. SIV holders can apply to be placed with a VOLAG in the U.S., and are eligible for the same resettlement services and benefits that cover refugees for their first 8 months after arrival if they accept them during their resettlement application (U.S. Department of State).

In the U.S. there are nine VOLAGs that provide resettlement placement and services to refugees. Although these agencies are non-profit agencies, they have cooperative agreements with the government to provide resettlement placement and services. VOLAGs determine where refugees will be resettled upon their arrival. If a refugee has family in the United States effort will be made to place them nearby. If this is unfeasible, refugees are placed in a community that
has resources available that best match their needs. Resettlement sites are evaluated on the availability of affordable housing, interpreters in the needed language, schools with appropriate ESL programs, medical care, English classes, and employment services (U.S. Department of State).

Upon arrival to the United States, refugees are met by a representative of their VOLAG or a family member. The cost of their travel to the U.S. is provided on a loan that refugees are required to pay back once they’ve established their lives in the U.S. Housing has been arranged by their VOLAG and contains basic furnishings, weather appropriate clothing, and food similar to that of the refugees’ home culture. VOLAGs continue to assist refugees with adjusting to life in the U.S. by helping refugees apply for a social security card, learn how to use public transportation, register children in school, buy groceries, and start English classes, among other case management tasks (U.S. Department of State).

Refugees are eligible for all social service programs that U.S. citizens are once they arrive in the U.S. The resettlement program’s goals are to “assist in the successful social integration of refugee populations, as soon as possible after their arrival in the U.S., into the communities where they are resettled and to do this with an emphasis on attaining the earliest durable economic self-sufficiency for individuals and families (Office of Newcomer Services, 2011).” Programs available include Temporary Assistance for Needy Families (TANF), Medicaid, Family Access to Medical Insurance Security (FAMIS), Supplemental Nutritional Assistance Program, Energy Assistance Program, and the General Relief Program. If a refugee does not meet TANF, Medicaid, or TAMIS requirements, then for a limited time they are
available for the Refugee Cash Assistance (RCA) and Refugee Medical Assistance (RMA) Programs.

The Refugee Cash Assistance program is for those refugees who meet the financial requirements of TANF, but do not meet other requirements. For example, TANF is only for couples who have children. Therefore, refugees who qualify for TANF financially but don’t have children would qualify for the Refugee Cash Assistance Program. Similarly, the Refugee Medical Assistance (RMA) program is for refugees who meet the financial criteria for Medicaid, but do not meet a non-financial requirement. A 19-year-old refugee would not qualify for Medicaid because he/she is a legal adult, but would qualify for RMA (Office of Newcomer Services, 2011). However, there is an eight-month time limit for both RCA and RMA, beginning upon arrival. If by the end of eight months refugees do not qualify for Medicaid and are unable to afford health insurance on their own, they are left without insurance. In 2010, the Affordable Care Act expanded Medicaid to cover all people who qualify based on income, regardless of family status, disability, or household size (U.S. Centers for Medicare and Medicaid Services, 2012). However, the Supreme Court decision in National Federation of Independent Business v. Sebelius determined that Medicaid expansion was not mandatory and left it up to the individual states to determine if they would expand Medicaid or not (Rosenbaum & Westmoreland, 2012). Therefore, whether or not a refugee has access to Medicaid after their eight months of RMA are finished is dependent on which state they were placed in. If their resettlement state has not expanded Medicaid, they are left without health insurance unless they can afford it on their own.

Refugees who experience this coverage gap after eight months are left in a very vulnerable position. Iraqi refugees in particular exhibit higher rates of chronic illnesses like
cardiovascular disease, diabetes, and high lipid profile than other refugee groups from Africa and Asia (Taylor et al., 2014). Chronic medical conditions that are left uncontrolled or untreated are dangerous themselves, but chronic conditions are also a risk factor for developing mental health illnesses (Mayo Clinic Staff, 2015). Since the passing of the Mental Health Parity and Addiction Equity Act in 2008, most Medicaid and insurance programs have been required to cover mental health services (American Psychological Association). However, if you are a refugee in a coverage gap, you cannot see mental health practitioners, counselors, or utilize any other mental health services that require insurance. This is very detrimental to refugee health, as the migration and resettlement experiences can significantly impact mental health.

**Refugees and Mental Health**

Coverage of mental health care for refugees is exceptionally important, as the refugee experience uniquely impacts mental health. Refugees are at a substantially higher risk of developing mental health disorders than other migrants from their own ethnic groups, as well as the general public of their resettlement countries (LeMaster et al., 2017; Kirmayer et al., 2011). Specifically, they are far more likely to develop post-traumatic stress disorder (PTSD), major depressive disorder, and anxiety disorders. When compared to the general population, refugees have been found to develop PTSD at ten times the average rate (Kirmayer et al., 2011). Other common mental health problems reported by refugees include sleep disorders, chronic pain, substance abuse problems, and other somatic symptoms of mental health disorders (Pottie et al., 2011; Kirmayer et al. 2011; Jaranson, Martin, & Ekblad, 2002).
There are many reasons that refugees experience such high rates of mental health disorders. Torture and cumulative trauma, both common among refugees from countries who have experienced war, are the strongest predictors of PTSD and are associated with chronic physical and mental health conditions (Pottie et al., 2011). However, the entirety of the migration process affects mental health as well. Factors of the pre-migration, migration, and post-migration stages all contribute to the risk of developing mental health disorders (Jaranson, Martin, & Ekblad, 2002).

In the pre-migration and migration phases of resettlement, the degree of trauma experienced correlates with the category of refugee experience individuals fall into: either anticipatory or acute. Anticipatory refugees see the danger of their situation early, allowing them more time to plan for departure and bring resources with them. Acute refugees do not plan their departure in advance and usually migrate when the danger becomes too great for them to remain in their home country. Acute refugees usually experience greater stress due to higher exposure to violence and torture. Leaving family members behind during migration, experiencing starvation and malnutrition during travel, head trauma, and injuries sustained during migration can also negatively affect mental health (Dow, 2011; Jaranson et al., 2002). Pre-migration trauma has been associated with increased incidence of PTSD and depressive symptoms upon arrival to the U.S. by Iraqi refugees, as well as decreased acculturation during follow-up a year post-resettlement (LeMaster et. al., 2017).

Many post-migratory stressors compound the trauma experienced prior to arrival in a resettlement country. Acculturative stress is experienced by refugees while trying to adjust to life in a new culture, usually very different from the culture they have previously spent their entire
lives in. Housing, clothing, diet, and mannerisms may all be different from their home culture, causing distress during adaptation. If their resettlement state has not expanded Medicaid, refugees have only eight months to find employment before government provided healthcare and financial support ends, creating stress about how to pay bills and afford healthcare (Yako & Biswas, 2014). Furthermore, refugees are job searching while navigating unfamiliar education, legal, and healthcare systems, as well as learning a new language. Stressful life situations are a known risk factor for developing mental illness (Mayo Clinic Staff, 2015). Many refugees left communities where they were highly respected and had strong social support systems, and now feel socially isolated away from friends and family (Morris, Popper, Rodwell, Brodine, & Brouwer, 2009). Having few friends is an additional risk factor for developing mental illness (Mayo Clinic Staff, 2015). Fear of repatriation due to misunderstanding of what rights refugee status entails may further compound pre-migratory stressors (Pottie, et. al., 2011). Additionally, ongoing conflict in the country of origin has also been associated with poor mental health in refugees, due to worries about family members and friends left behind (Slewa-Younan, Guajardo, Heriseanu & Hasan, 2015).

**Domestic Violence and Mental Health**

However, not only refugee-specific experiences effect the mental health of refugees after resettlement. Domestic violence and abuse (DVA) is experienced by the general population of western countries as well as by resettled refugees and can substantially influence mental health. The U.S. Department of Justice defines domestic violence as “a pattern of behavior in any relationship that is used by one partner to gain or maintain power and control over another
intimate partner.” It encompasses physical, sexual, emotional, economic, and psychological aspects of abuse (U.S. Department of Justice). This definition encompasses physical abuse as well as controlling behaviors, such as a partner forbidding contact with friends and family, limiting time outside the house, and controlling finances. Another definition from the World Health Organization defines intimate partner violence as the “experience of one or more acts of physical and/or sexual violence by a current or former partner since the age of 15 years” and emotional, economic, and psychological abuse to be intimate partner abuse (WHO, 2013). For the purposes of this paper, domestic violence and abuse will be used to refer to all aspects of an abusive intimate relationship, whereas domestic violence will only refer to physical and sexual violence. DVA affects couples of all genders, sexualities, and marital status. However, this paper will focus on married, refugee women experiencing DVA from their husbands post-resettlement to the U.S.

The experience of domestic violence and abuse is significantly detrimental to mental health. Women who have experienced domestic violence present with higher levels of PTSD than women who have experienced other types of trauma (Howard, Trevillion, & Agnew-Davies, 2010). One study of mental health service users has found that users who have experienced DVA have a risk of PTSD seven times higher than those who have not, and a risk of depressive disorders three times higher than normal levels (Trevillion, Corker, Capron, & Oram, 2016). In addition to PTSD and depression, domestic abuse has been strongly associated with suicidal behavior, sleep and eating disorders, and social dysfunction; all mental health problems that refugees tend to develop as well (Howard et al., 2010). Multiple risk factors for mental health disorders contribute to a higher likelihood of developing a mental health disorder than one risk factor alone.
Domestic violence and abuse has serious physical health consequences in addition to its mental health consequences. Forty-two percent of women worldwide experiencing domestic violence were physically injured by their partner. In the US, however, this number is estimated to be fifty percent. The most common types of injuries included head, neck, and facial trauma, followed by musculoskeletal and genital trauma. In addition to physical violence, DVA has been associated with an increased risk of unwanted pregnancies, contracting HIV and other STI’s, and low birth weight and premature babies. The psychological trauma and stress from DVA have been shown to increase substance abuse, that then leads to cardiovascular disease and hypertension. Additionally, somatoform symptoms of mental health disorders can include irritable bowel syndrome and chronic pain (WHO, 2013). Figure 1 below illustrates a few pathways that lead to death and disability for those experiencing intimate partner violence.
**Figure 1.** Illustration of the relationships between intimate partner violence and death and disability. Intimate partner violence has been shown to negatively affect all aspects of health and wellbeing (WHO, 2013).

Furthermore, mental illnesses, no matter the cause, are a leading cause of disability (Mayo Clinic Staff, 2015). If the goal of the refugee resettlement program is to achieve self-sufficiency for refugees, mental illnesses must be taken seriously and treated. As such, known risk factors of mental illnesses must be prevented as well as treated after they’ve occurred.
Unfortunately, even when domestic violence and abuse resources are available, refugees experience unique barriers that hinder their use.

**Barriers to Accessing Resources**

**Language Barriers:**

Although there are many domestic violence and abuse shelters, agencies, and therapeutic resources available in the U.S. to aid survivors, refugees have specific barriers to these resources that most programs are not adequately equipped to address. Language plays a vital role in communication with first responders, police, survivor advocates, counselors, and doctors. Refugees who are not native-speakers of their resettlement country’s language have a distinct disadvantage when trying to access healthcare and mental health counseling resources. In the U.S., Emergency Medical Services crews (such as ambulances and air care) and hospitals are required to provide access to an interpreter for individuals with low English proficiency. However, this mandate does not guarantee an in-person interpreter. Researchers from the Joint Commission sampled 60 hospitals nationally in 2007 in a study of how hospitals provide language and cultural services to patients. Ninety-eight percent of hospitals sampled provide telephone interpretation services upon request by a patient (Wilson-Stronks & Glavez, 2007). Although language line services provide an essential service to pre-hospital and hospital providers, they are not perfect. Telephone interpretation does not include the interpretation of the patient’s body language, a crucial component of communication. And in a study published by the American Academy of Pediatrics in 2012, all participants indicated that they preferred in-person interpretation over telephone-based interpretation services due to increased communication and
rapport that in-person interpretation provided. Increasing rapport between patients and medical staff is vital in refugee communities, as the greater the trust between a refugee and their clinician, the more likely that the refugee will disclose concerns and ask clarifying questions (Kroening, Moore, Welch, Halterman, & Hyman, 2016).

In-person interpretation is important, however accurate interpretation is imperative. In the Joint Commission study referenced above, eighty-eight percent of hospitals sampled provided interpretation through bilingual staff members; however, only fifty-three percent of those hospitals trained or assessed their staff members’ abilities. Inaccurate translations can cause dangerous medical misunderstandings. Additionally, only thirty-eight percent of hospitals employed their own in-house interpreters, separate from medical staff members (Wilson-Stronks & Glavez, 2007). This lack of appropriate translators can negatively affect interactions between refugees seeking medical care and their medical providers after a domestic violence incident and discourage survivors from seeking care.

When interpreters cannot be located in a time efficient manner during medical emergencies, often the closest “interpreters” available are the children of refugees. Children or younger family members often acculturate and learn the host country’s language faster than their parents and older family members (Marshall, Butler, Roche, Cumming, & Taknint, 2016). However, this practice poses many barriers to proper treatment. Children are generally unfamiliar with medical and counseling terms used by care providers and therefore cannot properly translate them. Additionally, older family members typically do not share sensitive or personal information with children or family members of the opposite gender. Younger family often do not feel comfortable questioning their elders for this information; even when requested
to do so by care providers. Therefore, information integral for proper diagnosis and treatment may be left untranslated. Finally, untrained interpreters tend to summarize what the patient stated rather than providing a direct translation of their statement. This trend can lead to misunderstandings that can again negatively impact the care of the patient (Singh, McKay, & Singh, 1999).

Even when trained interpreters are provided, this does not guarantee understanding between patients and providers. Interpreters must understand the ethnic culture that the patient comes from. Cultural connotations of words can be lost in translations that are technically correct but do not convey a cultural meaning (Singh et al., 1999). Expressions, mannerisms, and behaviors are all culturally derived and can be misinterpreted by interpreters unfamiliar with the refugees’ native culture, mainly impacting mental health counseling. Even within cultures there is a lot of variation among communication styles due to differences in socio-economic status, age, gender, and religion. These differences impact word choices, how clients conceptualize concepts, and how clients interact with therapists. Interactions between clients and therapists may be culturally related, such as how much eye contact clients use or how far away they sit from providers. These actions are subtle, but they impact how providers perceive their clients (Harmerdinger & Karlin, 2003).

Cultural Barriers:

Communication is heavily based in culture. However, other cultural barriers besides language can prevent refugees from seeking care or help when experiencing domestic violence and abuse. There is a social stigma about mental illness in Iraq that appears to be greater than in other parts of the world. A study in Baghdad found that approximately two-thirds of respondents
stated that mental illness is due to personal weakness, and four-fifths believed that individuals with mental illness were to blame for their disorder. Half of respondents believed that people with mental illness are dangerous and should not marry. Finally, more than half reported they would be ashamed if a family member had a mental illness (Bolton, 2013). Some of that community stigma has persisted among the resettled Iraqi community in the U.S. and discourages survivors of DVA with mental illness to pursue treatment. Additionally, the Iraqi community generally associates the treatment of mental health disorders solely with prescription drugs as psychotherapies are not widely used in Iraq. This can also create confusion about what treatment of a mental health disorder looks like in the U.S., as cognitive behavior therapy, narrative therapies, and other psychotherapies are widely used in conjunction with prescription drugs.

Culture also widely dictates what is considered acceptable behavior within a relationship or marriage. In the U.S., one partner limiting another partner’s ability to leave the house is considered domestic abuse. However, in Iraq, women routinely need permission from a husband or male relative to participate in activities outside the home (Organization for Economic Cooperation and Development). Male heads of household (including fathers, brothers, and husbands) can unilaterally dictate whether a woman can participate in the job market, go to school, and even who she chooses for a husband. Women routinely need permission from male heads of household to participate in economic activities, because female participation in the workforce can challenge traditional views of males as breadwinners (United Nations Development Programme, 2012). In addition to views about controlling behaviors, views as to whether violence is acceptable in relationships can also differ. The United Nations Children’s Fund (UNICEF) reports in their 2011 study on gender equality that fifty-nine percent of women
in Iraq aged 15-49 think that a husband is justified in hitting or beating his wife under certain circumstances (United Nations Children’s Fund, 2011). Therefore, community member’s norms and social attitudes create the first barrier to refugees accessing resources to help with DVA (Robert Wood Johnson Foundation, 2009). If DVA is normal behavior within a community, there is no community support available to those trying to leave relationships or seek mental health care for their situation. There may even be active resistance by community members as women are seen as going against social norms.

Financial Barriers:

Finally, financial factors can limit all victims of DVA from leaving abusive relationships; however, refugee’s situations may exacerbate the issues. Leaving an abusive partner can be very expensive. Expenses can include attorney’s fees, housing and utilities deposits, transportation, and childcare. Households must be restarted, and basic items must be replaced such as sheets, towels, cooking equipment, and other basic household supplies (Grigsby & Hartman, 1997). These financial barriers are exacerbated if you have never had a job or dealt with finances before. As stated by Ms. Emira Habiby Brown, a social worker who works with the Arab community in New York, “In Arab culture, women are brought up to be dependent. In America, women are expected to be more independent. This cultural difference has made it a challenge to develop programming that deals with women’s issues (NASW, New York City Chapter, 2000).” Imagine being expected to find a job, find new housing, and pay bills for the first time in your life, without any community support because your refugee community is shunning you for leaving your husband. In addition, you must now pay someone for childcare while you work, you are also still learning a foreign language, working out the local public transportation system, and
potentially have experienced trauma during your migration. Financial barriers and cultural barriers together may make the idea of leaving an abusive partner seem worse than staying for some women.

**Suggestions for Improving Mental Health and DVA Treatment in Refugee Communities**

Cultural Brokers have been suggested to improve communication between refugees and medical professionals. Cultural Brokers are trained interpreters who are accustomed to one or more minority cultures as well as the mainstream culture of the resettlement country. Generally, cultural brokers are of the same culture of the refugees that they work with, but can be of a different ethnic background as long as they have intimate knowledge of their client’s culture. Specifically, they’re familiar with a certain refugee group’s cultural views of mental health and illness, as well as the Western medicine view and treatment of that illness. Therefore, they can communicate the nuances of the patient’s complaint in terms of their culture to a clinician, as well as educate the patient on how the clinician view’s their complaint. Regular interpreters may not have knowledge of cultural concepts, rituals, and beliefs that patients hold about diseases, disorders, and mental health problems. Cultural brokers are familiar with these concepts as well as culture-bound disorders, such as ataques de nervios, pibloktoq, koro, and amok, and can communicate them to Western doctors and mental health professionals that might not be familiar with the specifics of these culture-bound disorders. Cultural brokers are additionally trained in medical and psychological terms in the refugee’s first language that might not be common knowledge to laypeople in a culture. This can allow them to better communicate medical directions to their clients. Overall, cultural brokers are unique as they combine their linguistic,
cultural, and mental health skills to bridge cultural differences between providers and patients of different cultures; improving understanding between all parties (Singh, McKay, and Singh, 1999).

Cultural or Healthcare Navigators are similar in concept to Cultural Brokers, but focus on integrating refugees into their resettlement communities and navigating them through the U.S. healthcare system when needed. Cultural Navigators are established leaders in the refugee’s community that are capable of guiding families through the acculturation process. Generally, they were refugees themselves, of the same group as the new arrivals, who have been established in the area long enough to help new arrivals with the acculturation process. These Navigators connect newly arrived refugees with the larger community, addressing the social isolation that often follows resettlement. In addition, they help new arrivals access the healthcare system and social services, introducing the idea of mental health and normalizing the need of mental healthcare in communities where mental health problems still carry a stigma (Henderson & Kendall, 2014). Most participants in the American Academy of Pediatrics study felt that they benefited from a Healthcare Navigator (Kroening et al., 2016).

Overall, these suggestions focus on addressing the linguistic and cultural barriers that prevent refugee women from seeking medical care after domestic violence injuries, as well as mental healthcare and therapy to address baseline mental health issues accrued during migration and the emotional and mental aspects of domestic abuse. Unfortunately, they do not address the cultural stigma that the Harrisonburg Iraqi refugee community holds about mental healthcare and addressing DVA in the home.
Experience in the Harrisonburg Area

Harrisonburg, Virginia is in northwestern Virginia, in the Shenandoah Valley (Figure 2). The Harrisonburg population as of the 2010 Census was 48,914 but the census-estimated 2016 population was 53,078 people (U.S. Census Bureau, 2016). Harrisonburg’s population changes seasonally as 22,667 college students attend James Madison University, also located in Harrisonburg, each year (James Madison University, 2017). Harrisonburg is a resettlement site for the state of Virginia. Church World Service, the VOLAG responsible for refugees placed in Harrisonburg, has been working here since 1988 (Church World Service Harrisonburg, 2017). Unfortunately, data on refugees resettled in Virginia has only been published for the public as far back as 2013. Since 2013, 2,432 Iraqi refugees have been resettled in localities across Virginia. 618 of these refugees were resettled in Harrisonburg (Berube, 2017).

The Virginia Department of Behavioral Health and Development Services (VDBHDS) has a Qualified Cultural Navigator-Behavioral Health (QCN-BH) program that combines the ideas of the cultural broker and healthcare navigator positions described above. Candidates can achieve a QCN-BH credential after submitting proof of completion of the six required competency areas: Mental Health, Language, Diversity and Culture, Facilitation Skills,
Screening Tool, and Experience. Accepted mental health training focuses on mental health and suicide prevention; such as a completed Mental Health First Aid certification or Question, Persuade, Refer Gatekeeper Training. To satisfy the language area, candidates must have a certification from a recognized training entity showing that they are a trained interpreter such as the Qualified Bilingual Staff, a Certified Personal Interpreter, or Qualified Mental Health Interpreter certifications. The Diversity and Culture Area is satisfied by attending three of the five trauma-informed cross-cultural psychoeducation courses offered by VDBHDS. One of these three courses must be “Navigating the Virginia Healthcare System.” Facilitator training includes either the VDBHDS sponsored Certified Cultural and Linguistic Competence Facilitator training or a similar certification program that focuses on intercultural development and cultural competence. To complete the screening tool competency area, candidates must complete a training on the Refugee Health Screener either from the Virginia Department of Health or the VDBHDS. Finally, candidates must show a year of experience working with refugees or immigrants in a behavioral health setting (Virginia Department of Behavioral Health and Development Services, 2014).

This program addresses many of the barriers that new arrivals face when trying to access mental health and healthcare. Requiring candidates to undergo mental health training addresses the issue of translators being unable to explain the western view of mental health to refugees unfamiliar with our perspective. Requiring a certified translation certificate and cultural linguistic facilitation training prevents children and other unqualified translators from potentially misinterpreting important medical, therapeutic, and personal information. Candidates will have a comprehensive knowledge of the Virginia healthcare system and how to guide new arrivals through it’s processes due to the required training. And, candidates will be able to triage baseline
mental health on arrival due to experience with the refugee health screener. The Qualified Cultural Navigator-Behavioral Health position could be a solution to the mental health and healthcare crisis that newly arrived refugees face. As such, qualified candidates must be paid for their expertise and services.

Observation in the Harrisonburg area has shown that refugees who go through this extensive process or have similar skills are expected by the community to volunteer their services to help make paid social worker’s jobs easier. We pay social workers for their knowledge and experience garnered through a degree. Why do we expect refugees to volunteer their services when their knowledge and experience are similarly needed? Not only does this program remove many of the barriers preventing women from receiving physical and mental healthcare, but paying qualified candidates for their services allows them to provide for their families, addressing the economic self-sufficiency concern that refugees often face. Overall, compensating cultural brokers and navigators for their time and expertise not only increases that health and wellbeing of the entire refugee community, but it creates jobs that would allow refugees to be financially independent.

Harrisonburg Church World Service has been actively working with local domestic violence and abuse resources to increase the cross-cultural accessibility of their programs. One such initiative has been partnering with First Step, a domestic violence resource center in the area. First Step provides emergency shelter, safety planning, support groups, and court accompaniment to women who have experienced DVA. CWS and First Step have partnered together to offer a support group specifically for Arabic-speakers. Because refugee women who have experienced DVA have different experiences and backgrounds than American women (pre-
migratory and post-migratory trauma experiences, acculturation difficulties, different cultural gender roles and expectations within relationships), the Arabic-speakers only support group gives them a space to meet other women who have similar experiences and common ground, and discuss those experiences with a trauma-trained facilitator. Unfortunately, the implementation of this program had pushback from the community and is not currently being offered. Although a few resettled Iraqi refugees have been willing to discuss the domestic violence and abuse they’ve personally experienced, they were unwilling to go to First Step or meet up with other women in a group for fear of community backlash. The women reported that if they were seen with women who had left their husbands due to DVA or at First Step, they would be shunned by members of their community. This fear of community isolation was so great that women were unwilling to attend the support group. Although not the initial purpose of this paper, the idea of the support group has been transferred to a group of Congolese refugees also resettled in the Harrisonburg area. Their community has been more open to discussing healthy relationship behaviors and domestic violence and abuse within the home.

Another initiative of CWS has centered around difficulties refugees face when trying to locate local resources. Language barriers can make reading maps, directions, and street signs more difficult. To make locating local resources easier, I created photo resource guides for local resources such as First Step, the Collins Center (provides sexual assault crisis services, child abuse services, and trauma-informed therapy), and the local court system (where women would go to file protective orders, file for divorce, or pursue child support agreements). The resource guide goes step-by-step from the closest bus stop to each of these destinations and provides pictures and arrows to help direct people with limited-English proficiency. An example of the photo resource guide is provided in the Appendix below.
Areas for Future Research

In the future, more research is needed about domestic violence and abuse; both within the general public of the U.S. and specifically within resettled refugee communities. Most research on domestic violence and abuse within refugee communities focuses on DVA in refugee camps located in secondary asylum countries. Although this is important research, the experience of DVA does not stop once refugees are resettled in America. Therefore, research must continue past resettlement as well. This paper did not address the incidence or prevalence of DVA in resettled refugee communities due to a severe lack of available data. Experience in Harrisonburg has proved to me that there is a true need for DVA prevention programs tailored to the unique needs of resettled refugees; however statistical data to back my observations and would make these recommendations stronger. Furthermore, increased research is needed to scientifically evaluate the outcomes of public health programs like DVA reduction programs. Unfortunately, this type of outcome based programmatic assessment is impossible if baseline information about how many people are affected is unavailable. Therefore, research much first focus on gaining accurate numbers of incidence and prevalence of DVA within refugee communities. Researchers can then then focus on the scientific implementation and evaluation of prevention and reduction programs.

Evidence-based practices are the gold standard of medicine and public health. However, evidence-based practices in DVA reduction are nonexistent in the U.S., even for the non-refugee community. In 2010, there was only one strategy for preventing intimate partner violence that could be considered effective, and it concerned the use of school-based programs to prevent violence within dating relationships (World Health Organization, 2010). DVA reduction research
is still in its early stages, and must be continued. DVA is a national public health problem, and should be treated as such, with national attention and funding in research.

Finally, research is needed to address culture and social stigma within communities surrounding DVA. Although progress has been made in addressing some of the linguistic and cultural barriers preventing DVA survivors from accessing resources, there is a lack of research about changing community views on gender roles, healthy relationships, and mental illness. These three cultural factors remain some of the biggest barriers to refugee women trying to leave abusive relationships. Furthermore, these areas are hard to address because community members, religious leaders, and even some DVA survivors themselves perpetuate them. Although it is important to respect other cultures, we must oppose aspects of culture that allow human rights violations to persist. As said by Kristoff and WuDunn in *Half the Sky* (2010), “If we firmly believe in certain values, such as the equity of all human beings regardless of color or gender, then we should not be afraid to stand up for them…” (p. 207) and so we must stand up against the continued allowance of domestic violence and abuse within the U.S. and resettled refugee communities.
Appendix

Directions to the Collins Center:

Get off the bus at stop 236. You will see a large building that looks like this:

Turn right and walk down the street
Enter the elevator and go to the 2nd floor. Turn right out of the elevator. You will see:

Turn right at the chicken.
Walk down the hallway to the Collins Center. You will see this door.

Walk to the counter and ring the bell. Someone will come to help you.
Bibliography


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