CHAPTER 51

Interpersonal Violence Towards Women

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Introduction

Violence pervades the lives of many around the world. A review of domestic violence suggests that it happens to women of all socioeconomic and educational backgrounds, in all types of communities, including egalitarian societies and among different groups and countries. However, there is little research about this issue among different ethnic groups and among economically disadvantaged communities.[1] In this chapter we will concentrate on violence, which is one of the most frequent traumatic stressors for displaced, immigrant, and refugee women. Violence is many things, including a social issue, exemplified by statements from the World Bank and United Nations. In November 2004, World Bank[2] President James Wolfensohn concluded in a workshop to mark the International Day for the Elimination of Violence Against Women: 'The workshop made it clear that violence against women exacts enormous cost to economies, to women's health and to women's rights, and that we need to join forces to combat this pressing development concern . . . women should no longer have to live in fear, their children should no longer witness daily acts of violence, and men should enjoy the dignity and freedom from want that enables them to use peaceful means to resolve conflicts.' The former UN Secretary General Kofi Annan[3] has called violence against women the most pervasive, yet least recognized, human rights abuse in the world. To stay out of harm's way some may be able to lock their doors; others have no possibility of escape. The threat is behind the closed doors (Brundtland foreword WHO World Report on Violence,[4] Beijing Declaration; see Box 51.1). Frequently hidden from the public eye, interpersonal violence is permeating the lives of a large proportion of women. Rape and sexual assault of women are also used as weapons of war and interpersonal violence. Such violence is a social issue and adversely influences general health, mental health, ability, and successful adaptation and integration. The violent abuses exacerbate discrimination against women, e.g. by intensifying women's exclusion from the public sphere and rendering access to social and health services more difficult.[6]

Setting the Scene

Types of violence against women

According to the UN Declaration on the Elimination of Violence Against Women, violence is defined as: '. . . any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women.'[7]

It is important to bear in mind that women are exposed to different kinds of violence and that violence may be rooted in gender inequality. The fact that women are frequently economically or emotionally dependent upon their perpetrators has implications for the dynamics of the abuse and ways to deal with it.[4] This report discusses two kinds of interpersonal violence: family violence and community violence, i.e., violence outside the home. The first

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Box 51.1

'. . . Violence against women both violates and impairs or nullifies the enjoyment by women of their human rights and fundamental freedoms . . . In all societies, to a greater or lesser degree, women and girls are subjected to physical, sexual and psychological abuse that cuts across lines of income, class and culture.' Beijing Declaration and Platform for Action, Paragraph 112.[5]

kind relates particularly to women, but, in areas of war and conflict, women are also more likely to face threats of community violence outside the home. There is increasing recognition and understanding of the particular risks that displaced and refugee women are facing in zones of conflict, in refugee camps, and in asylum centers[8] as they are disproportionately affected by violence. Women who seek shelter from the hardships of armed conflicts and strife may end up experiencing further harassment in what, from an outside perspective, should be a safe environment. According to findings by Basoglu et al.,[9] fear of threat to safety and loss of control over life appear to be the most significant mediating factors for PTSD and depression. Therefore, these findings highlight the importance of the combination of political action against impunity and attention to mental health consequences. Both from a public health as well as a judicial point of view these are issues requiring further attention.

Prevalence of violence

Violent acts against women and girls are reported worldwide. Numerous surveys have consistently demonstrated a high prevalence of physical assaults by intimate partners. Prevalence figures typically rely on self-reports and it is well known that in some cultures violence is frequently kept hidden from outsiders. This may be related to traditional views of a man's right to punish his wife, with victimization often being considered part and parcel of the daily burden of women. As a consequence, the violated women may be reluctant to identify themselves, as it may bring shame on the family and more victimization.[4]

According to Amnesty International,[10] 'domestic violence is the major cause of death and disability for European women aged 16–44 and accounts for more death and ill-health than cancer or traffic accidents. In South Africa more women are shot at home in acts of domestic violence than are shot by strangers on the streets or by intruders.' In other words, 'the prevalence of such violence suggests that globally, millions of women are experiencing violence or living with its consequences.'[11]

Unfortunately, many health professionals are not trained to discover consequences of violence. Thus, despite women's visits to health facilities, many incidents may go unnoticed.

Immigrant and refugee women, as well as those displaced within their own countries, are not beyond experiencing this kind of violence. But they are subjected to further atrocities as the nature of war and violent conflicts has changed, and an increasing proportion of reported casualties are no longer soldiers but civilians. Thus, such women may experience violent acts as seen in recent conflicts, including the ongoing one in the Darfur region of Sudan, as well as in the former Yugoslavia, the Democratic Republic of Congo, Rwanda, Sierra Leone, Liberia, northern Uganda, Chechnya, and the Russian Federation.[12] A global view starts to be evident among different UN organizations and NGOs: in areas of conflict, 'because of the sensitivity of the subject, violence is almost universally under-reported.'[11] Conducting research on these sensitive matters (i.e., sexual violence) is an extraordinary challenge even in relatively stable settings. During conflict and related crises, when there is a lack of stability and disruption of family and community support, such research may be impossible.[13]

Types of violence

Violence has many faces, and Watts and Zimmerman[11] have reviewed the magnitude of some of the most common and severe kinds of violent acts against women: intimate partner violence; sexual abuse by non-intimate partners; harmful traditional practices; trafficking; forced prostitution; exploitation of labor; debt bondage of women; physical and sexual violence against prostitutes; forced marriage; sex-selective abortions and dowry murders; and rape during war. Characteristically, women living in abusive relationships may be the targets of multiple acts of violence over time. The violence typically involves physical, psychological, and social aspects and frequently involves sexual abuse.[4]

In refugee women, experiences of sexual violence during armed conflicts are commonplace. The aggressor may use sexual assault to show superiority, to humiliate, to force abortions or to force pregnancy upon women as a strategy of war towards

another ethnic group.[14] Women may also feel forced to render sexual services to survive, in return for assistance or to protect their children. Traditionally, abusing the conquered women has been seen as part of the realities of war, and it was not until recently that rape in times of war was recognized as a war crime. Many women may face the threat of ostracism by their own families if sexual assault is revealed, leaving the women in question vulnerable and fragile. Women in armed conflicts are at extreme risk of sexual violence[8] and, therefore, impunity for rape and sexual violence must end.

Influence of culture and sociopolitical context on interpersonal violence

Culture influences the interaction of risk factors with social support and protective psychological factors that contribute to symptoms. While some studies suggest that acculturation decreases the likelihood of interpersonal violence,[15] recent studies find that acculturation actually increases this likelihood.[16] Increased opportunities for the woman may make the man increase his control in order to keep power in the patriarchal family model. This is a method of exerting control over and disempowering women.

Culture can confound diagnosis and management of care by influencing definition of diseases and delineation of abuse or symptoms. Culture also influences help-seeking patterns, perspectives on and expectations of the role of healthcare providers, and patient–practitioner communication. A recently arrived refugee woman may, for instance, expect a hierarchical relationship with a health professional and experience a sense of stigma and shame when confronted with the more egalitarian, consumer-oriented clinical model in Western society. The health staff must, in this context, evaluate the culturally relevant aspects of stress and encourage the protective factors in the present life of the abused woman.

Women of immigrant and refugee background are heterogeneous groups and do not share a common background or similar problems. What they may share are common influences of interpersonal violence within a sociopolitical and structural context.

Usually, migrant women carry a triple burden because of their gender, class, and ethnic background, and they often experience different kinds of psychosocial challenges due to prejudice and discrimination.[17] Women in minority communities may experience sexism from within their communities based on cultural values, beliefs, practices, etc. In addition, as members of minority communities, women may be affected by institutional racism from the dominant culture, 'as expressed through institutional policies, culture norms and prejudicial treatment.'[18] According to Sorenson,[19] institutional racism and sexism are not mutually exclusive; rather, the intersectionality of their multiple identities complicates immigrant and refugee women's experiences of violence.

Consequences of Interpersonal Violence

Health consequences

Violence may have a profound impact on health and functioning. Women who have survived interpersonal violence may display elevated rates of fear, depression, anxiety, post-traumatic stress disorder, substance abuse, tobacco and drug use, hormonal irregularities (e.g., bleeding), and suicide attempts. Perceptions of poor health and worsened health status are also common. The prevailing psychological symptoms include lack of energy, fear, anxiety, depression, feelings of hopelessness, apathy, cognitive dysfunction, insomnia, and somatization.

Physical manifestations may be related to the sexual abuse and include various complaints of the reproductive organs such as chronic pelvic pain, sexual dysfunction, and other types of pain. Musculoskeletal symptoms are also frequent, and some may further suffer a distorted body image.

Refugee women are often heads of households or single providers and are at particular risk of encountering psychological problems when their capacity to cope is overwhelmed or when they have no time to consider their own needs while protecting their immediate families.[14] Refugee women may be particularly vulnerable to stressors related to gender role conflicts and adverse life events and have an increased risk of affective disorders.[20] In a cross-sectional study, Johansson-Blight, et al.[21] used postal survey questionnaires distributed to a community sample (n = 650, 63.5% response rate) of participants who came to Sweden in 1993–1994 from Bosnia-Herzegovina. They showed that, while job occupancy might be important to the mental health of men in the study, job occupancy and living in an urban region appear to be associated with poor mental health for the women.

Having a job for women may be another stressor because of the traditional family model in which they live. On the other hand, not all who have

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suffered trauma become victimized and need professional help. Among the protective coping mechanisms are reality orientation, motivation for survival, and the existence of an inner locus of control.[22]

Therapeutic Aspects

Barriers to help-seeking

Barriers to help-seeking are related to the cultural context and may include social isolation, language fluency, beliefs about the woman's role in the family, loyalty to the husband and other male relatives, shame related to the abuse, lack of resources and lack of access to them, concerns about separation from extended family, and cultural stigma (Box 51.2). There is often a general distrust of governmental agencies due to previous experiences and the fear of deportation. Women may assume that legal proceedings will be decided in favor of the man. Female victims often believe that reporting their abuser to the police will increase the perpetrator's anger and escalate his violence or that the police may disbelieve the woman's story, resulting in further humiliation. For similar reasons, women may be unwilling to disclose their experiences to health professionals, fearing loss of confidentiality. Some immigrant women believe they have no right to legal protection and feel trapped in their abusive relationships; thus, much interpersonal violence remains unreported.[23]

Furthermore, granting permission to stay in a country may be linked to the male head of the household, thereby endangering the legal status of the woman if she decides to leave her violent husband.

Box 51.2

Barriers for disclosure to healthcare providers

- Fear of bringing shame to their families, other relatives, and communities.
- Fear of reinforcing stereotypes.
- Discourse between linear/individual and relational/collectivist contexts.
- Loss of socioeconomic status, poverty, and powerlessness may challenge the link between domestic violence and culture.
- Assumption by the woman of the role of primary family breadwinner, motivating her partner into using interpersonal violence to keep his dominant role in the traditional family.
- Lack of access to social care and healthcare.
- Loss of the social support previously received before migration and feeling marginalized from the mainstream culture may result in the woman increasing reliance on her partner.
- Reluctance to contact police or other legal authorities due to fear of these authorities from previous experiences of abuse, including torture, rape, and other forms of discrimination in her country of origin.
- Not speaking the mainstream language runs the risk that the abuser is the translator, which negates the woman's chance to reveal the abuse.
- Risk of deportation and fear of losing custody of their children discourages undocumented women from revealing their abuse because their partners may use threats of deportation to maintain control.
- Value conflicts between the mainstream culture and the culture of origin may increase levels of stress for more acculturated immigrant women due to loss of social control, alienation from traditional culture, and discrimination by the dominant culture.
- Abuse in the mainstream country by racial and ethnic discrimination and social class bias.

Clinical implications

Communication with patients

One of the main public mental health issues today is to identify displaced, immigrant, and refugee women as well as hidden and/or illegal foreign women who have been abused by interpersonal violence. Refugee women in mental health settings often share common denominators that are a challenge to health professionals.[14] As clinicians, we recommend the following approach for routine abuse screening (Box 51.3) in primary care settings (revised from[24]).

- Introduce yourself, your professional role, what your clinic can offer, your neutrality, and your respect for confidentiality. The concept of clinician–patient confidentiality may be alien to immigrant and refugee women if this is not the case in their home countries; therefore, it is important to discuss this concept and promise confidentiality in specific terms.
- Establish trust by listening to the woman's trauma story but always keep current stressors in the foreground.
- Assess the safety of the victim immediately and completely, as with any situation of ongoing violence.

Box 51.3

Women abuse screening tool

Note: Numeric scores ranging from 3 to 1 can be assigned to the answers below. The women can also complete numeric comfort ratings on each question, ranging from very uncomfortable (1) to very comfortable (4).

1. In general, how would you describe your relationship?
   A lot of tension Some tension No tension
2. Do you and your partner work out arguments with:
   Great difficulty Some difficulty No difficulty
3. Do arguments ever result in you feeling down or bad about yourself?
   Often Sometimes Never
4. Do arguments ever result in hitting, kicking, or pushing?
   Often Sometimes Never
5. Do you ever feel frightened by what your partner says or does?
   Often Sometimes Never
6. Has your partner ever abused you physically?
   Often Sometimes Never
7. Has your partner ever abused you emotionally?
   Often Sometimes Never
8. Has your partner ever abused you sexually?
   Often Sometimes Never

From Reference 1, page 103, also in Spanish.

- Try to get a view of the woman's expectations and hopes of this meeting (she may have unrealistic beliefs of a swift recovery or 'quick fix').
- Be sensitive to the possibility that the woman may feel forced to tell her story and mitigate this perception or experience.
- Pay attention to the woman's suicidal thoughts, somatization, and silence.
- Act in a humane and professional way, avoiding the waste of precious time resources due to communication difficulties. The woman may simultaneously visit other doctors, i.e., 'doctor shopping,' as long as she feels she is not getting the help she needs.
- Ensure that there is access to competent interpreters if the woman is not fluent in your language and explain the role of the interpreter, including that of confidentiality.
- Have a focus on normalization and empowerment and try to get a view of the woman's capabilities and economic resources (e.g., for transportation and medication) needed to complete treatment.
- Never end a meeting before the woman has the chance to communicate her perception of present and future (i.e., what does she plan to do next, after the meeting).
- End the diagnostic assessment phase by describing the options for intervention and by which local collaborative organizations.
- Pay attention in the assessment of key concepts such as attachment, security, identity/roles, human rights, and existential meaning systems, which have been more or less threatened on different intervention levels.[25]
- Give time to listen and reflect.
- Develop competence working with interpreters for immigrant and refugee patients.
- Do not work alone or full-time with severe traumatic patients, as this risks burn-out or vicarious traumatization.
- Recognize that many women may be polytraumatized, suffering from several traumatic experiences acting simultaneously.
- Be aware that refugee women may live under familial social control that may increase in the host country.
- Respect the cultural and social distances between clinician and client.

Interpersonal violence is described in this chapter, as mentioned earlier, as a traumatic event. Harvey's ecological model for psychosocial trauma postulates that reactions and recovery to trauma are related to person, event, and environment. In concrete, 'the efficiency of trauma-focused interventions depends upon the degree to which they enhance the person–community relationship and achieve "ecological fit" within individually varied recovery contexts.'[26] This is in line with Bracken, who emphasizes that responding to trauma need not be a pathological sign but may also be a reflection of learning, growth, and resilience.[27] According to Moos, 'we need a fundamental paradigm shift in how to construe and examine the aftermath of life crises.'[28] Ekblad and Jaranson[17] interpret this as meaning 'that theories of posttraumatic development and maturation differ

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from theories of learned helplessness and posttraumatic stress disorder.'[17]

Services

The coordination of victim services between general health, mental health, social services (for example, victim assistance) and the justice system is critical to ensure quality of care. For instance, a lack of financial resources affects women's ability to respond to abuse. Financial independence and employment facilitate escape from an abusive relationship. Linking women to victim services may provide assistance in obtaining crime victim compensation for their healthcare bills. An immigration lawyer can assist immigrant women whose petitions for residency may depend on the abuser's petition. The abused women may be invited to contact cultural, professional, and neutral interpreters, indigenous healers, women's organizations, culture brokers, and other local cultural resources to facilitate short-term and long-term interventions. Healthcare providers and care delivery systems should be aware of and have relationships with culturally competent resources in the community specific to patients' cultural groups and countries of origin.

Recommendations

We recommend that identification and management of potential risk factors during pre- and post-migration experiences, such as interpersonal violence including rape, be addressed by acceptable and available health systems. Institutionalizing this approach will help alert clinicians and other professionals dealing with immigrant women to possible treatment options. Care providers should also be aware that cultural context may exacerbate the consequences of violence and may limit preventive measures. Cultural traditions may also be protective.[4] Care providers should focus on the most vulnerable groups and recognize the role of poverty and inequality in rendering women more vulnerable.[4]

An important research step will be to agree on the collection of data on violence. The development of an inventory for measuring war-related events, including domestic discord and violence as well as sexual trauma or other abuse in refugees, may be useful but needs further testing.[29] The conventional use of current instruments fails to grasp cultural variations in question content, scale formats, and norms, and can lead to false-positive and false-negative cases of abuse.

Resolving the extensive public health problems of interpersonal and sexual violence in refugee women requires the collaboration of many agencies. The commitment of civil society and governments must focus on changing community and societal norms and on raising the status of women.[4] With migration in an interconnected world, new directions for action are needed.[30]

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