"We Have to Build Trust": Intimate Partner Violence Risk Assessment with Immigrant and Refugee Survivors

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Intimate partner violence (IPV) research highlights unique immigration-related risk factors, abusive tactics, and barriers to seeking help. With the aim of developing practice-informed guidance, data from nine focus groups ($N = 57$) were analyzed thematically to examine practitioners' experiences and approaches to risk assessment with survivors of IPV who are immigrants and refugees. Participants noted the importance of fostering relationships and trust in client disclosure and assessment of risk. Participants highlighted using a conversation-based approach; carefully chosen words; and open-ended, indirect, and probing questions to help clients feel at ease and generate information regarding risk. Additionally, practitioners emphasized the importance of conducting risk assessment and client education in concert with safety and service planning. However, safety and service planning must account for variations in context and language, as well as social pressures to keep families together. The adaptation of risk assessments to reflect immigrant experiences is a critical step forward. Nevertheless, listening to practitioners with expertise serving immigrant and refugee IPV survivors and developing additional guidance on *how* to use risk assessment tools and engage survivors are paramount to expanding relevant and responsive domestic violence services for diverse groups.

KEY WORDS: *culturally responsive practice; intimate partner violence; risk assessment; risk-informed practice; safety planning*

Intimate partner violence (IPV) research highlights unique immigration-related risk factors, abusive tactics, and barriers to help seeking (Messing et al., 2013; Raj & Silverman, 2002; Vidales, 2010). The confluence of risk factors and barriers compound safety concerns and hinder help seeking among immigrant survivors (Sabri et al., 2018). Therefore, it is imperative that advocates and other professionals respond effectively when survivors seek help. Assessing risk for serious injury and lethality within an evidence-based practice framework is a core component of a comprehensive response to IPV (Messing, 2019). Yet, it is important to consider the need for variation in *how* to assess risks and effectively engage survivors. Guidance, informed by the experiences and perspectives of practitioners who work with diverse groups of survivors, is vital to inform the administration of IPV risk assessments, subsequent safety planning, and service provision. This study sought the perspectives of practitioners to inform the practice of using risk assessment with immigrant and refugee survivors.

Intersection of IPV and Immigration

Immigrant women living in the United States face high risk of IPV (Lee & Hadeed, 2009; Runner et al., 2009; Sabina et al., 2014), yet prevalence estimates vary widely (Runner et al., 2009). Immigration-related factors are a critical consideration for immigrant women who experience IPV (Lee & Hadeed, 2009; Vidales, 2010). Women have reported experiencing an escalation or initiation of violence and abuse by their partners postmigration (Guruge et al., 2010). Moreover, research has indicated that foreign-born women are at higher risk of injurious and lethal outcomes compared with their U.S.-born counterparts (Raj & Silverman, 2003; Sabri et al., 2021). Analysis of U.S. national-level data (2003–2013) revealed a pattern in which foreign-born victims were significantly more likely to be victims of intimate partner

homicide (than non–intimate partner) and for a perpetrator to commit homicide/suicide (Sabri et al., 2018).

A growing body of research provides evidence for specific immigration-related factors associated with IPV. Risk of severe IPV among immigrants is associated with having a U.S.-born partner and the partner threatening to report the survivor to the Department of Homeland Security or Child Protective Services (Messing et al., 2013). Undocumented immigration status is likely to compound risk of IPV (Bhuyan et al., 2010). Social isolation, acculturation, and social support are additional immigration-related factors associated with IPV (Raj & Silverman, 2003). The intersections of immigration with structural and systemic racism, gender, class, religion, age, and other aspects of identity and positionality contribute to isolation and thus increase risk (Jiwani, 2005; Lee & Hadeed, 2009). A study with immigrant and U.S.-born South Asian women indicated that women who did not have family in the United States were more likely to be physically hurt by their partner compared with women with family in the country (Raj & Silverman, 2003).

Risk factors for re-assault, severe violence, and intimate partner homicide include nonphysical IPV (e.g., threats to harm children), past physical and sexual violence (e.g., abuse during pregnancy), abuser characteristics (e.g., alcohol abuse), and changes in abusive behavior (e.g., escalation in physical violence; Messing & Thaller, 2015). Access to guns, past threats with a weapon, nonfatal strangulation, and sexual assault have consistently been shown to be the strongest risk factors for intimate partner homicide across groups (Spencer & Stith, 2020). The confluence of these risk factors with additional immigration-related issues exacerbates risks of IPV and creates undue obstacles for seeking help among women who immigrate to the United States.

Immigration-Related Barriers

Immigrant IPV survivors face significant barriers accessing services, which impedes efforts to improve safety and exacerbates risks of severe or lethal violence (Messing et al., 2013; Raj & Silverman, 2002; Vidales, 2010). Abusers may control survivors' legal documents, withhold information about their immigration status, and/or use deportation as a threat (Ammar et al., 2012; Vidales, 2010). The fear of having a partner deported if they are reported to law enforcement is often a significant disincentive for survivors to seek help from social and legal services (Adams & Campbell, 2012; Raj & Silverman, 2002; Vidales, 2010). Moreover, immigration status can affect eligibility for social welfare programs that may serve as an economic safety net for survivors who consider leaving their abusive partners (Bhuyan et al., 2010; Vidales, 2010).

Language is another critical barrier. For survivors to seek help, access to professionals who speak the same language as survivors, or at a minimum access to trained language interpreters, is critical (Bhuyan et al., 2010; Lee & Hadeed, 2009; Vidales, 2010). In a study of immigrant women who sought protective orders, the majority of the sample first heard of orders from an advocate who spoke their language and only reported violations of the orders to someone who spoke their language (Ammar et al., 2012). Challenges related to information gaps and communication struggles also complicate help-seeking processes for IPV survivors among refugees in resettlement (Wachter et al., 2021). Differences in IPV definitions, impact, and solutions can foster miscommunication about survivors' experiences and safety planning options (Lee & Hadeed, 2009; Raj & Silverman, 2002; Vidales, 2010).

Mainstream domestic violence services in the United States are often insufficiently responsive to the needs of diverse groups (Kapur et al., 2017; Lee & Hadeed, 2009; Raj & Silverman, 2002). Research highlights areas of incongruence between refugee women's conceptualizations of their needs and established practice approaches, including differences in how survivors engage with service providers and how professionals perceive their roles (Wachter et al., 2019). Shelters may not adhere to specific religious requirements for preparing meals, such as access to a halal kitchen, or accommodate needs due to complex immigration status (Kapur et al., 2017). Service providers are challenged to recognize heterogeneity within and across immigrant groups to effectively address variations across circumstances and contexts.

Risk Assessment in Practice

Risk assessment is a cornerstone of domestic violence service provision across settings (Clough et al., 2014; Messing, 2019; National Association of Social Workers, 2021). Generally, IPV risk

assessments include a series of yes/no questions that are asked as part of a structured interview and added or weighted to obtain a score or risk category (Hilton et al., 2004; Messing et al., 2017; Williams & Grant, 2006). IPV risk assessments have been incorporated as a component of technology-based intervention (Glass et al., 2017) and may be used to assist in making determinations about appropriate services, including housing (National Network to End Domestic Violence, 2020). Police departments increasingly conduct IPV risk assessments (Klein, 2012), as do healthcare providers in medical settings (Alvarez et al., 2018; Messing et al., 2017). However, only one risk assessment, the Danger Assessment for Immigrant Women (DA-I), was developed by examining the risk of future severe IPV to account for risk factors specific to immigrant women's experiences (Messing et al., 2013).

Across multiple settings, IPV risk assessments focus on asking specific questions and developing a risk score to triage clients. The DA-I is intended to be a collaborative tool to enhance survivor safety (Messing et al., 2013), modeled after the original Danger Assessment, which includes a calendar component and a checklist of risk items (Campbell et al., 2009). The calendar, which asks the survivor to consider and document IPV over the prior year, is an open-ended strategy that gives the survivor an opportunity to tell her story, reflect on her experience of abuse, and identify patterns in those experiences. Practitioners can identify risk factors during the calendar exercise to return to with their client throughout the portion of the assessment that pinpoints individual risk items using a yes/no question format.

The development of a validated risk assessment tool for use with immigrant populations is a critical step toward expanding responsive services. However, questions remain regarding how to best approach its administration in practice to enhance safety and well-being. Training providers in *how* to deliver services and effectively engage diverse survivors is paramount (Ammar et al., 2012; Kapur et al., 2017; Wachter et al., 2019), yet research to date has not specifically examined how to effectively engage immigrant and refugee survivors in risk assessment. An essential starting point for developing and testing approaches to conducting risk assessment is garnering the experiences and perspectives of practitioners who have already made adaptations in practice. With the aim of developing additional guidance on the use of risk assessment, we undertook a qualitative study to examine approaches to risk assessment used by providers with expertise working with immigrant and refugee survivors.

METHOD

The current study draws from qualitative research on risk and protective factors among immigrant and refugee survivors of IPV; this was the formative phase of a multisite randomized controlled trial (Sabri et al., 2019). Researchers conducted focus groups with helping professionals in urban areas across seven states: Arizona, California, Maryland, Massachusetts, Minnesota, New York, and Wisconsin.

Participant Recruitment

Researchers recruited participants employed by agencies providing healthcare, legal, and social services to immigrants and refugees by posting flyers at agencies and conducting individual outreach (in-person, telephone, and email) to share information regarding the study. In some cases, staff from IPV and/or immigrant and refugee-specific community-based agencies reached out to their networks to assist with recruitment. Service providers who had worked for a minimum of two years with immigrant or refugee survivors or perpetrators of IPV and who were at least 18 years old were eligible to participate. Experience with formal risk assessment was not required for participation given that inquiry mainly focused on perceived risk and protective factors. Procedures encouraged practitioners who shared linguistic and cultural backgrounds with their clients to participate but did not limit inclusion based on this criterion.

Data Collection

Nine focus group (FG) discussions were held with 57 participants, organized into groups of five to nine participants based on their experience working with refugees or immigrants from the following countries or regions: the Democratic Republic of Congo (FG1), Somalia (FG2), Central America (FG3), Mexico (FG4), Caribbean (FG5), Ethiopia (FG6), Philippines (FG8), and India (FG9), as well as survivors who identified as Hmong (FG7). Each focus group averaged approximately two hours in length and was conducted in English. Each participant

completed a questionnaire pertaining to their demographic characteristics (e.g., age, gender, and race/ethnicity), professional background (e.g., role/job title, years of experience, and number of clients served in the past two years), experience working with clients who are victims or perpetrators of attempted or completed homicide, and personal experiences with IPV. Members of the research team at each site facilitated the focus groups at the university or within the community using a semi-structured guide. Questions engaged practitioners on their experiences with and perspectives on risk assessment, risk factors for homicide and severe re-assault, protective factors and unique strengths, service needs, and survivor acculturation.

Protection of Human Subjects

The institutional review boards at Johns Hopkins University and Arizona State University approved the research. Prior to data collection, researchers provided participants information about the study to inform their decision about whether to participate and be audio recorded. All participants provided oral informed consent. At the beginning and end of each group, facilitators reminded participants of the importance of keeping the conversation confidential. Participants received a $40 incentive.

Participants

Fifty-seven individuals participated in the study. The mean age of participants was 43.6 years (SD = 13.7). The majority of participants (93%) identified as women and reported being born outside of the United States (82.5%). Sixty-three percent had professional roles as advocates, healthcare providers, social workers, therapists, or attorneys, in which they provided direct services to clients. Others held management roles or worked with immigrants and refugees in another capacity (e.g., language interpreter, pastor, librarian, professor). Overall, participants reported multiple years of experience working with IPV survivors or perpetrators, with over half of participants reporting that they had five or more years of experience in the field. Over half of the participants (56.1%) reported that they had worked with a client who was a victim or perpetrator of intimate partner homicide or attempted homicide. Twelve participants (21.1%) shared that they had personally experienced IPV. See Table 1 for additional details.

Data Analysis

The focus group discussions were audio recorded and professionally transcribed. The aim of the analysis was to identity approaches to risk assessment that resonated thematically across focus groups and immigration experiences. The first step in data analysis involved applying structural codes to identify sections of the transcripts pertaining to the use of risk assessment. These transcript segments were then analyzed inductively using a thematic analytical approach (Guest et al., 2014), which produced an initial set of codes reflecting providers' experiences with and approaches to risk assessment. These first-order codes included communication, building a professional relationship with the client, family, question format, and practitioner considerations. The subsequent step involved team members carefully examining data captured in these codes to determine how they may group together as categories at a higher level of abstraction. Using memo writing and team-based discussions, this step in the analytical process produced the five themes presented in the next section. Researchers carried out the analysis in Microsoft Word and Excel.

To ensure rigor throughout the analytical process as outlined by Creswell (2013), members of the research team met regularly to review procedures, discuss emergent themes, and inform the analysis. This process, which encouraged reflexivity, served as a check against undue bias of researchers directly involved in interpretation of the data (Padgett, 2016). Furthermore, the team put measures into place to ensure the analysis remained closely connected to the data generated by the research participants. Researchers also documented key decisions throughout the course of the data analysis process (Rodgers & Cowles, 1993).

FINDINGS

Findings highlight five themes related to providers' experiences with and approaches to risk assessment with immigrant and refugee IPV survivors: (1) building relationships, (2) a conversational approach, (3) finding the right words, (4) risk assessment as education and intervention, and (5) assessing risk when forces compel women to stay.

Building Relationships

Participants discussed the importance of building relationships and trust and establishing rapport

Table 1: Participant Demographics (*N* = 57)

Characteristic	*n* (%)
Gender	
Female	53 (93.0)
Male	3 (5.3)
Gender nonconforming	1 (1.8)
Race/ethnicity	
Asian	21 (36.8)
Latinx/Hispanic	11 (19.3)
Black/African American	22 (38.6)
White/Caucasian	2 (3.5)
Unknown	1 (1.8)
Region and country of origin	
North America (USA)	10 (17.6)
East, Central, and Horn of Africa (Burundi, Democratic Republic of Congo, Uganda, Ethiopia, Somalia)	19 (33.3)
Asia and Southeast Asia (India, Philippines, Thailand, Laos, Vietnam)	18 (31.6)
Caribbean (Dominican Republic, Puerto Rico)	3 (5.3)
Europe (Bosnia, England, Spain)	3 (5.3)
Central and South America (Bolivia, Colombia, Mexico)	4 (7.0)
Practice role	
Advocate/social services	26 (45.6)
Advocate/healthcare	6 (10.5)
Advocate/legal services	2 (3.5)
Program management	8 (14.0)
Both direct services & program management	2 (3.5)
Other (e.g., language interpreter, librarian, professor, pastor)	12 (21.1)
Unknown	1 (1.8)
Experience working with IPV survivors	
More than 10 years	13 (22.8)
5–10 years	20 (35.1)
1–4 years	14 (24.6)
Less than one year	7 (12.3)
Unknown	3 (5.3)

Note: IPV = intimate partner violence.

with survivors. Practitioners described this as a process of connecting with clients, accompanying them through difficult processes, and making them feel safe. Participants discussed talking with clients as one would with a friend. They explained that without this connection in place, clients would neither disclose experiencing abuse nor discuss the risks associated with their relationships. Participants described the importance of letting clients know that they are safe talking about their relationships and disclosing their experiences with violence and abuse. Participants explained that if they "establish rapport with the clients, then they start to open up" (FG4) and share what is happening at home. Participants explained that the consequence of not establishing trust is that clients will not disclose.

Building relationships takes time, and participants emphasized the importance of starting slowly, not rushing the process, and being patient. One provider described, "I've seen so many practitioners or folks so impatient. Fifteen minutes into the woman's story, they're like, 'OK, can we get to the point?' " (FG7). Indeed, participants emphasized the connection between taking time and building trust with survivors. One explained (FG1):

> We have to build trust. Building trust has to do with knowing how you're going to approach your [client]. The cultural piece has to be handled very delicately because we want to make sure that they can trust us to come back. If we're gonna approach that issue [of IPV], then we have to start slowly, so maybe they can disclose the third or fourth visit.

A number of participants said that practitioners should not attempt to complete a risk assessment on the first visit or in a single session. One practitioner explained, "You just have to dig deeper . . . you still can't do it the first time, because there's so many layers that's involved" (FG8).

Conversational Approach

Providers indicated that it was important to use a conversational approach to gather a holistic picture of the relationship and the risk that a partner poses. Risk assessments were seen as a framework to guide a discussion of risk as clients increasingly feel safe, rather than a stand-alone strategy for determining risk. A practitioner described using risk assessment as

> a reference book . . . to make sure I'm catching all of the things that I could, but really starting out the conversation or the assessment with that person by building the relationship and really taking them where they're at. (FG8)

Practitioners explained that going through a checklist of risk assessment questions and expecting brief yes/no responses, the typical tool format, often does not work. As one practitioner shared:

> Those neat little boxes with the [yes/no questions on the] risk assessment, you can't fill them in properly. It can be a framework. . . . It's making sure you can gather as much information that you can to fit into some kind of risk assessment to be able to then refer on if necessary. (FG1)

This participant indicated the need to complete assessments with yes/no questions for referrals to police and shelter, yet in addressing the questions to clients, it was important to be open ended. As another participant explained, "If you ask a yes or no question, they're gonna give you a paragraph" (FG7). To open lines of communication that allow for better assessment of risk, participants emphasized inviting clients to tell their story and expand on their experiences. Otherwise, they indicated that practitioners might miss key information. As one participant explained:

> If you start going through the [risk assessment], they're gonna say no to a lot of things. When I'm working with the client, I just let them talk for a long time and then by that time I can usually fill in most of it. I just ask the things that maybe haven't come up. (FG3)

In addition to listening attentively, participants discussed the importance of knowing how to ask open-ended, indirect, and probing questions that help clients feel at ease and generate information regarding risk. Participants noted the need to ask clients questions about how they are doing in general and with regard to their health, and to inquire into the well-being of their family and children. One participant described that by asking general questions, "that's when the story pops up" (FG2). Another practitioner described avoiding asking closed-ended and direct questions and instead inviting clients to talk by asking broad-based questions, such as "How did the argument start?," order to explore the client's experience and to avoid minimization and normalization of abuse (FG4). Participants discussed that questions included in IPV risk assessments may make some women reticent to engage because they are not used to direct questioning and/or they come from contexts where being asked questions can have negative connotations. Practitioners also found that explaining risk assessments to clients prior to asking questions helped clients feel more comfortable answering. As one participant shared:

> I find myself a lot of times explaining why I'm asking. Because sometimes people don't understand why [I] want all this information. . . . Once they hear that, they feel more comfortable in talking about their story and answering the questions. (FG5)

Another participant said, "It's listening. You can't help them if you don't hear the story, if you don't see how violence has looked like, you don't see what justice looks like to this person" (FG7). Engaging in conversation and asking questions allows practitioners to assess their clients' nonverbal communication, such as their expressions, physical reactions, and tone of their voice, and to watch for signs that clients might need more in-depth conversation about particular risks.

Finding the Right Words

Participants shared language and communication challenges in using risk assessments with immigrant and refugee survivors in the United States because key terms and concepts do not easily translate directly from English into other languages. Practitioners discussed their own struggles with translating words and concepts from risk assessments, and feeling unsure about the extent to which they can deviate in their interpretation to another language. One practitioner indicated, "Like, I understand what the American or the English part is saying but . . . I kind of have to beat around the bushes a bit" when translating some terms (FG1). Similarly, practitioners discussed how clients might be familiar with words but not necessarily their meaning within the risk assessment process. They also described needing to explain concepts and ask questions that are broad enough to encompass a range of behaviors. As one practitioner explained:

> If you ask, "Has he hit you?" . . . "No, he hasn't hit me, but he's slapped me or he's

pushed me." *Hitting* to them is with a closed fist. . . . The same with, "Has he strangled you?" . . . "No," . . . versus saying, "Has he put his hand around your neck to the point where you couldn't breathe?" . . . "Oh yeah, he does that all the time." (FG4)

Another common observation among participants was that terms have different meanings across sociolinguistic groups. Practitioners spoke to the sensitivity involved in the way words translate and express specific ideas. In some cases, translating exact words could result in survivors taking offense and shutting down the conversation. One focus group participant shared:

> You have to choose the words [that] are not the direct language. . . . Some of the questions, they will not be, like, culturally transferrable. . . . It will be difficult to translate the concept as it is because it might be perceived as an insult for some . . . , and nobody would even agree to talk to you anymore. (FG1)

Participants discussed the sensitivity and intimidating nature of language describing anything to do with intimacy, sex, and sexual violence, as well as strangulation and attempted murder. This can also be the case for other terms, for less apparent reasons. A participant shared:

> Sometimes the word "safe" triggers either bad or good. . . . She's opened up to you, and then the word "safe" comes in. She shuts up, and she will never trust you again. . . . The word "safe" can be [interpreted] in so many ways. (FG2)

While IPV screening in the United States commonly consists of the question "Are you safe at home?" participants considered this type of question too direct. As one person shared, "Where we come from . . . we don't ask those questions" (FG2). Questions such as these may feel like an interrogation or even a reprimand. One participant explained that "questions lead to other things; they will choose not to talk to you or talk to you [because] they don't want to feel reprimanded" (FG2). Questions leading to "other things" may allude to lingering fears of interrogation and persecution associated with (past) contexts of war and political instability, in which human rights violations were rampant; involvement of family and community members who may pass judgment on women; and/or unsolicited intervention by law enforcement in the U.S. context.

Other participants indicated that the question around feeling safe at home would either illicit an automatic no or even laughter. One practitioner shared, "They will laugh at you—'Safe at home, what do you mean by that?' They will make fun of you, and you drop the question. There is no way you can ask it again." The sensitivity of certain words and directness of questions included on the risk assessment reiterates the importance of building rapport and trust and taking time with clients in anticipation of possible triggers that shut down the conversation.

Participants also spoke to the added complexity of using language interpreters in risk assessment, due in part to a lack of trust and how language is interpreted. Reliance on interpreters may derail an assessment process when important linguistic/cultural nuances are not captured.

Risk Assessment as Education and Intervention

Practitioners described that an important benefit of engaging clients in risk assessment is to educate them about specific risk factors and their level of danger, as well as about their rights, options, and healthy relationships. Practitioners described how less widely known risk factors were touch points that allowed them to talk to their client about risks. One participant said, "Like the unemployment questions. A lot of victims are really surprised to find out how much danger they're in because of that" (FG3). In the same focus group, practitioners talked about perpetrator suicide threats: "I teach them, if he dares to kill himself . . . he can kill you" (FG3). Participants indicated the importance of educating clients about risk while also providing information about safety. As one practitioner stated, "My aim is to make sure . . . the education part for the woman is clear. We give options: . . . 'This is what can happen, and this is what you should do'" (FG9).

Risk assessment and safety planning were described by participants as going hand-in-hand. Practitioners used the risk assessment process as an opportunity to discuss safety planning and suggest

strategies clients could employ to improve their safety and well-being as well as the safety of their children when applicable. Participants stressed the importance of ensuring that risk assessment with immigrant and refugee survivors leads to concrete action on behalf of clients. As one participant emphasized (FG6), "There should be an action that's immediately followed . . . the victim should know there will be an immediate outcome after the assessment." Because telling their story is so difficult, it is important that clients see the value in answering difficult questions. Indeed, participants described the potential harm in providers repeatedly asking survivors the same questions and underscored clients' discomfort with telling their story more than once or to more than one person and organization: "They don't want to tell the story here, there, no . . . Sharing information is not easy" (FG6). Having specific referral procedures, trusted colleagues across systems, and the ability to transfer information from one service setting to another were important components of successful referrals, particularly for clients at high risk. As one practitioner explained:

> When there is someone who scores [high risk] . . . we are able to call the team together to create the safety plan. A lot of times, that's partnering with the police, the probation . . . making sure that the person has all the services that they need. (FG5)

Assessing Risk When Forces Compel Women to Stay

Complicating the imperative to provide concrete solutions to survivors who engage in the risk assessment processes, participants highlighted the extent to which their clients may face social pressure to keep families intact and the importance of acknowledging and accounting for those dynamics in practice. Participants across groups discussed that some women are expected to "prioritize their families over themselves and their [ethnic] communities before their families" (FG8). In specific sociocultural contexts, women marry into a family as opposed to marrying an individual. This shapes survivors' abuse experience and options as women may experience abuse from a partner and other family members. One participant explained:

> We have to do additional safety planning for her around the family. It looks so different than the safety planning with her husband, because with his family abusing her, she's not safe talking to anybody. (FG7)

Societal norms that hold women responsible for maintaining domestic harmony in turn blames them for discordance or conflict among family members. As one participant illustrated, "If something doesn't go right, it's her fault, and you try again, and you try again better next time" (FG5). Another shared, "It's very hard on the woman when a family breaks. . . . The community blames the woman" (FG6). Women's reliance on male partners for financial and material support further contributes to the impetus to keep the family together out of fear of losing their home and ability to fulfill basic needs. This is exacerbated by fear of deportation, particularly for survivors who are undocumented. As one participant explained, "They're afraid that the husband is going to be deported or they are going to be deported" (FG4). Therefore, women may carry the burden of keeping their families together at a potentially significant toll to their health and well-being.

DISCUSSION

Grounded in the practices and perspectives of practitioners working with IPV survivors who have immigrated to the United States, the findings reveal key insights into ways in which risk assessments are administered, including the importance of providing relevant services and support. Participants highlighted interrelated techniques to conducting risk assessment with diverse groups of immigrants and refugees focused on building trust and provider–client relationships, taking sufficient time, using carefully crafted language, engaging clients in conversations, and intertwining risk assessment with education, safety planning, and referral. Keenly sensitive to the power of words and the limited transferability of terms from American English into other languages and cultural contexts, participants noted the importance of carefully translating key concepts to assess risk without alienating clients. Importantly, terms used in these contexts must have semantic equivalence in translation to optimize client understanding of sensitive concepts (Njie-Carr et al., 2018). Participants emphasized the

imperative for risk assessment to lead to tangible responses and outcomes rooted in survivors' perceptions of needs, which may not align with options offered by mainstream IPV services (Wachter et al., 2019). Safety and services planning must account for social as well as economic pressures to keep their family together. The findings reveal tensions between the realities and risks that women face and existing service paradigms, where the tools at practitioners' disposal may focus on helping women to leave.

Although IPV risk assessment research examines the reliability and validity of instruments, it has not systematically focused on the implementation of risk assessment instruments (Graham et al., 2021). Social workers have an opportunity to use IPV risk assessment as the best available evidence of the possibility of future severe violence or homicide (Messing & Thaller, 2015). These findings reiterate the importance of incorporating practitioner expertise and client self-determination to appropriately administer the risk assessment and to ensure that suitable interventions emerge from the process (Messing, 2019). Indeed, participants indicated that the *process* of risk assessment—beginning with building trust, engaging in conversation, incorporating education, and leading to intervention—is an important part of their practice. While building trust and engaging clients reflect good social work practice writ large, these data indicate that trust and engagement are particularly salient entry points for survivors who originate from contexts in which relational approaches are important in all aspects of life. Furthermore, building trust is paramount for people who are unfamiliar with how to navigate complex social service systems in the United States (Wachter et al., 2019) and may experience discrimination in all facets of life post-arrival to the United States (Grove & Zwi, 2006). The findings highlight the extent to which practitioners have drawn from deep knowledge of the contexts in which their clients contend with IPV and creatively develop processes for making existing tools work for their clients.

The time it takes for practitioners to build a rapport with immigrant and refugee survivors indicates that the use of IPV risk assessment in brief treatment settings, such as in the Emergency Department or at the scene of a police-involved IPV incident, may lead to an incomplete picture of risk. Further, because it is important that survivors do not have to tell their stories multiple times across multiple agencies, data sharing across service settings may also allow a linguistically and culturally informed advocate to gather risk information in a sensitive fashion and, with explicit consent from clients, communicate that information across systems in ways consistent with standard risk communication practices. Coordinating a community response through memorandums of understanding or interagency agreements that allow risk information to be shared, safely and ethically, across practitioners working with the same survivor, would provide advocates with needed risk information without alienating a survivor through repeated questioning regarding sensitive topics. In settings where risk assessment is not appropriate for immigrant and refugee survivors, universal education about IPV and risk factors for intimate partner homicide may provide the impetus for further intervention. Providing automatic connections or referrals to culturally and linguistically skilled social service providers rather than conducting risk assessment in brief treatment settings may facilitate intervention. This may be particularly important when strangulation, sexual assault, and/or near-fatal violence are suspected, as these topics were identified as sensitive by practitioners.

In combination with holistic assessment and service planning processes, risk assessment is, ultimately, a vehicle to intervention. With immigrant and refugee survivors, social workers and advocates may have to reconsider both the approach to and outcomes expected from assessing risk. Depending on survivors' self-determined goals, advocacy may need to focus on strategies of remaining safe within an abusive relationship or reducing the impact of violence. Assessing risk provides survivors and advocates with information they can use in the co-creation of safety planning strategies. Social workers and advocates may focus on education and risk mitigation strategies, such as ensuring a hospital visit after strangulation or harnessing community strengths to develop an emergency safety plan. Practitioners must be able to assess critically how their own positionality and values influence their perception of survivors options and decision making.

Focusing on a strengths-based approach recognizes how clients and their broader communities foster resilience in the face of trauma across the lifespan and from multiple sources (e.g., political vio-

lence, displacement). Social workers and advocates must also recognize the risks faced by immigrant and refugee clients given current policies and practices in the United States. Within an evidence-based framework, practitioner expertise must include knowledge of immigration policies that constrain options available to survivors with diverse immigration experiences and statuses (Messing, 2019).

Developing risk-informed practices attuned to diverse backgrounds, positionalities, and immigration experiences is imperative moving forward. In addition to possible shifts in how practitioners approach risk assessment highlighted by the current study, there are other points of consideration. For instance, responses to survivors who seek help should recognize the possibility of nonpartner perpetration of domestic violence. Adult survivors may experience abuse from other family members in addition to intimate partners, yet risk assessment instruments and processes do not currently address these dynamics. Furthermore, it is paramount that all responses take concerted measures to uphold survivors' privacy and rights to confidentiality to ensure women's safety and well-being at home and in their communities. The need to include language interpreters in sensitive conversations such as those necessitated by risk assessment processes may compromise survivors' confidentiality or hinder their ability to share freely.

Within an evidence-based framework, client self-determination is informed by the best evidence, including evidence of risk (Messing, 2019). Yet, tensions arise when survivors' lives are at risk; indeed, over half of focus group participants in the current study reported that a client had been a victim or perpetrator of intimate partner homicide or attempted homicide. Survivor-centered advocacy may include redefining success, enhancing safety, and ensuring safety of children (Davies, 2009). It is important to acknowledge the limitations of current intervention strategies (Ramsay et al., 2009), a persistent challenge for IPV advocates, and make strides to bridge these gaps.

Finally, while empirical evidence regarding the intersection of IPV and immigration is building, gaps in knowledge and methodological issues persist. Importantly, IPV research and practice must recognize and account for heterogeneity among people who immigrate, migrate, seek asylum, and resettle as refugees, both within and between groups, however socially constructed (Lee & Hadeed, 2009). U.S.-based responses to IPV must address individualist assumptions embedded in practice paradigms that affect goodness-of-fit between available services and survivors' experiences and needs (Ashbourne & Baobaid, 2019). In addition, an emergent body of research indicates important differences between foreign-born and multigenerational immigrant groups and highlights the need for longitudinal studies to further understand how intergenerational immigration, recency of immigration, and acculturation interrelate with IPV (Kimber et al., 2018; Raj & Silverman, 2003). Future research should explore differences between immigrant generational status to offer insights on the use of risk assessment related to differences in education, language, communication, trust, and acculturation.

Although this research is the first to examine *how* practitioners conduct risk assessment with immigrant and refugee survivors, it is not without limitations. The questions that pertained to risk assessment practices were only a portion of the focus group interview guide. While this analysis provides a broad overview of practices that spanned participants' experiences across groups, there are nuanced approaches specific to linguistic and/or sociocultural groups (e.g., religious affiliations), which were not captured or adequately addressed in this study. Although the sample reflected practice experiences with diverse groups across the United States, it may be that particular views were over- or underrepresented. Due to the purposive nonprobability sampling approach the study employed and aims of qualitative research, the findings are not generalizable beyond the study participants.

CONCLUSION

Risk factors and barriers to services exacerbate safety concerns among immigrant survivors. Therefore, when survivors connect with a helping professional, it is critical that providers engage in a way that resonates with diverse clientele. Listening to practitioners with expertise serving immigrant and refugee IPV survivors and training providers in how to assess risk and engage survivors is paramount to expanding the relevancy of domestic violence services for diverse groups. Findings of this study highlight the importance of engaging survivors in risk assessment and safety/services planning by building relationships, having conversations, using

culturally sensitive language, ensuring that risk assessment leads to survivor-defined intervention, and taking into account important contextual factors related to immigration. SWR

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