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"Where Is the Women's Center Here?": The Role of Information in Refugee Women's Help Seeking for Intimate Partner Violence in a Resettlement Context

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Abstract

A qualitative study examined factors that hinder help seeking for intimate partner violence among women who resettled to the United States as refugees. A refugee resettlement agency recruited female clients ($n = 35$) and service providers and stakeholders ($n = 53$) in the metropolitan area. The study employed individual interviews and focus group discussions to collect data. An inductive and interpretive thematic approach guided the analytical process. The analysis revealed challenges related to information gaps and communication struggles complicating help-seeking processes. The findings point to the importance of bolstering information sharing within and across informal and formal networks to help women navigate support and services in resettlement.

Keywords

health information, refugee, domestic violence, help seeking

Despite a robust system of social services, women who immigrate or resettle as refugees to the United States face social, legal, and economic disparities that hinder access to

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domestic violence services (Erez et al., 2009; Lee & Hadeed, 2009; Menjívar & Salcido, 2002; Rodríguez et al., 2009). Women are particularly vulnerable to violence during armed conflict and in forced migration (Usta et al., 2008), and women continue to face ongoing and emergent risks of violence upon arrival to a new country (Cook Heffron, 2019; Salcido & Adelman, 2004). Although estimating the prevalence of intimate partner violence (IPV) among immigrant populations is challenging, research indicates that women can experience an increase or emergence of violence and abuse by their partners post-migration (Guruge et al., 2010). Research has highlighted the need for domestic violence services that account for complex pre- and post-arrival experiences (Rees & Pease, 2007; Wachter, Dalpe, & Cook Heffron, 2019). Yet, comprehensively meeting the needs of immigrant and refugee IPV survivors remains elusive.

Immigrants comprise multiple groups of people who arrive with the intention to settle permanently in a new country. One of those groups includes refugees who resettle through federal refugee admissions programs. Resettlement refers to the transfer of refugees from a State in which they have sought protection to a third State that has agreed to admit them with the opportunity to naturalize (United Nations High Commissioner for Refugees, 2011). Since the authorization of the 1980 Refugee Act, the United States has resettled over 3 million people with refugee status (Connor & Krogstad, 2018). A national network of federal and state government agencies, nongovernmental and faith-based organizations, and community partners and volunteers support the resettlement of refugees in the United States. Federal funding prioritizes employment services, with the aim of ensuring that clients become economically self-sufficient in a matter of months (Office of Refugee Resettlement, n.d.).

While many dynamics of IPV are similar across all groups of women, specific factors exacerbate risks and shape experiences of IPV among immigrant women. Factors associated with the perpetration of IPV against women who immigrated to the United States include precarious immigration status, discrimination, unfamiliarity with laws, and lack of knowledge of services (Menjívar & Salcido, 2002). These risk factors also serve as barriers limiting women's access to services and assistance (Reina et al., 2014). In an effort to understand less commonly addressed facets of IPV help seeking, this analysis specifically examines information and communication challenges that hinder help seeking for IPV among women who resettled to the United States as refugees. In addition, by drawing from conceptual frameworks that theorize information in help seeking and network-oriented responses to IPV, this article considers the role of formal and informal networks in addressing information and communication gaps.

Help Seeking for IPV

Help seeking for IPV is the disclosure of violence to obtain assistance (Morrison et al., 2006). Seeking help from informal and formal networks is associated with numerous positive outcomes for IPV survivors. Informal networks refer to personal connections with family, friends, and neighbors, and formal networks comprise those who serve in professional capacities such as domestic violence agencies, law enforcement, health providers, and other social service providers. Friends and family have considerable

potential to play a significant role in women taking steps to improve their safety and well-being (Goodman et al., 2005). Trained domestic violence advocates assist clients with assessing options, risk assessment and safety planning, and connecting them to available legal, shelter, behavioral health, and financial services, among others (Messing & Thaller, 2015; Wood, 2015). Seeking informal help and social support can serve as a protective factor against future violence (Coker et al., 2012; Goodman et al., 2005) as women build a cadre of safety strategies. Seeking formal assistance and receiving supportive services can mitigate the myriad impacts of IPV on women's health, mental health, and social and economic outcomes (Coker et al., 2003, 2012; Ellsberg et al., 2008). Nevertheless, women disclose first and most often to people within close personal, or informal, networks (Barrett & Pierre, 2011; Sylaska & Edwards, 2014). Importantly, seeking help from informal networks can serve to connect survivors with formal services (Kyriakakis et al., 2015).

While benefits of seeking services and support are clear, immigrant women face numerous barriers that discourage disclosures of IPV. Being foreign-born, among other demographics, is associated with decreased formal help seeking (Cho et al., 2017). Barriers impeding help seeking include lack of familiarity and awareness of services in a new context, social isolation, gender role expectations, shame, silence, and discrimination (Adams & Campbell, 2012; Dutton et al., 2000). Immigrant women who seek help for IPV often do not have access to domestic violence professionals who speak the same language or trained language interpreters, both of which are instrumental to accessing viable services (Bhuyan et al., 2010; Lee & Hadeed, 2009; Raj & Silverman, 2002; Vidales, 2010). Furthermore, isolation can prevent survivors from getting help, and network members can fail to play a supportive role (Goodman et al., 2016). These factors play a role in how survivors weigh the costs and benefits of seeking help (Liang et al., 2005).

Zadnik et al. (2016) reported that lack of trust in, as well as increased fear of, formal service networks lead to limited use of formal support among undocumented Latina immigrants, in particular. Furthermore, undocumented immigrants, including immigrant women who experience IPV, often fear that reporting crimes, seeking shelter, or requesting help will lead to their deportation (Bauer et al., 2000; Becerra et al., 2017). In addition to specific political shifts, both help seeking and service access among immigrant survivors are further hindered by an increasingly anti-immigrant and xenophobic sociopolitical climate and by discriminatory practices encountered in formal systems of support (Bauer et al., 2000; Crandall et al., 2005; Guruge & Humphreys, 2009). While women who resettle as refugees may officially have stable immigration status, it is important to note that recent changes in the U.S. refugee program amid widespread immigration policy shifts may increase women's perception that their status is vulnerable. These changes in policy also serve to put on hold, indefinitely, the possibility of reuniting with family members, limiting women's options for seeking help.

Despite acknowledgment of the critical role trust, immigration status, and language play in shaping help seeking among immigrant survivors, the role of information in help seeking is an underexplored area of the IPV literature. Borgatti and Cross's (2003)

model of health information seeking posits that the probability of seeking information from another person depends on understanding and valuing what that person knows, having access to that person in a timely manner, and perceiving that the benefits of seeking information from that person outweigh the costs. In addition to actively seeking information, people may play a passive role and/or rely on others to search for information on their behalf (McKenzie, 2003). How individuals seek information is context specific and shaped by cultural norms, social positions, exposure to and accessibility of information sources, and type of information needed (Harris et al., 2012; Hiebert et al., 2018; Johnson, 2003; Lambert & Loiselle, 2007). Multiple factors shape health-related information seeking among immigrant groups (Johnson & Case, 2012), including lack of familiarity with the local social service landscape, language barriers, and loss of social networks (Kim et al., 2015).

Conceptual Frameworks

The current analysis draws from theoretical frameworks that seek to elucidate elements of help seeking related to information and communication not commonly addressed in the IPV literature. Dunne (2002) developed the *person-in-progressive-situations* approach to study battered women's information needs, barriers to information, patterns of information seeking, and ways of using information to inform decision making. This work highlighted the importance of treating information needs and information seeking among women experiencing IPV as progressive and dynamic (Dunne, 2002). In this model, information seeking begins when a woman perceives a gap in her knowledge and believes she needs information to solve her problem. The multifaceted nature of IPV (health, financial, legal, medical, emotional, and psychological components), personal factors (knowledge of resources, past experiences, cultural backgrounds), women's responses (feelings of responsibility, privacy, shame, fear), and situational constraints inform how women make sense of IPV and understand their information needs (Dunne, 2002). Later, Westbrook (2008) expanded this framework by developing a *progressive information engagement* model, which highlighted information needs, affective influences on efforts to meet information needs, and information myths that function as cognitive barriers as per four stages of information engagement among IPV survivors. While useful in exploring the identification of and action on women's IPV-related information needs, these frameworks to date have not been extended to specifically include the experiences of immigrant and refugee women nor the contemporary immigration-related sociopolitical context.

This study also drew from a second conceptual framework to consider network-oriented approaches to addressing communication and information barriers hindering help seeking for IPV among refugee and immigrants. A network-oriented approach involves initiating collaborations between domestic violence advocates and members of survivors' informal networks by helping survivors identify and engage potential support people from their networks, supporting network members in their efforts to support survivors, and assisting survivors to expand and/or build new support networks (Goodman & Smyth, 2011). The main tenet of this approach is that sustainable

solutions to IPV come from survivors, effective formal networks, activated network members, and the collaborations between them (Goodman & Smyth, 2011; Mancini et al., 2006). A qualitative study of network-oriented strategies applied in practice led to the articulation of five dimensions integral to the work, which involved helping survivors build capacity to form healthy relationships, identify helpful and harmful network members, reengage with existing networks, develop new relationships, and respond more effectively to network members (Goodman et al., 2016). These strategies are especially important when considering communities in which women face particular marginalization and social exclusion, such as new immigrants (Goodman et al., 2016).

Current Study

People with access to social support appear to have greater access to relevant health information and endorse healthy behaviors (Uchino, 2006). It follows, then, that people who have limited social support experience reduced access to good quality information, hindering help-seeking behaviors. People who resettle as refugees separate from extended family and community systems of support, and thus often arrive to the United States with reduced social support (Wachter & Gulbas, 2018). Therefore, women who experience IPV in the resettlement context may not have sufficient information to know what avenues to take in seeking help.

Existing literature highlights the need to understand help seeking and access to information among IPV survivors and articulates the function of informal networks. However, research and practice have not systematically addressed the confluence of information needs, communication challenges, and help seeking among women who experience IPV, nor sufficiently examined the role of informal networks in addressing gaps. This area of inquiry has particular implications for women who resettle to the United States and face complex barriers accessing help. Therefore, this analysis examined information and communication challenges associated with seeking help for IPV among women who resettled to the United States as refugees.

Method

The current analysis forms part of a broader study that employed qualitative methods to garner the perspectives of women who resettled to the United States as refugees and were clients of a resettlement agency, as well as service providers who work with immigrants and refugees on the topic of IPV help seeking (Wachter, Cook Heffron, & Dalpe, 2019; Wachter, Dalpe, & Cook Heffron, 2019). The study was conducted in an urban metropolitan area in a southeastern region of the United States. The city where the study was conducted is on the outskirts of the state capital and boasts a large multicultural population accompanied by a number of community-based organizations and social service providers. The International Rescue Committee (referred to below as the refugee resettlement agency) implemented the study from 2016-2018 in collaboration with the first author (an external researcher).

Recruitment

Agency staff recruited a purposive sample of participants comprised of women who had resettled to the United States through the federal refugee resettlement program in the past 5 years, as well as representatives from social service agencies and other local stakeholders. Refugee participants were clients of the recruiting agency. To ensure the inclusion of survivor voices in the study, staff recruited a subsample of women who resettled as refugees based on previous disclosures of IPV or sexual assault to the agency through routine screening procedures. To capture perspectives across the social ecology of potential helpers, at which survivors are at the center, the study design was intentional in its inclusion of women who had resettled as refugees to the United States and did not (or chose not to) disclose experiences with violence and abuse. Agency staff received in-depth training and guidelines based on institutional review board (IRB)-approved procedures to ethically engage vulnerable participants, who are also clients, in recruitment activities. Using these guidelines, staff spoke with women who resettled to the United States by phone and/or in person to share information about the study. In recruiting women who had previously disclosed IPV or sexual assault, staff followed specific procedures based on standards for conducting ethical research with survivors (Ellsberg & Heise, 2005). Recruitment procedures for all refugee clients involved informing each woman that they would receive transportation to and from the meeting location and a VISA gift card. In addition, agency staff emailed a wide range of service providers and community-based organizations inviting people in the area to participate in the study. All participants were over the age of 18 years old.

Participants

Table 1 provides information on participant demographics ($n = 88$). Participants who were recruited based on their status as refugees who resettled to the United States ($n = 35$) originated mainly from Central and East Africa, followed by South and Southeast Asia, and the Middle East. The majority of these participants indicated having fled their countries of origin, and a small number of women described threats of religious persecution. The majority (17 out of 35) were married; nine were divorced, separated, or their spouses had passed away; and seven indicated they were single. Most (19 out of 35) had been in the United States 12-24 months. Ten participants had disclosed having experienced IPV or sexual assault during routine screening carried out by the agency. The second group of participants ($n = 53$) included 29 participants who currently worked in the field of refugee resettlement and 13 participants who were employed by a domestic violence agency or community-based organization. Another 11 participants worked in other social service, health, legal, and political roles, which involved serving refugee and immigrant groups.

Data Collection Procedures

Data collection methods involved individual interviews and focus group discussions. All participants engaged in detailed informed consent procedures prior to

Table 1. Participant Demographics.

Demographics	Refugee clients (n = 35)	Service providers, stakeholders (n = 53)	Total (n = 88)
Region of origin			
South and Southeast Asia	8	4	12
Central and East Africa	25	10	35
West and North Africa	—	5	5
Eastern Europe	—	2	2
Middle East	2	1	3
Central America and Caribbean	—	4	4
North America	—	27	27
Gender			
Female	35	43	78
Male	—	10	10
Age			
18–29	10	16	26
30–39	10	24	34
≥40	15	13	28
Years of formal education			
0–5	20	—	20
6–12	14	7	21
4 years postsecondary (attained undergraduate degree)	1	27	28
≥4 years postsecondary (attained graduate degree)	—	19	19

Table 2. Study Participants by Data Collection Method.

Participants	Individual interviews	Focus group discussions
Refugee clients	10 participants/interviews	25 participants (8 groups)
Service providers, stakeholders	6 participants/interviews	47 participants (15 groups)
Total	16 participants/interviews	72 participants (23 groups)

starting any data collection. Overall, two members of the research team conducted 16 individual interviews and 23 focus group discussions (see Table 2 for details). Women who had disclosed experiences with IPV and sexual assault only participated in individual interviews with the lead researcher and a language interpreter in a confidential space at the agency. Focus group discussions with refugee clients were organized by language to facilitate the conversation among participants. By design, focus group discussions with refugee clients targeted a maximum of four people to accommodate for language interpretation; however, half of the eight focus groups ultimately had only two or three participants due to scheduling constraints.

Service providers and other stakeholders participated in individual and focus group discussions. Individual interviews conducted with the help of a language interpreter were on average 84 min in length, and interviews conducted in English averaged 68 min. Focus group discussions conducted with the assistance of a language interpreter were also on average 84 min, and groups facilitated in English averaged 72 min in duration. Data collection took place in a private room at the resettlement agency, a local church, or participants' workplaces. All data collection activities began by gathering non-identifying demographic information. Semi-structured interview guides developed for the express purpose of each category of participant queried various aspects of their personal and professional experiences. All interviews were audio recorded, professionally transcribed, and reviewed for accuracy. The study utilized professionally trained language interpreters who were part-time employees of the resettlement agency. Interpreters assisted with all interviews (n = 10) and focus group discussions (n = 8) with refugee women; languages included Swahili, Farsi, Bembe, and Burmese. Language interpreters received 3 hr of training and signed confidentiality agreements prior to assisting with the study.

Human Protections

The University of Texas at Austin Institutional Review Board reviewed and approved the study. The resettlement agency followed approved guidelines to recruit and protect the identity of all participants. In addition to specific considerations for conducting research with IPV and sexual assault survivors (Ellsberg & Heise, 2005), recruitment guidelines emphasized measures to avoid pressuring refugee clients to participate. For example, participants who were clients of the recruiting agency were informed that their decision to participate would not have any impact on their relationship with the organization and current/future services at a minimum during recruitment and informed consent procedures. All agency staff responsible for recruitment were part of the research team. As such, they participated in standard human subjects training, received additional training from the lead researcher, and were bound to rules of confidentiality. If people expressed interest in participating, agency staff moved forward with scheduling. Prior to starting any data collection, a researcher conducted detailed informed consent procedures with all potential participants. Those who gave their verbal consent to participate and to allow researchers to audio-record the discussion proceeded with the interview or focus group discussion. Participants who were recruited based on refugee status received a US$25 gift card and two round trip tickets for the local public transportation system.

Data Analysis

The analysis software (NVivo, Version 11) was used to manage and code data. Thematic analysis (Guest et al., 2012) guided the overall analytical approach to examine and interpret factors shaping women's help seeking for IPV in resettlement. Two of the researchers started the analysis process by reading through all the transcripts,

taking notes, and discussing preliminary impressions and ideas that arose. Structural codes, including one labeled as *barriers to IPV help seeking*, were first applied to the data to assist with data management. Subsequently, and within those structural codes, the lead researcher used an inductive approach to code the transcripts. Individual interviews and focus group discussions were analyzed at an individual level, an approach supported in the methodological literature (Carey & Smith, 1994). The lead researcher then grouped inductive codes under the barriers to IPV help seeking structural code into preliminary categories and labeled them (e.g., not knowing how things work here, keeping quiet, and language issues). Based on these groupings, the team worked together to refine these categories and facilitate a broader level of abstraction (Saldaña, 2012), consulting the IPV help seeking and health information seeking literatures to further situate and make meaning of the findings. This interpretive work culminated in the three themes related to information and communication in help seeking for IPV that form the basis of the findings presented below.

The researchers followed procedures to establish rigor in qualitative data analysis (Creswell, 2013), which included regular meetings to discuss processes and emergent findings. This team-based analytical process served as a check against undue and unchecked bias on the part of any one person involved in interpretation. Related researchers engaged individually and collectively in a reflexive process to reduce the possibility that pre-existing understandings affected the veracity of the analysis (Padgett, 2016). In addition, to promote transparency and organization, researchers documented key activities and decisions in an audit trail (Rogers & Cowles, 1993).

Findings

The analytical process produced three themes related to information and communication in the context of IPV help seeking among refugee women in the United States: (a) “Where’s the women’s center here?” (b) “When we don’t talk” and (c) “All I can do is ask if you’re safe and hope you understand.”

“Where’s the Women’s Center Here?”

Women who resettled to the United States as refugees indicated not knowing what service options were available in the United States for women experiencing abuse. Participants repeatedly posed questions over the course of the discussions such as, “Where is the women’s center here?” and “Where can a woman who is suffering in America go for help?” A client who had disclosed experiencing IPV indicated, “I don’t know who else I could ask for help, the only person I could ask is my caseworker [at the resettlement agency].” Women were keen to know how they could be supportive to “sisters” experiencing IPV and expressed feeling uninformed and ill equipped to be of assistance. Another woman, who after years of abuse sought and received help from an international organization while in a refugee camp overseas, did not know if the U.S. arm of the same organization was set up to help women who had experienced

IPV. She assumed that they had “an advice office” for women here as well but was unsure. Another client shared,

> Even if we know what resources are there, we don’t know how to go about it, where to start. So if my friend decides she going to leave her husband, and she asks me, I would refer to somebody who might know this kind of information. Maybe someone who has been here longer. Because if I don’t know, I can’t help her. . . . Everything is so hard, just getting things done.

Another group of refugee clients discussed women struggling with husbands abandoning them post-arrival to the United States and not knowing where to turn for help. Three main service and support options for women in abusive relationships in the resettlement context emerged over the course of the discussions: women might turn to a trusted family member or friend, a resettlement agency, or to the police. However, when asked to describe specific pathways for seeking help in the United States, women spoke in vague terms. As one group discussion participant shared, “I’ve heard about going to an office, like getting help from an authority. I heard about that but I’m not sure what that is or what the process is, . . . or where even to start.”

In contrast, women indicated having a better sense of service options in their countries of origin and while in displacement, prior to resettling to the United States, and noted the central role family played in the past in help seeking for IPV. Women frequently mentioned the presence of women’s rights organizations, women’s programs, and community-based options in their countries of origin as well as in refugee camps, and other sites of displacement. Women in a focus group of refugee clients described in their country of origin female elders to whom they would go for advice when there were problems in the home, who would listen to wife and husband separately, and then advise them together. However, they had not heard of “anything like that since we came to the U.S.” Another group of clients described,

> Back home we had a program the government created for people who needed help, if the husband was physically abusing them they can go and report. They had a representative in the community and you would go to her first and make an appointment. And then she would look at the case and then if she thinks this is something she thinks needs to be taken care of, then she takes it to the next level. . . . But we don’t know anything about that here.

Notably, women pointed to the need for professional domestic violence services. A client who had suffered years of abuse shared, “There should be a group of people who are really experts, who want to do this work. The resettlement agency is all bureaucracy and paperwork. They never go deep down into a problem to solve it.” Clients in one group shared, “Women should go to professionals that specialize in domestic violence, like women rights people, leaders who would actually get things done.” Participants expressed an assumption that such services or organizations existed and that it was just a matter of knowing about them. In the same group of clients, women expressed, “We don’t go out that much, so we don’t know and since we haven’t had

that problem yet we haven't looked for the information, but if it came to it, I know there is help." Women talked about the need for more information sharing with resettling women, and that while the role of responding to IPV should be in the hands of experts, the resettlement agencies had an important role to play in sharing information and promoting discussion. One provider echoed this sentiment,

> When they come here to the States, we educate them about paying taxes and educate them about health. [IPV] is another health thing. They need to know their rights, options, and where to go.

"When We Don't Talk"

The silence surrounding women's experiences and suffering emerged as a significant factor shaping women's access to support and services. Women described keeping quiet at all phases of their experiences—from when they entered the relationship and the abuse began, living over time with the abuse, and even after they left the abusive relationship. For some, the silence reflected entrenched social and familial norms that equated being a woman with suffering. For others, staying silent was a strategy for keeping themselves safe and financially stable as they navigated daily life with abusive partners.

Service providers, often equipped with insider knowledge and language skills, spoke ardently of the silence surrounding women's experiences of IPV. In a focus group of service providers, participants described women opening up about challenges they were facing at home, such as a husband's infidelity, but not able to verbalize their experiences with violence. One provider described acting in the role of interpreter for a caseworker at her agency. She shared,

> Because we know. We know how our people react when they talk, *when we don't talk*, I can see it. . . . Sometimes I was crying. I told the other caseworker, "Please, can you go deeper because now I see this woman's beaten at home even if she cannot say it." Because she knows if she says it, maybe she going to be more in trouble because she depends on the man.

Providers shared, "This is the problem here because they don't tell you. They don't tell you what they're suffering from, what problem they have." Another provider described,

> There are so many woman out there [experiencing abuse]. Most of them, they don't speak up. They don't talk about it. They don't feel comfortable about it. It's like a stigma. Just today, a lady said to me, "Well, I thought that you knew." I said, "How can I know?"

A frequent sentiment expressed by participants was that providers are unable to offer help if women do not disclose.

Providers attributed the silence cloaking women's experiences with IPV to cultural and gender norms, and economic vulnerability. One provider observed, "Most women

[we serve] seem almost shy to share what's going on and disclose any needs. It's almost like you have to push to ask." Another provider shared, "We may be working with a victim who wants to gets out, but she lives with her family, and her family applies pressure and says, 'No, in our culture we just work this out. This is a family issue so . . . *be quiet*.'" This pressure extended beyond the immediate family. Participants explained how community members would apply pressure and invoke religious doctrine to persuade women to persevere, have faith, and keep the family intact, all of which pointed to silence as a reaction to violence. Women also described how anticipation of certain reactions on the part of family and community members shaped what they revealed, actions they took, and what they chose to live with. Another provider explained,

> . . . so this one individual in this whole community may have a total different outlook on how things should be, but they still have to live and operate within that same community. So, although they may want to get out and their family may want them to get out of that violent situation, they've still got to go to church, they've still got to go to the supermarket.

Even if a woman is prepared to break the silence to seek help, she risked experiencing backlash, isolation, and stigma in the community.

In contrast to the silence women maintained, participants also discussed what women *do* say. Almost all participants referenced the palpable fear women had of losing their husbands' financial support. Women perceived separating from their husbands as setting into motion a chain of events that would render them financially destitute and unable to pay for housing or provide for their children. Not being able to pay for housing was particularly distressing, especially for women who did not work outside of the home, speak English, drive, or know how to navigate the public transportation system. As described by this provider,

> In almost every case is the financial risk. . . . They're often put in a really precarious situation where they don't know if they can support their family. So, it takes a lot of financial support to get them out, and that's often their first worry.

"All I Can Do Is Ask If You're Safe And Hope You Understand"

Opportunities to disclose and communicate concerns were instrumental to accessing domestic violence services. However, barriers to facilitating meaningful communication loomed large. Providers spoke at length of challenges associated with finding someone who speaks the language of a given client and whom the client deems trustworthy. The lack of translated and interpreted resources compounded communication challenges, especially for complex processes such as filing a temporary protection order. As one provider described,

> You cannot just Google it. . . . You call the courthouse to get instructions. That person doesn't speak your language, nor do they understand what you're even asking. . . . How many times are you going to call before you give up and you don't do anything about it?

Providers highlighted the importance of facilitating linguistic communication as a starting point and elaborated on the added complexity of building trust between women and providers. They explained that a language interpreter or service provider who is directly or indirectly known to the client may signal that they cannot be trusted for fear that they will breach confidentiality and share sensitive information with members of their shared community. From providers' perspectives, earning and protecting trust with clients was challenging. As one advocate shared,

> Just the criminal justice business within itself and being able to trust the individuals that work in it. No matter how many times we may say we're a different entity from the investigations and attorneys, and we're here to support you, they're not going to look at advocates as a separate part of the criminal justice system.

Providers perceived trust as instrumental to helping women overcome the shame they felt disclosing experiences with IPV and stressed the importance of clients getting to know them and gaining a better understanding of the services their agencies provide. Providers felt as if they had to demonstrate and prove to clients that they could be of service to them before they would open up. They also acknowledged that women had to be vigilant in terms of figuring out in whom they could put their trust. For instance, one provider shared, "You have other community members who may seemingly seem like they're going to help you, but they may also be taking advantage of the situation. So it gets very complicated."

The lack of privacy and time created additional communication barriers. Providers noted limited resources related to space and time hindering the privacy and confidentiality necessary for facilitating communication. Those working in open floor plans or crowded office spaces spoke of the challenges involved in creating a space conducive to women sharing openly and safely about IPV. Barriers impeded clients and providers in communicating the urgency oftentimes associated with IPV. Providers shared the imperative to be able to react and respond in the moment when a client was interested in and able to share sensitive information, and the necessity of flexibility and resources to execute protocols to ensure linguistic access, privacy, and confidentiality. As one provider described,

> I had this victim call me and say "I have something I have to tell you." But she can't just tell me because she said, "Can you get the interpreter on the line so that I can explain it to you in full detail?" But I'm in the middle of a trial right now. So, that is another challenge because I can't just get the information immediately from you. *All I can do is just ask if you're safe and hope that you understand what I mean.*

Discussion

Situated within a broad spectrum of needs and challenges, the findings from this analysis revealed information gaps and communication struggles that complicate help-seeking processes for IPV among women who resettled to the United States as

refugees. The women in this study indicated not knowing what service options existed for women experiencing abuse in the United States, limiting their ability to help themselves and play a supportive role in helping others. Information gaps compounded the silence surrounding women's experiences with IPV. Providers highlighted challenges facilitating meaningful communication with refugee and other immigrant clients and pointed to the complexity of building provider–client trust. The findings thus highlight the importance of bolstering information sharing and opening communication channels within and across informal and formal networks in efforts to help women navigate IPV support and services in resettlement contexts.

The findings underscore key constraints women face in expressing and communicating IPV-related concerns in resettlement. Information gaps highlighted by study participants do not come as a surprise. Resettlement agencies share voluminous information with clients within a short window of time as required by federal funding. Agencies are aware that they run the risk of inundating clients with information in the midst of grappling with dramatic shifts in context and a plethora of tasks, including health screenings, school enrollment, and securing employment. The topic of IPV is typically included in standard cultural orientation workshops held within the first 6 weeks of arrival, with a focus on U.S. laws and reporting to the police. Agencies also attempt to streamline information by encouraging clients to bring concerns to an assigned caseworker. In practice, social and health services typically place the burden on women to come forward without investing the necessary face time to establish and maintain trust. Lack of adequate and immediately accessible language interpretation (Asgary & Segar, 2011) further hinders the trust-building necessary for information sharing. Posing an additional communication barrier, providers are not always able to recognize the ways in which women communicate IPV-related concerns, often through subtle clues rather than explicit disclosures.

The analysis reinforces the complexity of information needs among IPV survivors who recently immigrated to the United States, due to lack of familiarity with legal and social service systems, disrupted support networks, and language and literacy barriers (Westbrook, 2008). Without linguistic access, meaningful communication, or sufficient trust, a progressive engagement process to support survivors' decision making cannot ensue. The health information seeking and progressive information perspectives thus highlight the importance of equipping potentially supportive network members with relevant information and opening up communication channels to bridge informal and formal networks of support. The dissemination and circulation of accurate information in and among informal networks is especially important for immigrant groups because it can dramatically expand the scope of information sources available to members who might otherwise not have access (Kim et al., 2015). Indeed, survivors engage with their own networks earlier and with greater frequency and longevity than with formal services and systems (Goodman & Smyth, 2011). However, new arrivals to the United States often do not have viable networks in place that can help them navigate new systems.

Implications for Practice

The findings point to enhancing survivors' capacities to identify, assess, and repair existing social networks and forge new connections across informal and formal sources of support (Goodman & Smyth, 2011). Schultz and colleagues (2016) highlight the importance of community connectedness in interventions "given that both trauma and healing happen in a social context" (p. 42). A network-oriented approach to domestic violence service provision prioritizes helping IPV survivors (re)connect, (re)engage, and foster informal networks as sustainable sources of social support beyond the tenure of professional assistance (Goodman & Smyth, 2011). This approach calls for activation and collaboration between survivors and members of formal networks as critical to sustainable solutions to IPV (Goodman & Smyth, 2011; Mancini et al., 2006). The design of network-oriented interventions can help women rebuild networks ruptured by war, displacement, and resettlement to the United States and provide opportunities for connection, mentorship, and peer support for women who are isolated, experience distress, and have endured a history of IPV. Network approaches may also serve to increase the likelihood and/or timeliness of access to formal provider services (Kim et al., 2015).

The findings also support the development of interventions that seek to improve women's knowledge of locally available domestic violence services in tangible and useful ways so that they can explain services in their own words and know how to access them on their own terms. Expanded programming would involve equipping cadres of women and men with relevant information to help themselves and other network members in response to IPV and other salient health concerns. The *Promotora* or health promoter peer-based model holds promise for getting information out to refugee and immigrant groups (Boothroyd & Fisher, 2010; Im & Rosenberg, 2016; Serrata et al., 2016). Further examination of meanings and expectations of a "women's center" would inform the development of culturally responsive services that refugee and immigrant groups may more readily recognize and access. Providers should thus explore possibilities of standalone or integrated services as a go-to service center for immigrant and refugee women, including those experiencing IPV and/or suffering from long-term consequences of IPV and sexual violence post-migration in the United States.

Women's economic concerns may also open potential avenues for communication and information sharing related to IPV. Providers in this study noted that unlike the silence and stigma surrounding their experiences with IPV, women are more likely to discuss financial concerns with resettlement providers, given the resettlement program's overarching goal of economic self-sufficiency. In recognition of the dynamics of economic coercion in abusive relationships (Postmus et al., 2012), providers may be able to leverage communication about economic self-sufficiency to incorporate information on IPV and the availability of domestic violence services.

Finally, private individual-level interactions are a vital component of a comprehensive information sharing strategy. Linguistically and culturally responsive screening initiatives that normalize talking about experiences of past and current violence,

promote information sharing, and encourage help-seeking behaviors are another promising practice (Wachter & Donahue, 2015; Wirtz et al., 2013). Universal and conversation-based screening initiatives may also have the added benefit of forging stronger connections and trust between clients and providers. However, screening is only a first step. Strong collaborations between service sectors are instrumental to securing refugee and other immigrant women's access to supportive services.

Future Research

Women who experience the loss of supportive networks due to forced migration and resettlement face unmet information needs. As suggested by Kim et al. (2015), the utilization of social networks by immigrants can provide insights into communication patterns used to seek relevant health information, thus shaping health and well-being. The information seeking and network approaches examined in this analysis hold significant potential for IPV among refugees in resettlement and other immigrant groups, particularly those with precarious immigration status, and should be studied further to inform the development and evaluation of practice. In addition, studies of cross-sector collaborations focused on improving refugee and other immigrant women's access to supportive services would address gaps in the academic and practice literatures.

Limitations

A number of limitations associated with this analysis are important to note. Generalizability is not an aim in qualitative research, and readers should consider the analysis and conclusions with this constraint in mind. Language interpreters with a range of skills played a key role in the data collection process. Time constraints and disparate work schedules posed scheduling conflicts, which resulted in a small number of participants in some of the focus group discussions. While facilitators made an effort to stimulate interaction and discussion in these small groups, some functioned more akin to interviews, limiting the generation of group-level data. This was less of an issue in focus group discussions with low numbers of refugee women, which were small by design and because it did not seem to impede the quality of discussion among participants, compared to discussion groups with a low number of service providers and stakeholders, which did not generate as much cross-participant discussion. The original study examined help seeking for IPV among women who resettled to the United States as refugees and the challenges associated with the themes addressed here arose inductively from the analysis. This analysis thus reflects a starting point for subsequent studies that systematically examine IPV-related information seeking among similar groups.

Conclusion

This study highlights the role of information and communication in women's journeys to navigate IPV and its ramifications in a resettlement context. In recognition of both the importance and precariousness of interpersonal networks among refugee and other

immigrant groups, the findings accentuate the need to address information gaps, foster channels of communication, and bridge formal and informal networks in research and practice. Furthermore, findings point to the benefits of blending perspectives from information-seeking and social network models, with broader IPV and refugee research and practice. This study reiterates Goodman and Smyth's (2011) call for the adoption of a network-oriented approach "to frame IPV as an issue that is everyone's responsibility and within everyone's power to address" (p. 90). We join in this call for researchers and providers who serve refugee and immigrant communities to address information gaps, foster channels of communication, and bridge formal and informal networks in practice.

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