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Intimate Partner Violence among South Asian Women in the United States: Prevalence and Help-Seeking Behaviors

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By
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Abstract of the Dissertation

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by

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Data suggests that over 35% of women in the United States have experienced rape, physical violence, and/or stalking by an intimate partner in their lifetime and have reported significant short and long-term impacts, such as post-traumatic stress disorder symptoms and injury (Breiding et al., 2011). Ethnic/minority women are especially vulnerable to IPV with rates ranging from 44% for African American women to 46% for American Indian/Alaska Native women (Breiding et al., 2011).

Although South Asians are some of the most recent immigrants, they are one of the fastest growing ethnic groups in the United States, with a current population of 3.4 million (US Census, 2010). The World Health Organization (2013) estimates that South Asia has the highest regional prevalence of IPV worldwide at approximately 40 percent. Community-based studies conducted in the United States have similarly indicated that South Asian women experience IPV at rates ranging from 40 percent (Mahapatra, 2012; Raj & Silverman, 2002) to 60 percent (Adams, 2000). In contrast, national studies conducted in the United States have found that Asian women have the lowest IPV

prevalence rates compared to their White and non-White counterparts (Breiding et al., 2011).

In order for social work practitioners, policy makers, and researchers to effectively attend to the needs of this rapidly growing population in the United States, it is imperative to understand their experiences with violence and service utilization. Due to the fact that most South Asians in the United States are Indian immigrants (US Census, 2010), this dissertation study utilized secondary data from the National Family Health Survey (NFHS-3) from India to understand the landscape of violence and help-seeking among women in India and to provide a contextual basis to understand the experiences of South Asian (immigrant) women in the United States. The knowledge and insight gained from the secondary data analyses were utilized to inform the design, collection, and analyses of primary mixed methods data examining IPV among South Asian women in the United States. Qualitative data comprising of interviews with service providers identified cultural values that perpetuate and sustain IPV among South Asians and barriers and facilitators to service utilization among survivors. Implications for practice, research, and policy are discussed.

I. Introduction

Intimate partner violence (IPV) is a serious and pervasive public health problem that has deleterious implications for individuals, communities, and society as a whole. According to the Centers for Disease Control and Prevention (CDC-P), IPV encompasses physical, sexual, and/or psychological harm inflicted by a current or former partner or spouse. The CDC-P's National Intimate Partner and Sexual Violence Survey (NISVS) found that more than one in three women (35.6%) have experienced rape, physical violence and/or stalking by an intimate partner in their lifetime and reported significant short- or long-term impacts, such as post-traumatic stress disorder symptoms and injury (Breiding et al., 2011). In addition, the NISVS found that ethnic/minority women are particularly vulnerable to IPV compared to their White counterparts. Approximately four out of every ten women of non-Hispanic Black or American Indian/Alaska Native race/ethnicity (43.7% and 46.0% respectively), and one in two multiracial non-Hispanic women (53.8%) have experienced rape, physical violence and/or stalking by an intimate partner in their lifetime (Black et al., 2011).

Although South Asians are some of the most recent immigrants, they are one of the fastest growing ethnic groups in the United States, with a current population of 3.4 million (US Census, 2010). South Asians are individuals who trace their lineage to one or more of the following South Asian countries: India, Nepal, Pakistan, Bangladesh, Sri Lanka, Bhutan and Maldives; in the United States, 94% of South Asians are Indians (US Census, 2010). According to the World Health Organization (2013), South Asia has the highest regional prevalence of IPV worldwide at approximately 40 percent. Community-based studies conducted in the United States, albeit scant and with limited sample sizes,

have similarly indicated that South Asian women experience IPV at rates ranging from 40 percent (Mahapatra, 2012; Raj and Silvernman, 2002) to 60 percent (Adams, 2000). In contrast, the NISVS, the United States' leading surveillance survey of violence against women, found that Asian women have the lowest IPV prevalence rates compared to their White and non-White counterparts.

The inconsistency in IPV prevalence rates gleaned from regional and community-based studies and national surveillance studies (NISVS) in the US may be reflective of methodological limitations, chiefly in study design and measurement. The NISVS collapsed all Asian groups into one category ("Asian") irrespective of important regional differences that exist between South Asia and South Eastern Asia (e.g., China, Japan). Additionally, the NISVS employed methods that may have inhibited the participation of South Asian women (primarily immigrants), such as administering the survey via telephone and only in English or Spanish. Furthermore, standardized measures that have been found to be limited (i.e. CTS-2) were utilized to assess IPV (DeKeseredy & Schwartz, 1998). These measures do not necessarily ascertain the ways in which ethnic/culturally diverse women define and experience IPV. These methodological issues combined may contribute to an underestimation of IPV among ethnically diverse communities, such as South Asians.

While there is a dearth in research pertaining to IPV prevalence among South Asians, studies on their service utilization are even scarcer. Shelter services (Sullivan and Bybee, 1999); advocacy (Sullivan and Bybee, 1999); supportive counseling (Golding, 1999; Iverson, 2011); and screening in healthcare settings (Edelson, 2013) have been empirically documented to be effective at mitigating the harmful effects of IPV in

mainstream populations. Yet, racial minorities may cope with IPV differently, seeking help from informal supports (e.g., family and friends) as opposed to formal supports (e.g., mental health services, law enforcement) (Coker, 2000). It is important to understand culturally diverse help-seeking behaviors in order to assure access to quality services.

According to Liang and colleagues (2005), culture may influence a woman's perception of what IPV is and what it entails, as well as her decision to seek help and from whom. Values that foster women's submissiveness, collectivism, and stigma/shame may serve as barriers to help seeking (Dasgupta, 2000; Abrahams, 2000; Ahmed et al., 2000). Additionally, the paucity of culturally competent and relevant services may serve as another barrier to formal help seeking (Flicker et al., 2011). Women who are dependents (i.e. immigrants) and/or are from economically disadvantaged communities may have particularly limited access to formal services due to lack of insurance, transportation, childcare and disposable income (Flicker et al., 2011).

South Asian Women's Organizations (SAWO) originally started to raise awareness about violence amongst South Asians and to offer culturally/linguistically sensitive services to South Asian women experiencing violence in the United States. Services that SAWOs offer include: counseling, legal advocacy, transitional housing and community outreach. However, we know nothing about women's experiences accessing such services (e.g., barriers and facilitators to help-seeking, usage of informal services).

In order for social work practitioners, policy makers, and researchers to effectively attend to the needs of this rapidly growing population in the United States, it is imperative to understand their experiences with violence and service utilization. Due to the fact that most South Asians in the United States are Indian immigrants (US Census,

2010), this dissertation study utilized secondary data from the National Family Health Survey (NFHS-3) from India to understand the landscape of violence and help-seeking among women in India and to provide a contextual basis to understand the experiences of South Asian (immigrant) women in the United States. The knowledge and insight gained from the secondary data analyses were utilized to inform the design, collection, and analyses of primary data examining IPV among South Asian women in the United States. This study aimed to:

1. Examine IPV prevalence rates among women in India;
2. Understand the risk and protective factors associated with IPV among women in India;
3. Examine the proportion of survivors in India who utilized IPV related services and from whom;
4. Understand the predictors of service utilization among survivors in India;
5. Examine IPV prevalence rates among South Asian women in New Jersey, New York, and Connecticut;
6. Understand the risk and protective factors associated with IPV among South Asian women in New Jersey, New York, and Connecticut;
7. Examine the proportion of survivors in New Jersey, New York, and Connecticut who utilized services and from whom;
8. Understand the predictors of service utilization among survivors in New Jersey, New York, and Connecticut; and

9. Qualitatively examine SAWO service providers' perceptions of IPV among the South Asian community in the United States and help-seeking behaviors of survivors.

Aims #1-4 were addressed using secondary data from 69, 484 ever-married women of reproductive age (ages 15-49) in India who were administered a domestic violence module as part of The National Family Health Survey.

Aims #5-8 were addressed using primary data collected in New Jersey, New York, and Connecticut using an adapted version of the World Health Organization's Survey on Women's Health and Domestic Violence. Aim #9 was addressed using primary data collected through qualitative interviews with SAWO service providers in New Jersey, New York, and Connecticut.

II. Background and Theory

2.1 Prevalence of IPV

According to the NISVS, more than one in three women have experienced rape, physical violence, and/or stalking by an intimate partner in their lifetime (Black et al., 2011). Of these women, more than 33 percent experienced multiple forms of rape, stalking and physical violence by an intimate partner (Black et al., 2011). Nearly 70 percent of women reported being victimized by an intimate partner prior to the age of 25 (Black et al., 2011).

Ethnic/minority women are particularly vulnerable to IPV. Over half of multiracial non-Hispanic respondents (53%) and 46 percent of Native American women have experienced IPV (Black et al., 2011). Four out of 10 African American women (43.7%) and 37.3% of Hispanic women have experienced IPV (Black et al., 2011). Rates of IPV appear lowest among Asian Americans and Pacific Islanders (19.6%) and Caucasian women (34.6%) (Black et al., 2011). However, data from regional reports suggest that South Asian women have the highest IPV prevalence rates (WHO, 2013; Hindin et al., 2008); an area that requires further exploration for South Asian women in the United States.

Community-based studies that have been conducted (mostly over a decade ago) among South Asians in the United States have corroborated the prevalence rates of IPV ascertained by regional studies. In a study conducted by Mahapatra (2012) with 215 women, the largest sample to date, 38% of women experienced some form of IPV in the year preceding the study. A widely cited study conducted by Raj and Silverman (2002) found that 41% of a sample of 160 South Asian immigrant women in Boston reported experiencing either physical or sexual abuse during their lifetime by an intimate partner.

In a study conducted by Adam (2000) with a sample of 114 Indian and Pakistani immigrant women, the lifetime occurrence of intimate partner violence was over 60 percent.

While these community-based studies are instrumental in elucidating the landscape of violence against South Asian women in America, they too are subject to methodological limitations. First, most of the existing studies are over a decade old, and may or may not be reflective of the current prevalence of IPV amongst South Asians in the United States. Second, existing prevalence studies are largely reliant on the Revised Conflict Tactics Scale (CTS-2) without making adaptations to account for cultural nuances that may affect the way South Asian women define and perceive violence. Third, existing studies almost exclusively examine prevalence of IPV 12 months prior to the study, limiting our understanding of the lifetime prevalence and burden. Fourth, existing studies predominantly focus on South Asian immigrant women. Though most South Asians in the United States are immigrants, generation status (first versus second) may serve as a risk or protective factor to violence. Studies capturing lifetime prevalence in the United States with a broader representation of South Asian women using culturally sensitive measurement tools are needed.

2.2 Risk Factors for IPV

There are a multitude of risk factors at the individual, relational/household, and societal levels for IPV victimization that have been empirically documented. However, there is a paucity of literature focusing exclusively on South Asian American women. As a result, the risk factors discussed below may or may not be applicable to South Asian American women and need to be examined among this population.

Young age has consistently been documented as a risk factor for IPV perpetration and victimization (Black et al., 2011; Romans et al., 2007). A study utilizing data from the National Survey of Families and Households (NSFH) found a negative association between age and experience with IPV (Rodriguez et al., 2001). This is consistent with findings from multivariate prospective longitudinal studies that have demonstrated that IPV declines with age (Kim, Laurent, Capaldi & Feingold, 2008).

Intergenerational transmission of violence is empirically supported as a strong risk factor for both IPV perpetration and victimization. Children who either witness IPV or are subjected to IPV are more likely as adults to adhere to violence-supportive attitudes (Flood & Pease, 2009). A narrative review found that previous exposure to abuse may contribute to future victimization by influencing a woman's attitude towards violence, decreasing her ability to recognize risk, lowering her self-esteem, increasing her guilt and shame and reducing her sexual assertiveness (Söchting, Fairbrother & Koch, 2004). Men with a history of abusive or violence behavior are more likely to exhibit abusive behavior in their future relationships, especially during pregnancy and the post-natal period (Chan, 2009; Jewkes et al., 2006). For adult women who have experienced IPV in the past, the risk of future victimization is quite large. In one study, 50 percent of IPV survivors who sought emergency room care experienced another violent incident perpetrated by the same or a new partner within a year (Sonis & Langer, 2008).

Race and ethnicity are also associated with IPV. However, similar to other demographic characteristics, race/ethnicity is seldom the focal point of IPV studies (Capaldi et al., 2011). In a systematic review conducted by Capaldi and colleagues (2011), being a member of a minority group was consistently determined to be a risk

factor for IPV with the greatest risk for African American women. Other studies have found that the prevalence of IPV was higher among African Americans and Hispanics compared to their White non-Hispanic counterparts (Caetano et al., 2005).

The "(mis)use" of religion to justify violence against women and perpetuate women's vulnerability to victimization is extensively documented in existing literature (Flood & Pease, 2009). In Islam, parts of the Koran have been selectively interpreted to justify domestic violence as an observance of God's commandments (Douki et al., 2003). In Hinduism, the salience of marriage and religious edicts that promote the idolization of husbands as Gods/Lords may place pressure on women to tolerate violence for the preservation of marriage (Sharma et al., 2013). Similarly, Christian evangelism's emphasis on rigid gender roles and wifely submission may serve as a barrier to women leaving an abusive relationship (Giesbrecht & Sevcik, 2000; Nason-Clark, 1997). However, these religions and others also emphasize kindness and compassion, which offer unique opportunities for religious communities to mobilize in opposition to IPV (Ware et al., 2004).

The relationship between educational attainment and IPV in prior research is complex. There is an established body of literature that suggests that low levels of educational attainment are the most consistent factor associated with both IPV perpetration and victimization (Ackerson et al., 2008; Boy & Kulczyki, 2008; Boyle et al., 2009). However, there is another body of literature that suggests that the relationship between education and IPV is an inverted U-shape; where the more educated a woman is, the greater the risk of her experiencing violence up to a certain point, beyond which the risk declines (Jewkes, 2002). It is probable that the greater educational attainment of

women encourages more resistance against rigid gender norms; thus, IPV is perpetrated as a mechanism to maintain control of women.

IPV spans socio-economic strata. However, research demonstrates that poverty and associated stress is related to higher levels of IPV (Jewkes, 2002). Yet, it remains unclear whether poverty in and of itself or if factors associated with poverty (e.g., homelessness, job insecurity) increases the risk of IPV. The National Survey of Families and Households found that individuals with household incomes below $25,000 were 40 percent more likely to report IPV than those in higher income levels (Cunradi, Caetano & Schafer, 2002). Economic stressors including unemployment, low-wage employment and/or dependence on the welfare system may also create barriers for women seeking to address IPV (e.g., medical care, legal services, housing) (Phillips et al., 2004).

Immigration and immigrant status is another factor that is associated with IPV. Studies conducted among Hispanic, South Asian and Korean immigrants have suggested that these women are highly vulnerable to IPV with victimization rates ranging from 30% to 50% (Dutton et al., 2000; Raj & Silverman, 2004; Song, 1996). Furthermore, homicide data from New York City indicate that immigrant women are disproportionately represented among female victims of male-partner-perpetrated homicide (Frye et al., 2000). Immigrant status offers complexity that increases women's vulnerability to experiencing IPV and staying in violent relationships. Immigrant women often enter the country as dependents and are often disadvantaged in regards to language capabilities, economic/educational resources and access to social support networks (Parrenas, 2001; Sweetman, 1998). Immigrant women may also face increased vulnerability due to their lack of awareness of their legal rights, especially those afforded

to them under the Violence Against Women Act (VAWA). For example, VAWA 2000 reauthorization created the Battered Women Protection Act (BIWPA), which created immigration relief for immigrant survivors of violent crime ("U" visas). (Kwong, 2002). The U visa grants survivors permission to live and work in the United States and may result in the dismissal of any case in immigration court filed against them. In VAWA 2005 reauthorization the requirement that U visa holders must demonstrate "extreme hardship" in order to maintain their immigrant status was waived (VAWA, 2005).

Research on patriarchal immigrant communities in the United States suggest that acculturation to a new society has an effect on attitudes towards and experiences with IPV (Ganguly, 1998; Sorenson & Telles, 1991). Similar to the relationship between education and IPV, the relationship between acculturation and IPV is mixed. There is empirical evidence that suggests that a higher level of acculturation to the relatively egalitarian United States culture is associated with higher levels of domestic violence or attitudes condoning violence. Studies focused on Hispanic Americans have found that acculturation can increase the likelihood of IPV because of the challenges it poses to natal beliefs systems (e.g., familialism, collectivism) (Lown & Vega, 2001; Sorenson & Telles, 1991). Furthermore, studies that have focused on Chinese-American women have found that highly acculturated women are more than twice as likely to have been the victim of severe physical violence by an intimate partner compared to their less acculturated counterparts (Yick, 2000, Caetano et al., 2000; Ingram, 2007).

However, there is another body of literature that suggests the opposite—less acculturation leads to a higher likelihood of IPV (Champion, 1996; Ganguly, 1998). Studies among South Asian Americans have found that lower levels of acculturation is

associated with increased acceptance of and increased experience with IPV (Dasgupta, 2000; Ganguly, 1998). The inverse association between acculturation and IPV may be attributed to the interaction of acculturation and other risk factors associated with immigrant status (e.g., support networks, linguistic capabilities, employment) (Bhanot & Senn, 2007).

While extant literature has documented risk and protective factors for IPV, most studies have examined these factors among Caucasian and African American women. Few studies have examined risk and protective factors for IPV specifically for South Asian women. As a result, it is unknown whether or not these risk and protective factors are the same for South Asian women. The identification of risk and protective factors is crucial to the creation of prevention and intervention programs and strategies targeted to South Asian women. Therefore, this present study sought to elucidate the risk and protective factors for IPV specific to South Asian women.

2.3 Consequences of IPV

The consequences of violence against women are far reaching and extend beyond the woman herself to the household/community and to society. Individual level consequences include physical injuries (e.g., head and abdominal injuries, scratches, morbidity) (Campbell, 2002), gynecological injuries (e.g., sexually transmitted diseases, unintended pregnancies, abortions) (Campbell, 2002), and mental health consequences (e.g., post-traumatic stress disorder, depression, anxiety) (Ansara, 2011; Blasco-Ros, 2010; Eshelman, 2012).

Household/community level consequences include childhood exposure to violence, overlap of intimate partner violence and childhood abuse and neglect (Kohl and

Macy, 2007) and subsequent developmental and behavioral challenges incurred by the child (Zuckerman et al., 2013; Hamby et al., 2011). Societal consequences include the costs incurred by society as a result of the violence, such as cost of the criminal justice system and healthcare systems and absenteeism, loss of productivity, and loss of wages (CDC, nd). According to the Centers for Disease Control and Prevention (CDC), when updated to 2003 dollars, the costs of intimate partner violence exceeded $8.3 billion, which included $460 million for rape, $6.2 billion for physical assault, $461 million for stalking, and $1.2 billion in the value of lost lives. While these numbers reflect the most up-to-date data for 2003, 14 years later, these amounts would be much greater.

2.4 IPV among Women in India

Existing studies have consistently indicated relatively high prevalence rates of IPV in India, hovering around 40 percent (Kumar et al., 2005; Ackerson et al., 2008; Hassan et al., 2004). Several socio-demographic characteristics have been associated with IPV among women in India including: age (Ackerson, 2008), place of residence (Boyle et al., 2009; Ackerson, 2008), religion (Kimuna, Djamba, Ciciurkaite, & Cherukuri, 2013; Koenig, Ahmed, Hossain, & Mozumder, 2003), and educational attainment (Ackerson et al., 2008). There is a large body of work that has documented the health implications of IPV in India including maternal mortality, gynecological infections, induced abortions, unwanted pregnancies, and sexually transmitted infections (Asling-Moemi, Pena, Ellsberg, & Persson, 2003; Cokkinides, Coker, & Sanderson, 1999; WHO, 2005). Additionally, several studies have documented the economic implications of IPV in India through women's decreased labor participation and the subsequent increase in disability

and medical expenditures (Kimuna et al., 2012; Ahmed, Koenig, & Stephenson, 2006; Singh, Mahapatra, & Datta, 2008).

Within the past decade, India has made significant progress in recognizing the existence of IPV and increasing efforts to address it (UNIFEM, 2005). In October of 2006, India enacted a landmark domestic violence law that broadened the definition of domestic violence to include physical, sexual, emotion, verbal, and economic abuse (Jaising, 2009). Additionally, under this legislation, men who beat, threaten, and/or shout at their wives or live-in partners could be jailed for up to a year and fined 20,000 rupees (Bhat, 2006). This legislation also allows abused women to complain directly to judges instead of police; studies have previously noted a systematic bias of the police towards the abuser (Kethineni & Srinivasan, 2009).

Despite advances to address IPV in India, there mere existence of laws and policies do not necessitate action. Additionally, there is a scarcity of literature examining the help-seeking behaviors of survivors and barriers and facilitators to service use among women in India; an area that was examined by the present study.

2.5 The South Asian Context

2.5.1 Immigration to the United States

According to the 2010 United Census, there were a total of 17, 320, 856 Asian Americans, including multiracial Americans identifying as part Asian (US Census, 2010), living in the United States. Thus, Asians comprise 5.6 percent of the total American population. The largest ethnic groups represented in the Census were Chinese (3.79 million), Fillipino (3.41 million) and Indian (3.18 million) (US Census, 2010).

The migration of South Asians to the United States took place in three major waves (Dasgupta 2000; Abraham 2006; Sandhu & Madathil 2007). The first wave of migrants arrived from India between 1897 and 1924 (Sandhu & Madathil 2007); most of these migrants were farmers, ship workers and railroad workers (Sandhu & Madathil 2007; Abraham 2006). Despite the labor that they offered, these groups were not allowed to own land or bring spouses and other family members to the United States. According to scholars such as Takaki (1989), these policies reflected the inherent biases against racial and cultural differences in the United States at the time.

The second wave of migration was largely attributed to the passage of the Immigration and Naturalization Act of 1965. Immigration was no longer contingent upon race; instead, more credence was given to what immigrants could offer the United States in regards to skills and education. As such, the second wave of immigrants from South Asia brought highly successful, technically trained and highly English proficient individuals (Dasgupta 2000). The individuals were able to become successful in the United States, obtain citizenship and bring their spouses and children with them (Sandhu & Madathil 2007). To support their communities in the US, the South Asian community began establishing numerous cultural associations to help maintain its cultural integrity (Dasgupta 2000).

The third wave of immigration, prompted by the Family Reunification Act, took place in the 1980s (Dasgupta 2000; Abraham 2006; Sandhu & Madathil 2007). South Asians who immigrated to the United States during the second wave were able to sponsor their extended family members to come to the United States. This wave included a shift

demographics and brought in many blue-collar workers such as cab drivers, convenience store clerks and motel owners (Dasgupta 2000; Sandhu & Madathil 2007).

2.5.2 Demographic Trends

These immigration trends created significant heterogeneity within the South Asian community (Sandhu & Madathil 2007; Liao 2006). There is great diversity within these populations reflected in national origin, religion, immigration history and generational status, caste background, language, educational attainment, occupation and class. However, these populations are still grouped together under the category of South Asians due to shared geographic origin, as well shared cultural characteristics that set them apart from other cultures, these characteristics are: customs, values, family expectations, and beliefs about mental health problems (Maker, Mittal, & Rastogi 2005).

Today, there are over 3.4 million South Asians living in the United States, an 81 percent increase from the 2000 Census. A little over half (54%) of the South Asian population is male and 46% is female. New populations have seen particularly high increases in recent years. The United States agreed to accept nearly 100,000 Bhutanese refugees of Nepali origin starting in 2008 and this community has experienced the most significant growth, jumping at least 8,25% (US Census 2010). After the Bhutanese community, the next fastest growing South Asian group was Nepali, followed by Maldivians, Bangladeshis, Pakistanis, Sri Lankans, and Indians (US Census, 2010). However, Asian Indians remain the most prevalent South Asian group in the United States, with a population of 3.2 million (US Census, 2010). The states with the largest concentration of South Asians include California, New York, New Jersey, Texas, and

Illinois. Table 1 below provides changes in the South Asian American population from 2000 to 2010.

Table 1: Changes in South Asian American Population 2000 to 2010 (US Census, 2010)

	Single Ethnicities Reported			Single and Multiple Ethnicities Reported		
	2000	2010	% Change	2000	2010	% Change
Bangladeshi	43, 280	138, 792	212%	57, 412	143, 300	157%
Bhutanese	183	15, 290	8, 255%	212	19, 439	9, 069%
Indian	1, 678, 765	2, 483, 391	69%	1, 899, 599	3, 183, 063	68%
Maldivian	27	98	263%	51	127	149%
Nepali	7, 858	51, 907	561%	9, 399	59, 490	533%
Pakistani	153, 533	363, 699	137%	204, 309	409, 163	100%
Sri Lankan	20, 145	38, 596	92%	24, 587	45, 381	85%
Total South Asians	1, 901, 791	3, 441, 733	81%			

2.5.3 Poverty among South Asian Americans

South Asian Americans are often lauded for high-paying occupations and achieving material success; however, large portions of South Asians are in lower-wage occupations such as cashiers, taxi drivers, and restaurant workers. In 2010, Asian Indian Americans had the highest population of South Asians living in poverty (246, 399). However, Asian Indian Americans' 2006 to 2010 aggregate poverty rates were relatively low at 8.5% (Ramakrishnan and Ahmad, 2014). Ethnic groups with the highest concentration of poverty have some of the smallest representation in the total US population. For example, the 2006 to 2010 aggregate poverty rate for Bangladeshi Americans was 21.1%, which equates to 21, 284 people (Ramakrishnan and Ahmad, 2014).

Asian Indians are documented as the most financially and materially successful South Asian group. According to the Current Population Survey (2012), Asian Indians have the highest labor force participation at 68% as well as the highest employment-to-population ratio (65%) compared to any other ethnic group. However, the same study showed that Indians have the smallest share of employed women (37%).

According to Abraham (2000a), cultural norms and gender-role socialization intersect to lead even highly educated and financially independent women to feel a sense of heightened accountability to their spouses and families. Even women who are working outside the home, but are married to controlling and domineering men, may not enjoy the economic and emotional freedom one might expect from that employment (Abraham,

2000a). As a result, despite being employed, these women may still be financially dependent upon their husbands.

2.5.4 Impact of Immigration Policy on South Asian Women

Immigration policy in the United States has historically been markedly male-centric, built upon primary entry for males and secondary entry for females generally as wives and fiancées (Kelkar, 2011). Women's legal rights were tied to their husbands, granting the men full legal rights over their wives and children (Abraham, 2000). As of February 2015, the United States Department of Homeland Security extended eligibility for employment authorization to certain H4 dependent spouses of H1B nonimmigrants. However, this legislation was recently enacted and it is too early to assess the effects that it has had. Additionally, in January 2017, Donald J. Trump was inaugurated as the 45th president of the United States. President Trump is more conservative, especially in regards to immigration policy, than his predecessor President Barack Obama. Therefore, the future of this legislation and its potential impact remains to be seen.

Despite the advancement that the H1B visa represents in regards to the legal system's gender imbalance, immigration law still tends to force women into a position of dependence, placing control of their lives in the hands of their spouses (Abraham, 2000). For example, the passage of the Immigration and Nationality Act resulted in the H1B visa, which allows an immigrant (typically male) to sponsor his wife on the H4 derivative visa (Kelkar, 2011). However, the H4 visa does not permit the holder to work and it does not assign the individual a social security number (Kelkar, 2011). In addition, the individual is banned from opening or operating a bank account and cannot obtain a driver's license without additional paperwork initiated by the holder of the H1B visa

(Kelkar, 2011). As a result, dependency on the male is fostered, leaving women experiencing violence little to no redress.

This legislation proves to be increasingly restrictive in cases where the marriage dissolves and/or children are involved. After the marriage is terminated, the dependent spouse loses her visa and is therefore subject to deportation (Balgamwalla, 2013). Women who stay in the United States for more than one year without lawful status and are forced to leave are barred from reentering the United States for ten years (Balgamwalla, 2013). Custody issues resulting from divorce place immigrant women in extremely precarious situations. Child custody judgments typically favor the financially stable and secure parent who is westernized, fluent in English, and savvy enough to understand the intricacies of the legal system who is most often the husband (Abraham, 2000; Kelkar, 2011). Once a custody case is initiated, the dependent spouse is unable to take her children out of the country (Balgamwalla, 2013). Even in instances where dependent women may be eligible to stay in the United States, challenges in accessing legal services make it difficult for women to obtain representation (Balgamwalla, 2013).

2.5.5 Immigrant Status and IPV

The majority of South Asians who live in the United States are foreign-born and possess a range of immigrant statuses from undocumented immigrants to student and worker visa holders and their dependents, legal permanent residents and naturalized citizens (SAALT, nd). According to the American Community Survey (2012), 72% of Asian Indian Americans were foreign born and 28% were native born. Unfortunately, other South Asian groups were lumped into the "other" category of the ACS with Asians not specifically from South Asia.

Because women have traditionally immigrated to the United States from South Asia as dependents, often through their husbands, much of their knowledge of and exposure to the world around them is arbitrated through their husbands. As a result, their knowledge of and exposure to the world around them is further limited by economic, cultural, social and linguistic barriers (Mehtrota, 1999; Natarajan, 2002); thus fostering their dependence on their husbands. Women experiencing violence are consequently isolated and confined to a life of violence.

Furthermore, as a result of immigration, they are often without the support systems offered by their immediate and extended families in South Asia. Much of their social networks in the United States are through their husbands. As a result, friends and relatives of the husbands are either unaware of the violence or turn a blind eye to it (Dasgupta 2000a).

Table 2: Percent of Foreign Born South Asians (2008-2012 ACS Estimates)

Nationality	Foreign Born
Sri Lankan	80%
Bangladeshi	74%
Indian	72%
Pakistani	67%

2.5.6 Culture, Gender, and IPV

Help seeking is a coping strategy that has been found to have a positive association with lower levels of distress among abused women (Ahmad, Driver, Mcnally & Steward, 2009; Kemp, Green, Hovanitz, & Rawlings, 1995; Mitchell & Hodson, 1983). However, delayed help seeking plagues abused women from all backgrounds (Reidy&VonKorff, 1991) and South Asians are no exception. Raj and Silverman (2002) found that six percent of the abused South Asian immigrants reported a need to see a doctor due to

injuries sustained from abuse; however, only half sought care. Similarly, Ahmad and colleagues (2004) found that abused South Asian immigrant women rarely sought help from professional sources; instead, they often turned to informal sources such as friends and family. In a comparative study comprised of abused South Asian, African American and Hispanic women, Yoshioka and colleagues (2003) found that counselors, law enforcement, doctors, or clergy were approached much less for disclosures of partner abuse suffered by South Asian women compared to abused women of underrepresented minority groups.

2.5.7 Cultural Factors

There are certain factors that serve as barriers to service utilization among all women, such as fear of retaliation, shame, and larger societal myths. Scholars argue low levels of service utilization among South Asian women can be attributed to factors that are contextualized by culture (Dasgupta, 1998; Dasgupta & Warrier, 1997; Dasgupta, 2000). The following section elucidates these factors.

Family

Family is central in the lives of South Asians with equal importance given to immediate and extended family members. The concept of family is shaped by a collectivist mentality where the needs and wants of the family supersede those of the individual (Dasgupta, 2000; Dasgupta & Warrier, 1996; Ayyub, 2000), very similar to Latina and African American women (Yoshioka, 2003). Furthermore, the actions and decisions of one individual are thought to have implications for the rest of the family. As such, decisions and actions are typically not made without consulting and obtaining the blessing of the elders in the family first.

Because of the central role of the family in an individual's life, there are clear delineations of "insiders" (family) and "outsiders" (others). As such, discussion of personal issues such as experience with violence is discouraged with people outside of the family. In addition, while family can offer social support and comfort, it can function in the opposite capacity as well. It is not uncommon in the South Asian context for families to place pressure on individuals to act or behave in a certain way—sometimes even resorting to threats and use of violence (Dasgupta, 2000; Ahmed, 2007). For example, a woman experiencing violence may be forced or coerced into staying with her abusive partner or not reporting sexual violence due to the implications her departure would have on her family.

Gender Roles and Socialization

According to Dasgupta (2000), immigration to the United States has not enhanced women's status within the family. Despite the fact that immigration provides many opportunities, it has not prompted South Asians to abandon traditional gender asymmetries. In their attempts to preserve culture and heritage, the community has actively tried to recreate traditional gender relations, which inherently privilege men (Dasgupta 2000).

Within such traditional gender roles, the model South Asian female is often defined as being "chaste, virtuous, traditional, nurturing, controlled, and obedient" (Bhattacharjee, 1992). In addition, South Asian women have traditionally been defined by their roles as daughters, wives, mothers and daughters-in-law who sacrifice personal freedom and autonomy (Dasgupta 2000). From childhood, South Asian women are socialized with the primary intention of marriage. The marriage is most often arranged to

an individual of similar cultural and religious background and ideally, to someone of equal or higher socio-economic status.

After marriage, it is common for South Asian women to live in the homes of their in-laws, which can include their husband's siblings. The power in the family follows the following order as outlined by Hines and colleagues (1992): the eldest male possessing the highest power, followed by his sons in order, the mother-in-law, any unmarried daughters in the home and finally, the daughter-in-law. Due to the fact that the woman becomes answerable to many people, the likelihood of tension and subsequent abuse is elevated. According to Dasgupta (2000a), the husband may be a participant or observer of his wife's abuse by his parents and/or siblings. Other times, the woman's mother-in-law will encourage her son to keep his wife under control and use force and/or violence to do so (Hines et al., 1992; Raj et al., 2011).

Because a woman's identity is tied to her role as a wife and mother, a divorced and/or single mother is perceived to be a failure, regardless of the abuse she endured by her partner (Dasgupta and Warrier, 1996). Single motherhood is seen as highly detrimental to the development and future of the children (Dasgupta and Warrier, 1996). Also, divorced women are stigmatized and discouraged from participating in cultural and religious events as their presence is perceived to be bad luck (Ayuub 2000). The fear of the stigma associated with divorced and/or single motherhood serves as a barrier to leaving an abusive partner/spouse.

Model Minority

People of color in the United States have historically encountered institutionalized cultural and economic racism as a result of immigration status, gender, ethnicity and race (Abraham 2006). In an attempt to buffer the implications of racism, South Asians have retained their strong cultural values (Abraham, 2006; Dasgupta, 2000). Women of color are further marginalized by the intersection of their "host and natal cultures, which places them in a disadvantaged position as an ethnic minority and a woman" (Liao 2006, p. 28).

According to Abraham (2006), due to the perception that South Asians have achieved a "fine balance between upholding cherished values of South Asian culture, such as family solidarity and harmony, while simultaneously adopting American capitalism," the South Asian community has been labeled a "model minority" (p. 98). Furthermore, community leaders have emphasized the importance of upholding this image, thus stigmatizing and causing the denial of the existence of social problems such as sexual assault, mental illness, homelessness, intergenerational conflict, unemployment, delinquency and domestic violence (Abraham 2006; Dasgupta 2000; Singh & Jamayla 2007; Liao 2006).

The pressure to uphold the model minority image transcends generational barriers and has shaped the way immigrant parents raise their second-generation South Asian children (Venkataramani-Kothari, 2007). Having been raised with traditional values and rigid gender roles in their natal countries, "immigrant parents become overwhelmed by the omnipresent influence of Western culture on their children as manifested through the child or teenager's increased freedom of expression and open sexuality" (Venkataramani-Kothari, 2007; p. 16). Parents perceive such behaviors as disobedient and disrespectful

(Hines et al., 1992) and subsequently attempt to recreate the traditional family structure in which they were raised (Venkataramani-Kothari, 2007).

The current study examined these cultural considerations in the context of South Asian women's experience with IPV. Since most South Asians in the United States are Indian immigrants (US Census, 2010), this study first examined the prevalence and cultural context of IPV and help-seeking behaviors among women in India. The knowledge and insight gained from the analyses of data from India were then utilized as a frame of reference to understand the experiences of South Asian women in the United States with violence and help-seeking.

Existing literature has elucidated the cultural context that shapes South Asian women's experience with IPV in the United States (Dasgupta & Warrier, 1996; Dasgupta, 2000; Ayuub, 2000; Abraham, 2006). However, none of these studies have utilized extant data from South Asia as a starting point to first understand the cultural context that South Asian immigrants in the United States are coming from and how this may impact their experiences with violence. Additionally, with the exception of a few studies (Adams, 2000; Raj & Silverman, 2004; Mahapatra, 2013), most existing work in this field are anecdotal. Also, the majority of these studies were published ten to twenty-five years ago (Bhattacharjee, 1992; Dasgupta & Warrier, 1996; Dasgupta, 2000) and may not be relevant to the current landscape of IPV among South Asian women in the United States. Therefore, this present study fills a gap in extant literature by providing up-to-date empirical data on the experiences of South Asian women in the United States with IPV and the ways in which culture contextualizes their experiences.

Furthermore, SAWOs in the United States have provided services to South Asian women experiencing IPV for over thirty years. As a result, SAWO service providers have unique insight into the experiences of their clients, especially their help-seeking behaviors. However, very few studies have incorporated the views of SAWO service providers (Abraham, 1995; Rudrappa, 2004). This present study addressed this gap by qualitatively examining the perceptions of SAWO service providers on IPV in the South Asian community and the help-seeking behaviors of survivors.

2.6 Theoretical Frameworks

Over the past several decades, IPV has garnered scholarly attention that has led to a dramatic increase in the amount of private and public funds that have been allocated for research, education, treatment services and prevention programs (Kelly, 2011). As a result, numerous theories have been offered to address social structures, cultural traditions, and personal behaviors that perpetuate and sustain IPV (Kelly, 2011). Two theoretical frameworks have been instrumental in guiding the conceptualization of this proposed study: intersectionality theory and the ecological framework. Combined, these theoretical perspectives offer insight into the unique positioning of South Asian women in the United States that may increase their vulnerability to IPV. These theoretical perspectives also provide insight into opportunities for intervention efforts to target and mitigate the effects of IPV in the lives of South Asian women.

2.6.1 Intersectionality Theory

In response to the omission of traditional feminist theories regarding the multiple forms of oppression faced by women experiencing violence, intersectionality theory emerged (Anderson and Collins, 2001; Crenshaw, 1991). Kimberle Crenshaw, a lawyer

and prominent figure in critical race theory, first developed and utilized intersectionality theory to analyze the race and gender based discrimination faced by minority women in the labor force. She later argued that intersectionality is also an applicable framework to understand the interplay of racism and sexism in the lives of women experiencing violence (Crenshaw 1991b, Crenshaw1997).

Intersectionality theory is built on the assumption that:

> Every social group has unique qualities; that individuals are positioned within social structures that influence power relationships; and that there are interactions between different social identities, for example race, gender, and class that have multiplicative negative effects on health and well-being. (Kelly, 2011 p. E43)

According to Crenshaw (1991b), this assumption highlights the "structural intersectionality," which is comprised of "the ways in which the location of women of color at the intersection of race and gender make our actual experience of domestic violence, rape, and remedial reform qualitatively different than that of white women" (p.1245). Therefore, if counselors and shelters are to effectively meet the needs of these women, they must be attuned to and prepared to address the barriers caused by these differences.

Crenshaw (1991b) noted that higher incidence of poverty among minority women coupled with a paucity of available jobs in their neighborhood served as a financial barrier to leaving their abuser. Furthermore, she found that poor minority women are also less likely to have support networks that can facilitate their departure from their abuser. For immigrant women, their experience with violence is further complicated by the fact that their immigrant status is dependent on their abuser (Crenshaw, 1991b; Narayan, 1997; Dasgupta, 2000). According to Sokoloff

and Pratt (2005), these analyses demonstrate "the ways in which particular social locations of women based on race, ethnicity, class, immigrant status, and familial relationships shape their experiences with violence and demarcate the available options for dealing with their situations (p. 86).

2.6.2 Ecological Framework

The ecological framework emerged from the work of American developmental psychologist Urie Brofenbrenner. Brofenbrenner (1977) originally posited that in order to understand human development, the entire ecological context in which growth occurs must be accounted for. Expounding on Brofenbrenner's original model, Lori Heise (1998) later published and helped popularize the integrated ecological model for IPV. This model that suggests that IPV is the result of the interaction of factors across four major levels: the individual, relationship, community and societal levels.

The World Health Organization utilized this framework to conceptualize its Survey on Women's Health and Domestic Violence. According to the WHO (2014), the individual level encompasses an individual's personal history and biological factors that influence how they behave and how susceptible they are to becoming victims or perpetrators of violence. Examples of factors at the individual level include: being the victim of child maltreatment, having psychological and/or personality disorders and having a substance abuse history. At the relationship level, the WHO (2014) states that the individual's relationships with family, friends, intimate partners, and peers influence their risks of becoming a victim or perpetrator of violence. For example, having a parent who exerts violence over the other parent may increase the likelihood of a child becoming a victim or perpetrator of violence. The community level encompasses the

contexts in which social relations occur, such as the neighborhood the individual resides or the school that they attend (WHO 2014). Risk factors in neighborhoods that may affect the likelihood of becoming a victim or perpetrator of violence include unemployment and population density. Lastly, the societal level encompasses factors that dictate whether or not violence is tolerated; this includes: patriarchal values, socio-economic inequality and enforcement of the law.

The integration of intersectionality theory and the ecological framework for the purposes of this current study provided insight into the unique social positioning of South Asian women in the context of their environment, both in India and the United States. Intersectionality theory elucidated how South Asian women's individual identities are shaped by the intersection of their gender, ethnicity, class, and immigration status and how these identities serve as risk factors for and/or protective factors against IPV. The ecological framework incorporates the social, cultural, and religious norms that contextualize South Asian women's experiences with violence and how these norms may perpetuate and sustain IPV by reinforcing power inequities between men and women (Liang et al., 2005; Connell, 1987).

Additionally, the integration of these two theories clarified the interpersonal and sociocultural influences that serve as barriers or facilitators to informal and/or formal help seeking among South Asian survivors of IPV. For example, immigrant South Asian women in the United States experiencing IPV may lack financial resources and the support of their extended family and friends back in their natal country (Liang et al., 2005). As a result, these women may be financially, socially, and emotionally dependent on their partners and therefore, unable to leave their abusive relationship (Liang et al.,

2005). Additionally, immigrant women who lack education and linguistic capabilities may not be aware of available resources and/or experience difficulty articulating the help that they need (Liang et al., 2005; Huisman, 1996). The experiences of these women are further contextualized by cultural norms that emphasize privacy, family, and gender roles that privilege men over women (Dasgupta, 2000; Abraham, 1995). As such, in order to understand South Asian's survivors decision to seek or not seek IPV-related services, it is imperative to understand their experiences through the utilization of the ecological framework and intersectionality theory.

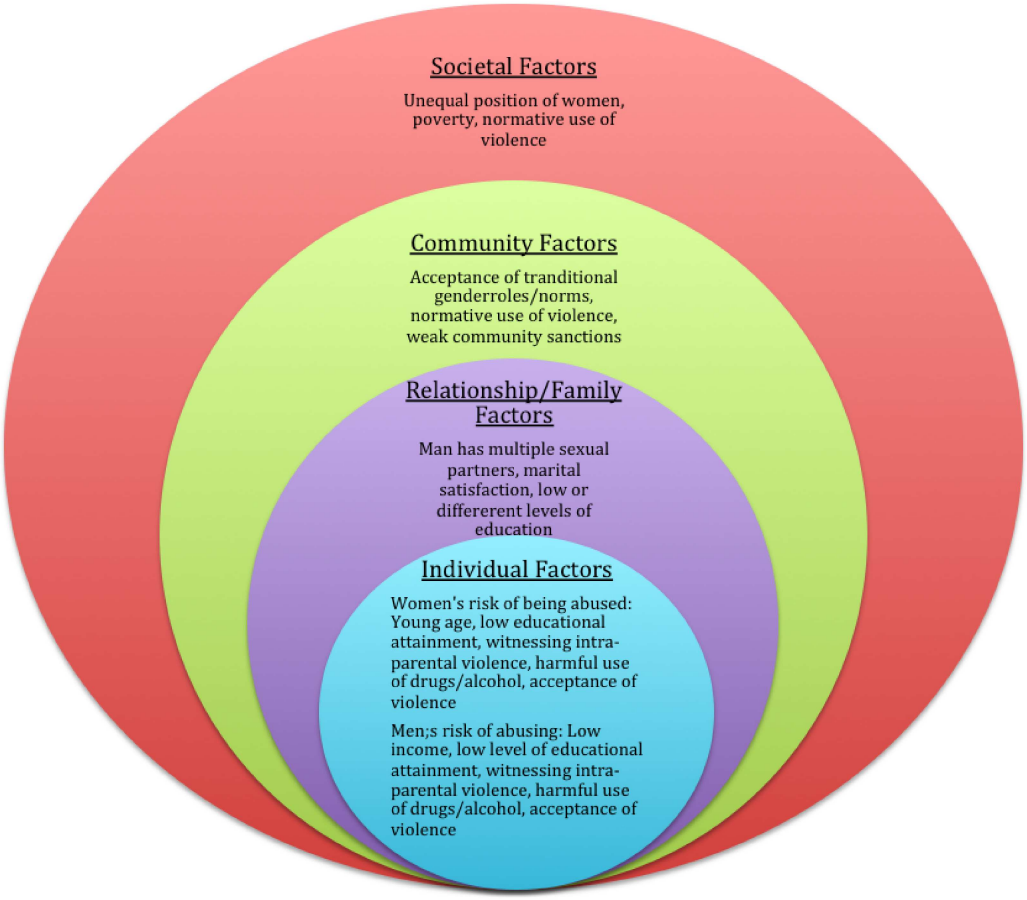

Figure 1: Factors associated with violence against women based on the ecological framework (WHO)

III. Study Purpose, Aims, Research Questions, and Hypotheses

3.1 Study Purpose and Rationale

This study fills several gaps in existing empirical literature pertaining to IPV among South Asian women in the United States. Currently, studies examining IPV among South Asian women in the United States are subject to methodological limitations both in sampling and measurement. Since most South Asians in the United States are Indian immigrants, this study first utilized secondary data to understand the prevalence, risk and protective factors for IPV, and service use among women in India. Then, this study utilized a sample of South Asian women in the United States, many of whom were Indian immigrants, to understand their experiences with violence and service use and to determine if their experiences differed in practically large ways from the experiences of women in India. The primary data were collected using an adapted version of the World Health Organization's Women's Health and Domestic Violence Survey that was administered in 80 countries internationally. Additionally, qualitative interviews were conducted with SAWO service providers to understand their perspectives on IPV in the South Asian community in the United States and the help-seeking behaviors of survivors.

3.2 Aims, Research Questions and Hypotheses

In order to address the gaps in understanding the prevalence and experience of IPV among South Asian women in the United States and the subsequent help-seeking behaviors of survivors, the aims and research questions for the study were as follows:

Secondary Data

Research Aim 1. To examine the prevalence of IPV among women in India.

Research Question 1. How prevalent is IPV among women in India?

Research Aim 2. To understand the risk and protective factors of IPV among women in India.

Research Question 2. What are the risk and protective factors of IPV among women in India?

Research Aim 3. To understand the IPV service use among Indian women.

Research Question 3. What proportion of IPV survivors seek services in India and from whom do they seek out services?

Research Aim 4. To understand the predictors of IPV service use among survivors in India.

Research Question 4. What are the predictors of IPV service use among survivors in India?

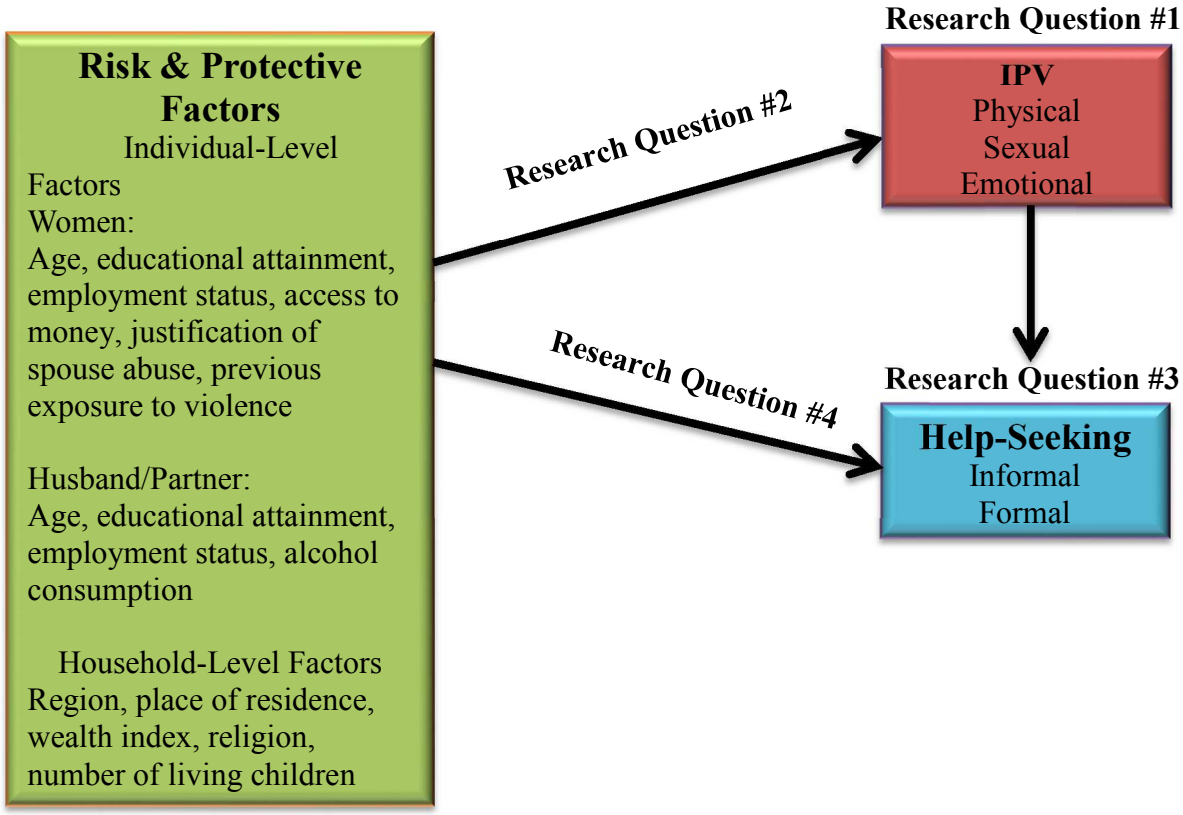

Figure 2: Conceptual Framework for Secondary Data Analysis

Primary Data

Research Aim 5. To examine IPV prevalence rates among South Asian women in New Jersey, New York, and Connecticut.

Research Question 5. How prevalent is IPV among South Asian women in New Jersey, New York, and Connecticut?

Research Aim 6. To understand the risk and protective factors for IPV among South Asian women in New Jersey, New York, and Connecticut.

Research Question 6. What are the risk and protective factors for violence against South Asian women in New Jersey, New York, and Connecticut?

Research Aim 7. To understand the IPV service use among South Asian women in New Jersey, New York, and Connecticut.

Research Question 7. What proportion of IPV survivors in New Jersey, New York, and Connecticut seeks services and from whom?

Research Aim 8. To understand the predictors of IPV service use among South Asian women in New Jersey, New York, and Connecticut.

Research Question 8. What are the predictors of IPV service use among South Asian women in New Jersey, New York, and Connecticut?

Research Aim 9. To understand SAWO service providers' perceptions of IPV in the South Asian community and help-seeking behaviors of survivors.

Research Question 9. What are SAWO service providers' perceptions of IPV in the South Asian community and help-seeking behaviors of survivors?

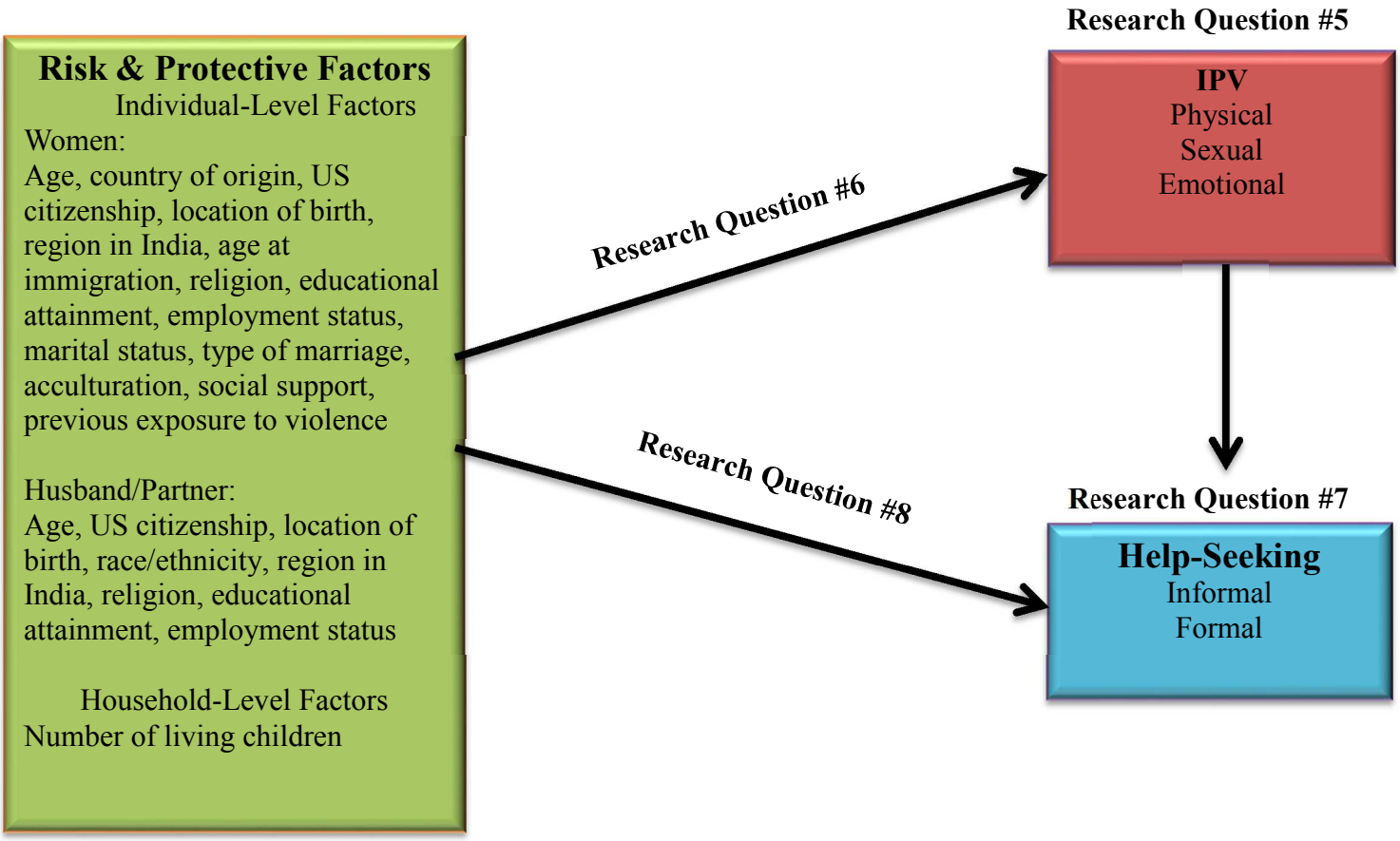

Figure 3: Conceptual Framework for Primary Study (Quantitative)

IV. Methodology

4.1 Overview of the Methodology for Secondary Data

To address research aims 1-4, data from the National Family Health Survey (NFHS-3) were analyzed. The NFHS-3 was coordinated by the International Institute for Population Studies (IIPS) during 2005-2006. The NFHS-3 is a nationally representative, cross-sectional survey that used a systematic, two- stage cluster sample of households. The NFHS-3 covers 99 percent of India's population living in all 29 states (IIPS, 2007).

4.1.1 Study Population and Participant Demographics for Secondary Data

The NFHS-3 includes a sample of 124, 385 women age 15 to 49. Of these women, 83,703 were administered the domestic violence module that ascertained information on physical, sexual and emotional abuse perpetrated by husbands as well as other family members. Of the 83, 703 women, 14, 219 were not married and/or did not have intimate partners; therefore, they were excluded from further analysis. The final sample consisted of 69, 484 ever-married women.

4.1.2 Data Collection for Secondary Data

Data collection was carried out in two phases. The first phase was conducted between December 2005 and May 2006. The second phase was conducted between April and August 2006 (IIPS, 2007). In the first phase, 12 states were covered; in the second phase, the remaining 17 states were covered (IIPS, 2007).

The NFHS-3 contained interviews with eligible respondents using a Household Questionnaire, a Woman's Questionnaire (for women age 15-49), and a Man's Questionnaire (for men age 15-54). Trained field staff collected data using structured

questionnaires on topic including fertility, mortality, family planning, HIV/AIDS, and domestic violence.

This study utilized data from the Domestic Violence Module contained in the Women's Questionnaire. Prior to the start of each interview, informed consent was obtained. A list of organizations providing IPV-related services was compiled and disseminated in a participant expressed the need for help. For detailed information on sampling procedures and IRB approval for the NFHS-3 study, see IIPS, 2007.

4.1.3 Measurement for Secondary Data

Dependent Variables

The dependent variables for Aims 1 and 2 were physical violence, sexual violence, and emotional abuse. For Aims 3 and 4, the dependent variables were informal service utilization, formal service utilization, and any service utilization.

Independent Variables

The independent variables were clustered in two sets of variables, individual-level (women's characteristics and husband/partner's characteristics) and household-level. Individual-level characteristics were: women's age, women's educational attainment, women's employment status, women's access to money, women's endorsement of wife abuse, women's previous exposure to violence (father abusing mother and participant's own experience violence), husband's age, husband's educational attainment, husband's employment status, husband's alcohol consumption, and husband's controlling behaviors. Household-level characteristics were: region, place of residence, religion, wealth index, and number of living children. For aim 4, analyses were restricted to women's characteristics and household-level variables.

See Table 3 for the operationalization of variables

Table 3: Operationalization of Variables for the Secondary Study

Dependent Variables	
Intimate Partner Violence	The domestic violence module (physical, sexual, emotional) used questions constructed from the Conflict Tactics Scale (Straus, 1990)
Physical	This variable was dichotomized. If the participant indicated "yes" to experiencing any of the following, physical was coded 1; else=0 Does/did your husband ever do any of the following in the past 12 months: (a) Push you, shake you, or throw something at you? (b) Slap you? (c) Punch you with his fist or something that could hurt you? (d) Kick you or drag you? (e) Try to strangle you or burn you? (f) Threaten or attack you with a knife, gun, or any other weapon? (g) Twist your arm, pull your hair?
Sexual	This variable was dichotomized. If the participant indicated "yes" to experiencing any of the following, sexual was coded 1; else=0 Does/did your husband ever do any of the following in the past 12 months: (a) physically force you to have sexual intercourse when you did not want to? (b) force you to perform any sexual acts you did not want to?
Emotional	This variable was dichotomized. If the participant indicated "yes" to experiencing any of the following, emotional was coded 1; else=0 Does/did your husband ever do any of the following in the past 12 months: (a) Humiliated you? (b) threatened you with harm? (c) insulted you or made you feel bad?

Any experience with IPV	This variable was dichotomized. If the participant indicated "yes" to experiencing any type of violence above, any violence was coded as 1; else=0
Help-Seeking	
Informal	This variable was dichotomized. If the participant indicated "yes" to receiving IPV-related help from any of the following, informal was coded as 1, else=0. Did you receive help from: Husband? Mother? Father? Sister? Brother? Daughter? Son? Own family? Husband's family? Friend? Neighbor? Stranger? Teacher? Employer? Religious leader?
Formal	This variable was dichotomized. If the participant indicated "yes" to receiving IPV-related help from any of the following, formal was coded as 1, else=0. Did you receive help from: Police? Social Service Organization? Lawyer? Doctor/medical professional?
Independent Variables	
Individual-Level (Women)	
Age	This was a continuous variable representing participant's age.
Educational Attainment	This was a continuous variable representing women's educational attainment in years.
Employment Status	This variable was dichotomized. If the participant indicated that she is working, employment status was coded as 1; else 0
Money	This variable was dichotomized. If the participant indicated that has access to money, money was coded as 1; else 0
Justification of wife abuse	This variable was dichotomized. If the woman endorsed any of the following statements, justification was given 1; else=0

	Wife-beating is justified if a woman (a) goes out without telling her husband, (b) neglects children, (c) argues, (d) refuses sex, (e) burns food
Previous exposure to violence	This variable was dichotomized. If the participant answered "yes" to the following, exposure was coded as 1; else=0. Did your father beat your mother?
Individual-Level (Husband)	
Age	This was a continuous variable representing the participant's husband's age.
Educational Attainment	This variable was dummy-coded into 3 categories: no education (reference), primary education, and secondary/higher.
Employment Status	This variable was dichotomized. If the participant indicated that her husband is employed, employment status was coded as 1; else 0
Alcohol Consumption	This variable was dichotomized. If the woman stated that her husband consumes alcohol, then alcohol was coded 1, else=0
Household-Level	
Region	This variable was dummy-coded into 6 categories using the states in India where participants indicated that they lived (categorization based off of Indian government's specification): North, Northeast, East, West, Central, South (reference)
Place of Residence	This was a dichotomous variable representing household location 0=urban, 1=rural
Wealth index	This was a continuous variable representing the wealth index of the household poorest, poorer, middle, richer, richest

Religion	This variable was dummy-coded into 4 categories: Hindu (reference), Muslim, Christian, Other
Number of living children	This was a continuous variable representing the number of living children the respondents had

4.1.4 Data Analysis strategy

Data Analysis was conducted using SAS Version 9.4. First, univariate analyses were conducted to examine all individual and household level variables to assess normality and to examine missing data. Univariate analyses demonstrated that there were no concerning departures from normality for any continuous outcome variables (respondent's age and educational attainment, partner's age, and wealth index). Additionally, missing data/item non-response was determined to be below 10% and random.

Aim #1: To assess prevalence rates of intimate partner violence (IPV) (physical, sexual, emotional) among women in India.

Data Analysis Strategy: The frequency and percentage of IPV among women in India

Aim #2: To assess individual-level and household-level risk and protective factors for IPV (physical, sexual, emotional).

Data Analysis Strategy: Bivariate analyses were conducted to test the association between the predictor variables (individual-level factors and household-level factors) and outcome variables (physical, sexual, emotional). Associations between the predictors and outcome were tested using the chi-square test. Next, variables significant at the bivariate level ($p<.05$) were included in the logistic regression model. Prior to running the

regression model, assumptions for logistic regression were ascertained: independence of observations, the outcome variable (experience with IPV) was binomial, the sample size was sufficiently large to meet the minimum requirements of 25 observations per variable, and none of the independent variables perfectly predicted the outcome variable (Allison, 2012). Additionally, there was no multicollinearity: All VIF (variance inflation factors) were under 2.

For Aims 3 and 4, a new dataset was created comprising of only women who indicated that they have experienced IPV (any experience with IPV).

Aim #3: To determine the proportion of IPV service utilization by survivors and the source of the sources (informal, formal, any services).

Data analysis Strategy: The frequency and percentage of survivors in India who use services (informal and formal).

Aim #4: To determine individual-level (women's only) and household-level predictors of service utilization among survivors in India.

Data Analysis Strategy:

Bivariate analyses were conducted to test the association between the predictor variables (individual-level factors (women's only) and household-level factors) and the outcome variable (by type: informal, formal). The same steps explicated under Data Analysis Strategy for Aim #2 were followed: bivariate tests of association, assumption/logistic regression diagnostic tests, and ORs calculations.

4.2 Overview of the Methodology for Primary Data

4.2.1 Research design:

The primary data collection employed a convergent parallel research design with mixed methods data collection (Creswell, 1999). The convergent design occurs when quantitative and qualitative data are collected and analyzed during the same phase of the research process and are then merged into an overall interpretation. The purpose of the convergent design is to collect different yet complementary data on the same topic so as to better understand the research problem (Morse, 1991). According to Patton (1990), the convergent design brings together different strengths and non-overlapping weaknesses of quantitative methods (e.g., large sample sizes, trends, generalization) with those of qualitative methods (e.g., small sample, details, in depth).

Convergent Parallel Research Design

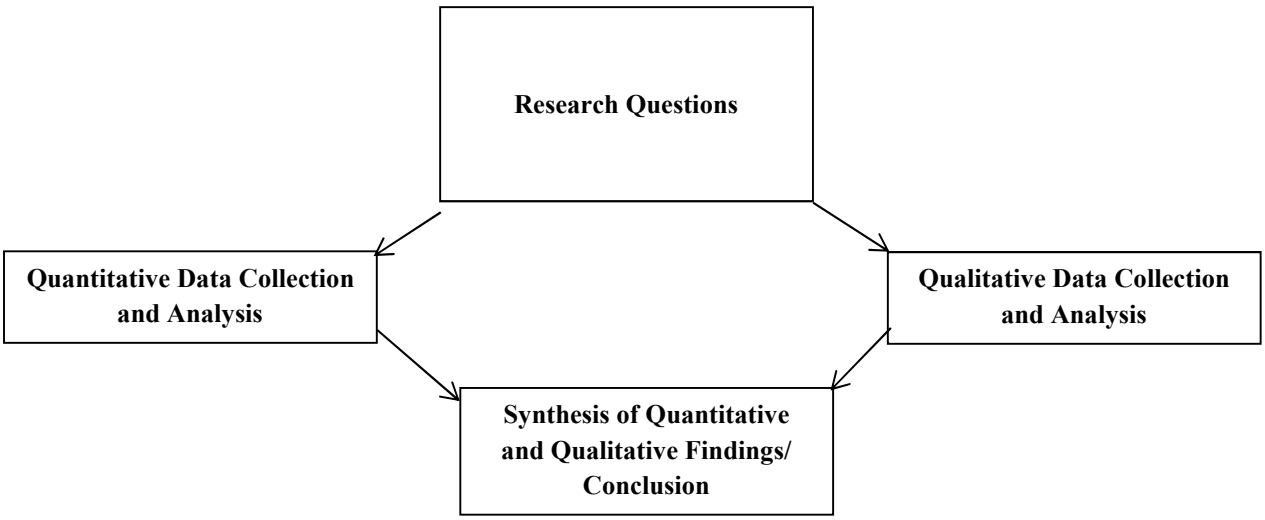

Figure 4: Flowchart of Basic Procedures in Implementing a Convergent Design (Creswell&Plank, 2011)

Research questions, conceptual framework development, and data collection and analysis occurred in three stages that are explicated below.

Stage One (January 2016-May 2016) began with outreach to Manavi, the nation's first South Asian women's organization located in New Jersey. The researcher discussed the goals of the study with the Board of Directors (N=12) and the benefit of information acquired from this study for the agency and similar South Asian Women's Organization (SAWO). A partnership between the researcher and the agency were subsequently formed for the purposes of this study (see letter of support). The Board of Directors reviewed the quantitative and qualitative research questions (see analysis section for more detail) and provided feedback that enhanced the clarity and cultural sensitivity of the questions included in the final study.

Stage Two (December 2016-May 2017) a web-based quantitative survey was administered to a non-probability purposive sample of South Asian women in New Jersey, New York, and Connecticut (see survey text). Potential respondents were contacted until a final sample of 125 respondents was obtained. A set of screening questions were asked before eligible participants completed the survey. The survey included questions about South Asian women's life experiences including views on the relationships between men and women. The survey asked about demographics, social support, acculturation, isolation, other social factors, any experiences of intimate partner violence, and help sought when intimate partner violence occurred.

Stage Three (January 2017-April 2017) consisted of qualitative interviews with South Asian women's organization (SAWO) service providers in New Jersey (Manavi), New

York (Sakhi), and Connecticut (Sneha) (N=12). Participants were recruited through non-probability snowball sampling. The researcher reached out to her own personal connections at all three South Asian women's organizations and explained the purpose of conducting the qualitative interviews. The researcher then asked her connections to pass along details of her study and contact information to colleagues interested in being interviewed. Qualitative interviews were focused on understanding the perceptions of SAWO providers on micro-level factors that perpetuate and sustain violence in the community and structural factors that influence service provision and delivery for this community (see interview guide).

*Incentives were not offered to participants in any stage of the study

4.2.2. Study Population, Sampling, and Participant Demographics

The study included two populations- South Asian women living in New Jersey, New York, or Connecticut and service providers at South Asian women's organizations (SAWOs) in New Jersey, New York, or Connecticut.

Quantitative Survey (N=125)

Quantitative web-based data collection began in December 2016 after obtaining IRB approval from Washington University in St. Louis; IRB obtainment took 6 months (IRB approval #201607063). Originally, the quantitative survey was going to be available in both online and paper-format. However, due to input from the partner organization and low response rate in the paper form (N=1), the quantitative survey became entirely web-based.

The sampling frame originally comprised of all South Asian women who: (1) were born in South Asia (India, Pakistan, Bangladesh, Nepal, Sri Lanka, Bhutan, or Maldives) or born to a parent or parents from South Asia; (2) were 18 years and older; (3) lived in New Jersey; (4) had ever had an intimate relationship with a man (spouse/partner, live-in mate, boyfriend); and (5) could read, write and understand English. New Jersey was selected because of three major reasons: (1) According to the United States Census Bureau (2010), the largest population increase was in the number of South Asians—Asian Indians, Pakistanis, Bangladeshis and Sri Lankans accounted for 57.2% of New Jersey's gain in Asian population between 2000 and 2010 (Wu, 2012). In 2010, there were approximately 292,256 Asian Indians in New Jersey, accounting for 40% of the Asian population in the state (Wu, 2012); (2) The main partner agency for this study, Manavi, is located in New Jersey; (3) the researcher is from New Jersey and has ties to numerous South Asian networks (e.g., family, Hindu temple). The sampling frame was amended to include South Asian women residing in New York and Connecticut in order to achieve an adequate sample size. New York and Connecticut were selected due to the presence of South Asian Women's Organizations (SAWO), Sakhi and Sneha (respectively) and because of the researcher's own personal South Asian networks in those states.

Participants for the quantitative survey were recruited through e-mails to Manavi, Sakhi, and Sneha's listservs and to the researcher's own personal South Asian networks. Additionally, details of the study were posted on the social media pages (Facebook and Twitter) for the respective organizations and the researcher's own personal social media page (Facebook).

Of the 130 eligible participants, 5 did not complete the survey past the demographic questions and were therefore removed from further analysis. The final sample comprised of 125 South Asian women from New Jersey, New York, and Connecticut.

Qualitative Interviews with SAWO Service Providers (N=12):

Twelve qualitative interviews with SAWO service providers were conducted. Interviews were conducted over the phone from January 2017 to April 2017. Participants were recruited through non-probability, purposive sampling. The researcher reached out to her contacts at each partner SAWO, Manavi, Sakhi, and Sneha. The researcher described the goal of the study and asked her contacts to pass along the study information to colleagues at the respective SAWO who might be interested in participating. In total, 12 participants contacted the researcher to discuss participation and all 12 consented and participated in the over-the-phone semi-structured interview with the researcher on a day and time of the participant's choosing.

4.2.3. Measurement

4.2.3a Quantitative Measurement

The survey was pilot tested with Manavi board members to ascertain the appropriateness of the questions and the length of the survey. Based on the recommendations from the Board, revisions were not necessary. The survey contained 151 questions and took approximately 30 minutes to complete. The survey is an adapted version of the World Health Organization's Survey on Women's Health and Life

Experiences. The World Health Organization's survey was administered in 80 countries internationally, including some countries in the South Asian region.

The survey was made available electronically from December 2016-May 2017. The single survey returned by mail (hard copy) was kept in a locked file cabinet in this researcher's office. Surveys returned electronically were stored in this student's password-protected Survey Monkey account. At the close of the study, all surveys were entered from an Excel spreadsheet downloaded from Survey Monkey into Statistical" Package for the Social Sciences (SPSS version 22) file. Data were cleaned and coded using SPSS and subsequently analyzed using SAS Version 9.4.

Screening Questions: Only participants who indicated "yes" to all of the questions below were eligible to participate in the study. These questions were "Are you a woman?"; "Are you 18 years or older?"; "Were you either born in South Asian (India, Pakistan, Bangladesh, Nepal, Sri Lanka, Bhutan, or Maldives and/or born to a parent or parents from South Asia?"; Have you ever had an intimate relationship with a man (spouse/partner, live-in mate, boyfriend)"; and have you lived or currently live in New Jersey, New York, or Connecticut?"

Table 4: Operationalization of Variables for the Primary (Quantitative) Study

Dependent Variables	
Intimate Partner Violence	The domestic violence module (physical, sexual, emotional) used questions constructed from the Revised Conflict Tactics Scale (Straus, 1996)
Physical	This variable was dichotomized. If the participant indicated "yes" to experiencing any of the following, physical was coded 1; else=0 Does/did your husband ever do any of the

	following in the past 12 months: (a) Push you, shake you, or throw something at you? (b) Slap you? (c) Punch you with his fist or something that could hurt you? (d) Kick you or drag you? (e) Try to strangle you or burn you? (f) Threaten or attack you with a knife, gun, or any other weapon? (g) Twist your arm, pull your hair?
Sexual	This variable was dichotomized. If the participant indicated "yes" to experiencing any of the following, sexual was coded 1; else=0 Does/did your husband ever do any of the following in the past 12 months: (a) physically force you to have sexual intercourse when you did not want to? (b) force you to perform any sexual acts you did not want to?
Emotional	This variable was dichotomized. If the participant indicated "yes" to experiencing any of the following, emotional was coded 1; else=0 Does/did your husband ever do any of the following in the past 12 months: (a) Humiliated you? (b) threatened you with harm? (c) insulted you or made you feel bad?
Help-Seeking	
Informal	This variable was dichotomized. If the participant indicated "yes" to receiving IPV-related help from any of the following, informal was coded as 1, else=0. Did you receive help from: Husband? Mother? Father? Sister? Brother? Daughter? Son? Own family? Husband's family? Friend? Neighbor? Stranger? Teacher? Employer? Religious leader?
Formal	This variable was dichotomized. If the participant indicated "yes" to receiving IPV-related help from any of the following, formal was coded as 1, else=0. Did you

	receive help from: Police? Social Service Organization? Lawyer? Doctor/medical professional?
Reason for help-seeking	The participants were asked to indicate their reasons for seeking help and were told to pick all that apply: encouraged by family/friends, could not endure abuse any more, badly injured/feared for life, husband/partner threatened to kill her, husband/partner threatened or actually hit the children, saw the impact on the children, thrown out of home, afraid she would kill her husband/partner, other
Most helpful help (qualitative)	The participants were asked to describe the most useful form of help received and from whom
Least helpful help (qualitative)	The participants were asked to describe the least useful form of help received and from whom
Reason for not seeking help	The participants were asked their reasons for not seeking help and were told to pick all that apply: don't know/no answer, fear of threat/consequences, violence is normal/not serious, embarrassed/ashamed/afraid they would not be blamed or that they would be blamed, know of other women who have not been helped, afraid partner would end the relationship, afraid they would lose their children, afraid they would bring a bad name to the family
Left because of violence (even if only for a night)	This variable was dichotomized. The participants were asked if they ever left their partner, even if only overnight, because of the violence. If they indicated "yes" left was coded as "1"; else "0"

Location (where the participant went)	The participants were asked to indicate where they went the last time they left their husband/partner due to the abuse: her relatives, his relatives, her friends/neighbors, hotel/lodging, street, temple/church/mosque, shelter, other
Return/stayed	The participants were asked to indicate why they returned/stayed and were asked to pick all that apply: didn't want to leave the children, sanctity of marriage, didn't want to bring shame to her family, love for husband/partner, didn't want to be single, family said to stay, forgave him, thought husband/partner would change, threated her and/or the children, nowhere to go, other
Independent Variables	
Individual-Level (Women)	
Age	This was a continuous variable the participant's age
Country of origin	The participants were asked to indicate their country of origin. This variable was dummy-coded into 4 categories: India, Pakistan, Bangladesh, other (Nepal, Sri Lanka, Maldives)
US Citizenship	This variable was dichotomized. The participants were indicated they are a US citizen, citizenship was labeled 1; else=0.
Location of birth	The participants were asked to indicate the location of their birth. This variable was dummy-coded into 4 categories: United States, India, Pakistan, Bangladesh, other (Nepal, Sri Lanka, Maldives)
State in India	If participant indicated they were born in India, they were asked which state

Region	This variable was dummy-coded into 6 categories using the states in India where participants indicated that they lived (categorization based off of Indian government's specification): North, Northeast, East, West, Central, South
Age at immigration	This variable was dummy-coded into 2 categories based off of the participant's age at immigration: 12 years or younger; 13 years or older
Religion	This variable was dummy-coded into 3 categories based off of the participant's religion: Hindu, Muslim, Other (e.g., Christian, Jain)
Educational Attainment	This variable was dummy-coded into 4 categories based on the participant's educational attainment: High school or less, Some college, Bachelor's Degree, Graduate Degree
Employment Status	This variable was dummy-coded into 4 categories based on the participant's occupation unemployed ,employed, retired, student
Marital Status	This variable was dummy-coded into 4 categories based off of the participant's marital status: currently married, dating (not married), single, other
Type of marriage	This variable was dummy-coded into 2 categories based on the participant's type of marriage: Arranged or Love
Social support	Social support was ascertained by four questions: (1) Does your family live close or near to you? (2) When you have a problem, can you depend on your family for help? (3) Do your friend live close or near to you? (4) When you have a problem,

	can you depend on your friends for help?
Acculturation	This was a continuous variable representing the participant's level of acculturation. Marin and Marin Acculturation Scale (Marin et al., 1987) was utilized. Responses to all items are given on a five-point bipolar scale where 1 is "Only Native language" and 5 is "Only English", with a midpoint (3) of "Both equally". To score the Acculturation, Marin and Marin (1987) recommend calculating the average rating across all answered items and utilizing an average of 2.99 as recommended cut point – scores above this point represent higher levels of acculturation and scores below this point represent lower levels of acculturation. The questions included: (1) In general, what language (s) do you read and speak: English only, Mostly English, Half and Half, Mostly South Asian language, Only South Asian language? (2) What language(s) do you usually speak at home: English only, Mostly English, Half and Half, Mostly South Asian language, Only South Asian language? (3) In which language(s) do you usually think: English only, Mostly English, Half and Half, Mostly South Asian language, Only South Asian language? (4)What language(s) do you usually speak with your friends: English only, Mostly English, Half and Half, Mostly South Asian language, Only South Asian language?
Previous exposure to violence	This variable was dichotomized. If the participant answered "yes" to the following, exposure was coded as 1;

	else=0. Did your father beat your mother?
Individual-Level (Husband)	
Age	This was a continuous variable representing the participant's husband's/partner's age
US Citizenship	This variable was dichotomized. If the participant answered "yes" to their husband being a US citizen, citizen=1; else=0
Race	This variable was dummy-coded into 4 categories based on the participant's husband's/partner's ethnicity: South Asian , White, Black, Other (East Asian, Hispanic, Native/Pacific Islander)
Country of Birth	The participants were asked to indicate the location of their husband's/partner's birth. This variable was dummy-coded into 4 categories: United States, India, Pakistan, Bangladesh, other (Nepal, Sri Lanka, Maldives)
Religion	This variable was dummy-coded into 4 variables: Hindu, Muslim, Christian, Other
Educational Attainment	This variable was dummy-coded into 4 categories: High School or less, Some college, Bachelor's Degree, Graduate Degree
Employment Status	This variable was dummy-coded into 4 categories: Unemployed, Employed, Retired, Student
Household-Level	
Number of living children	This was a continuous variable representing the participant's number of children

4.2.3b. Qualitative Measurement

Qualitative interviews were conducted based off a semi-structured interview guide (Appendix B). Interviews were recorded using QuickTime Player on her computer and transferred to a removable file storage device immediately after the interview. Audio recordings were stored on the flash drive and deleted immediately after the researcher transcribed and entered the de-identified transcripts into Dedoose, a qualitative data management and analysis software.

4.3 Data Analysis Strategy

4.3.1. Quantitative Data Analysis strategy

Aim #5: To assess prevalence rates of intimate partner violence (physical, sexual, and emotional) among South Asian women in New Jersey, New York, and Connecticut.

Data Analysis Strategy: The frequency and percentage for physical, sexual, and emotional, violence experienced by South Asian women in New Jersey, New York, and Connecticut.

Aim #6: To assess individual-level and household-level risk and protective factors for IPV (physical, emotional, sexual).

Data Analysis Strategy:

Predictor variables were recoded as explicated in Table 5 below. Bivariate analyses were conducted to test the association between the predictor variables (individual-level factors and household-level factors) and outcome variables (physical, sexual, emotional violence). Associations between the predictors and outcome were tested using Fishers Exact Test . Next, variables significant at the bivariate level ($p<.05$) were included in the logistic regression model. Prior to running the regression model, assumptions for logistic

regression were ascertained: independence of observations, the outcome variable (experience with IPV) was binomial, the sample size was sufficiently large to meet the minimum requirements of 25 observations per variable, and none of the independent variables perfectly predicted the outcome variable. Additionally, there was no multicollinearity: All VIF (variance inflation factors) were under 2. Due to the small sample size, the Firth Correction for logistic regression was utilized. Parameter Estimates Profile Likelihood were used for confirmation of significance.

Table 5: Recoded Predictor Variables for Regression Analyses (recoded variables are bolded)

Individual-Level (Women)	
Age	This was a continuous variable the participant's age
Country of origin	The variable was dummy-coded into 2 categories: India (reference); Other (Pakistan, Bangladesh, Nepal, Sri Lanka, Maldives)
US Citizenship	This variable was dichotomized: US citizen, not US citizen
Location of birth	The participants were asked to indicate the location of their birth. This variable was dichotomized: US (reference); South Asia
Region	This variable was dummy-coded into 2 categories: South India (reference); Other (North, East, Northeast, West, Central)
Age at immigration	This variable was dummy-coded into 3 categories based on the participant's age at immigration: Did not immigrate (born in the US), 12 years or younger, 13 years or

	older
Religion	This variable was dummy-coded into 2 categories based off of the participant's religion: Hindu (reference), Other (Muslim, Christian, Jain)
Educational Attainment	This variable was dummy-coded into 3 categories based off of the participant's educational attainment: Some college or less (reference), Bachelor's Degree, Graduate Degree
Employment Status	This variable was dummy-coded into 2 categories based off of the participant's occupation unemployed (unemployed, retired, student) (reference), and employed
Marital Status	This variable was dummy-coded into 2 categories based on the participant's marital status: currently married (reference), not married (dating, single, other) dating
Type of marriage	This variable was dummy-coded into 2 categories based on the participant's type of marriage: Arranged (reference), Love
Social support	Social support was ascertained by four questions: (1) Does your family live close or near to you? (2) When you have a problem, can you depend on your family for help? (3) Do your friend live close or near to you? (4) When you have a problem, can you depend on your friends for help? Each question was dichotomized with "yes"/no" A response of "no" served as the reference category
Acculturation	This was continuous variable representing the participant's level of acculturation. Marin and Marin Acculturation Scale

	(Marin et al., 1987) was utilized. Responses to all items are given on a five-point bipolar scale where 1 is "Only Native language" and 5 is "Only English", with a midpoint (3) of "Both equally". To score the Acculturation, Marin and Marin (1987) recommend calculating the average rating across all answered items and utilizing an average of 2.99 as recommended cut point – scores above this point represent higher levels of acculturation and scores below this point represent lower levels of acculturation. The questions included: (1) In general, what language (s) do you read and speak: English only, Mostly English, Half and Half, Mostly South Asian language, Only South Asian language? (2) What language(s) do you usually speak at home: English only, Mostly English, Half and Half, Mostly South Asian language, Only South Asian language? (3) In which language(s) do you usually think: English only, Mostly English, Half and Half, Mostly South Asian language, Only South Asian language? (4)What language(s) do you usually speak with your friends: English only, Mostly English, Half and Half, Mostly South Asian language, Only South Asian language?
Previous exposure to violence	This variable was dichotomized. If the participant answered "yes" to the following, exposure was coded as 1; else=0. Did your father beat your mother?
Individual-Level (Husband)	
Age	This is a continuous variable representing

	the participant's husband's/partner's age
US Citizenship	This variable was dichotomized: US citizen (reference); not a US citizen
Race	This variable was dummy-coded into 2 categories based on the participant's husband's/partner's ethnicity: South Asian (reference), Other (e.g., White, Black, East Asian, Hispanic, Native/Pacific Islander)
Country of Birth	The participants were asked to indicate the location of their husband's/partner's birth. This variable was dummy-coded into 2 categories: United States (reference), South Asia (e.g., India, Pakistan, Bangladesh, Nepal, Sri Lanka, Maldives)
Religion	This variable was dummy coded into 2 categories: Hindu (reference); Not Hindu
Educational Attainment	This variable was dummy coded into 3 categories: Some college or less (reference), Bachelor's Degree, Graduate Degree
Employment Status	This variable was dummy coded into 2 categories: Unemployed (reference); Employed
Household-Level	
Number of living children	This was a continuous variable representing the participant's number of children

For Aims 7 and 8, a new dataset was created comprising of only women who indicated that they have experienced IPV (any experience with IPV).

Aim #7: To determine the proportion of IPV service utilization by South Asian survivors in New Jersey, New York, and Connecticut and the source of the sources (informal, formal, any services).

Data analysis Strategy: The frequency and percentage of survivors use of services (informal, formal, and any services).

Aim #8: To determine individual-level (women's only) and household-level predictors of service utilization.

Data Analysis Strategy:

Bivariate analyses were conducted to test the association between the predictor variables (individual-level factors (women's only) and household-level factors) and the outcome variable (by type: informal, formal).

4.3.2. Qualitative Data Analysis strategy

The Grounded Theory approach (Strauss & Corbin, 1994) was utilized to analyze the qualitative interviews with SAWO service providers. The Grounded Theory approach has three key features: theoretical sampling, an iterative study design, and a system of analysis (Kennedy & Lingard, 2006).

The researcher began her qualitative data collection by asking SAWO services providers about their perceptions of intimate partner violence in the South Asian community and the help-seeking behaviors of survivors. Based off of a few interviews (3) with SAWO service providers in New Jersey, the researcher decided to expand her sampling to SAWO service providers in New York and Connecticut due to the diversity

within the South Asian community across the states; this process is called theoretical sampling (Strauss & Corbin, 1994). The researcher continued collecting and analyzing data until saturation was achieved. Saturation is the point where there are no new ideas and insights emerging from the data (Strauss & Corbin, 1994).

An iterative study design involves the researcher moving in and out of data collection, simultaneously collecting and analyzing the data (Strauss & Corbin, 1994). Essentially, the analysis informs the next cycle of data collection (Kennedy & Lingard, 2006). In the present study, preliminary analyses of interviews with SAWO service providers suggested a theme of "therapeutic alliance" between the SAWO service provider and the survivor. The theme of "therapeutic alliance" was further explored and refined by asking the remaining participants (SAWO service providers) about their therapeutic alliance with their clients.

The analysis of the data involved three levels of coding, as per Strauss and Corbin (1994). First, the researcher conducted open coding where the researcher divided the data into preliminary categories pertaining to IPV in the South Asian community and help-seeking behaviors of survivors. Next, the researcher conducted axial coding where she grouped together the categories that were coded during open coding into themes. The themes that the researcher identified were demographics of survivors that seek services, factors that increase vulnerability to IPV, barriers to formal services, the therapeutic alliance between SAWO provider and survivor, and the role of the South Asian community in the prevention of IPV. Last, the researcher organized the themes and integrated the most relevant and compelling quotes that capture each theme.

4.4 Integration of the Secondary and Primary Data Analysis

Figure 5 below illustrates the integration of the secondary and primary data. First, the results from the secondary data analysis informed the primary data collection and analysis. The secondary data suggested that there are regional differences in both experiences with IPV and help-seeking behaviors. As a result, a question was added in the primary quantitative survey to ask women who indicated that they were from India to specify the region that they were from. Additionally, while the secondary data inquired about the service use of survivors, it did not (1) ask survivors the rationale behind their decisions to seek services or not or (2) gauge survivors' satisfaction with the services that they received. Therefore, the primary quantitative survey included questions to ascertain survivors' rationale for seeking or not seeking services and their satisfaction with the help that they received. Furthermore, qualitative interviews were utilized to gather rich data on factors that increase South Asian women's vulnerability to violence and barriers and facilitators to service use among survivors; information that would be difficult to ascertain from quantitative surveys alone.

Following the synthesis of the primary quantitative and qualitative data, the secondary and primary data were then synthesized. Areas of similarity and dissimilarity were highlighted and discussed (see Chapter 7).

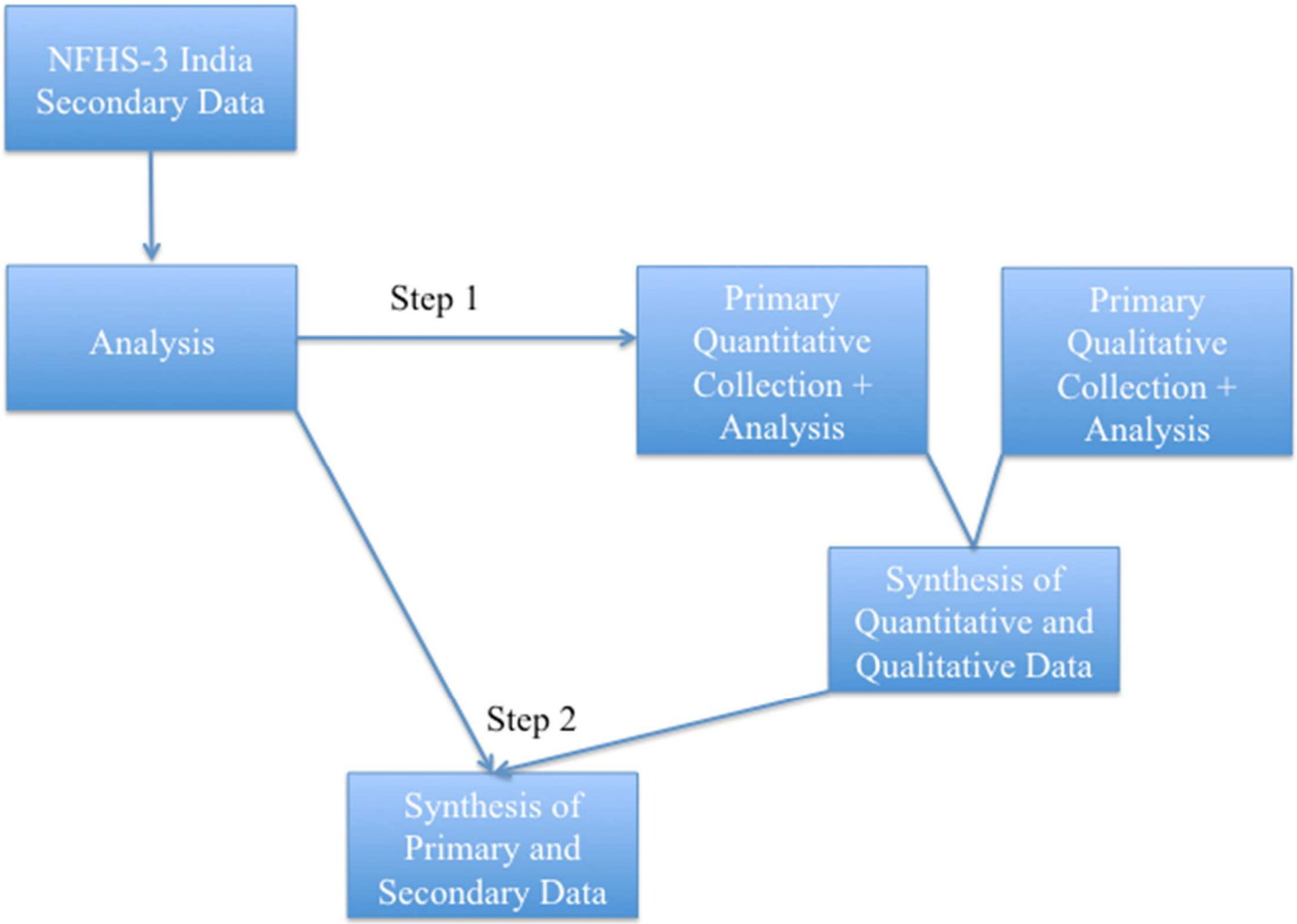

Figure 5: Synthesis of Secondary and Primary Data

4.5 Research Ethics

4.5.1 Institutional Policies

The investigator obtained permissions from the Washington University Institutional Review Board for research involving human subjects, which is guided by the ethical principles regarding research involving human participants, as set forth in the standards outlined by the Office for Human Research Protection (OHRP), as codified by 45 CFR 46 and its Subparts A, B, C, and D and the FDA in 21 CFR 50; 21 CFR 56; the Belmont Report; the Declaration of Helsinki and the Nuremberg Code. The IRB approval number for this project is 201607063.

4.5.2 Ethics in Research with Survivors

The study recruited a mixture of South Asian women who have and have not experienced IPV. The following section discusses ethical issues that have been considered to ensure the safety of survivors of IPV.

Survivor's Safety

Protecting the safety of the woman is paramount and thus, all possible precautions were taken to minimize the risks associated with participating in the research study. According to Sullivan and Cain (2004) considerations that must be taken to ensure the women's safety involve: how to first contact women about participating in the research; where data collection will occur; and how to protect women's safety before, during and after data collection.

Disclosure of abuse has potential to leave the participants vulnerable to risk of retaliation by their abuser or by family members. Additionally, recollection of past events may be painful, especially if the woman does not have adequate support (Ellsberg et al., 2001). On the other hand, however, there is a body of literature that exists that suggests that survivors may directly benefit from disclosing their abuse and trauma (Griffin et al., 2003; Dyrerov, Dyregrov, & Raundalen, 2000 Parslow, Jorm, O'Toole, Marshall, & Grayson, 2000; Ruzek & Zatzick, 2000). For example, studies have found that survivors found their participation in research to be positive and insightful (Newman & Kaloupek, 2004). Even in studies where participants reported intense activation of emotion related to the trauma, they did not regret participation in the study (Johnson & Benight, 2003). Specific guidelines proposed by Sullivan and Cain (2004) to enhance women's safety and address such concerns are listed in the Appendix IV.

Consent and Voluntariness

A large portion of clinical and advocacy work with women who experience violence pertains to empowerment or giving women the opportunity to make informed decisions about their beliefs, attitudes, behaviors and life (Sanderson, 1995). While researchers' values generally align with these sentiments, they have a competing aim of maximizing participation, which may inadvertently contribute to coercion in the research process (Fontes, 2004). In addition, the perceived authority that researchers have may make it difficult for potential participants to refuse consent. Typically, researchers study individuals or groups who are poorer, less educated, more discriminated against, less healthy and in a multitude of ways are less socially powerful than themselves (Koocher &

Keith-Spiegel, 1998), thus making it particularly difficult for potential participants to decline participation.

According to Campbell & Dienemann (2001), coerced participation may be likely in situations where women are dependent on others. For example, women in shelters, prisons or substance abuse centers may believe that they will obtain special benefits for participating or believe that their services/service quality are contingent upon participation.

To avoid coerced participation, the researcher emphasized the voluntary nature of participation in the study. In addition, the researcher gave the participants clear decision points during the course of the survey to decide whether or not they would like to continue to participate (Fontes, 2004). According to Ford and Reutter (1990), stressing the voluntary nature of participation throughout a study may ultimately be more important than the informed consent forms provided at the beginning.

Cultural Competence

South Asian women may be reticent to participate in research studies due to cultural norms such as familialism and collectivism, which discourages women from speaking out about their abuse. Despite safeguards and other mechanisms that serve to protect research participants and their confidentiality, immigrant women may still experience mistrust. Immigrants may fear familial or societal repercussions if their participation in the study becomes known.

Access to ethnic communities (i.e. South Asians) can be accomplished by working collaboratively with agencies or organizations trusted by the particular

community (Sullivan et al., 2005). In order to execute the study in a culturally-competent manner, this study underwent a cultural review and partnered up with three SAWOs.

Additionally, non-hierarchical and culturally sensitive interview techniques should be used (Bryne et al., 2009). Culturally matched researchers may be able to facilitate rapport and enhance relationship building with the potential participant (Anderson, Silver, & Abramson, 1988; Brunswick, 1997). The researcher is from the South Asian community and was involved in all aspects of the research process. Additionally, the IRB application underwent an external cultural review process. Cultural competence is also just as importance in data analysis and interpretation as it is in other parts of the research process. Results were analyzed and interpreted in a culturally specific context.

4.5.3 Addressing Harm Caused by the Study

A participant may become distressed as a result of answering questions if she has been the victim of domestic violence, especially if the violence occurred recently. To address this, all participants received a list of phone numbers and, where applicable, the addresses of Manavi, Sakhi, Sneha, and the National Domestic Violence Hotline, and shelters in the community that can be of help. The same information was available on the electronic survey.

Another possible concern is that women who are in abusive relationships might be further victimized if a male partner learned that they completed the survey. To minimize this risk, the survey was titled " South Asian Women's Health and Life Experiences Survey" rather than utilizing "domestic violence" in the title since the survey also asked about other aspects of women's life in addition to domestic violence. The cover letter

also suggested that women not take the survey if they thought they might experience harm as a result of participating and it asked that they not discuss the survey with others to further prevent any risk of harm to them or to others who might take the survey.

Another potential risk to respondents was that of fear about the security of web-based survey data. The following safeguards were taken to eliminate this risk: 1) The Survey Monkey web server was used to store data. SurveyMonkey uses multiple layers of security to make sure that the account and data remain private and secure. It employs a third-party firm to conduct daily audits of the security, and data remains behind the latest in firewall and intrusion prevention technology; 2) All completed research materials (surveys either use the word questionnaire or survey consistently throughout this document) were stored in a password-protected computer file; 3) No identifiers such as names were collected, quantitative findings were reported in the aggregate, and any written (qualitative) comments that respondents made were reported in ways that would not allow any individual to be identified.

V. Secondary Data Results

5.1 Description of the NFHS-3 Sample (Secondary Data)

The final sample of the secondary quantitative analysis consisted of 69, 484 ever-married women in India who were administered the domestic violence module. Demographic information included individual and household level factors. (See Table 6 for complete demographic data). Individual-level factors included information about the respondent (female) and the respondent's partner or husband.

Women's Demographic Characteristics

Participants were on average 32 years old (SD=8.9) and had 5.2 years of education (SD=5.2). Most of the respondents were not currently working for pay (63%) and had no access to money in the household (55%). More than 56% of the participants agreed that wife beating was justified in some circumstances. Almost 20% (18.1) of the respondents indicated that they were aware of domestic violence perpetrated by their father against their mother.

Husband's Demographic Characteristics

Respondents' husbands were on average 38 years old (SD=9.0). About 23% (23.1%) of the husbands in the sample had no education and a little over 60% (61.3%) had at least a secondary education. Almost all of the respondents' husbands were employed (98.2%). Approximately 37% (37.3%) of the husbands consumed alcohol.

Household-Level Factors

Approximately 56% (56.1%) of the households were located in rural areas and 44% are located in urban areas (43.9). Respondents proportionately represented all regions of India, with most from South Asia (19.5%). About 14.0% of households in the same area were in the poorest wealth index, compared to 27.4% being in the richest wealth index. Most of the respondents were Hindu (74.5%). The average number of children was two (SD=1.6).

Table 6: Demographics of NFHS-3 Study Participants, India, 2005-06 (n=69,484)

Variable	**Sample Mean(SD)/ %**	**Number reporting**
Individual Level		
Women's Variables		
Age	32.0 (SD=8.0)	69, 484
Educational Attainment	5.2 (SD=5.2)	69, 479
Employment Status		69, 362
Not working	63.1%	43, 756
Working	36.9%	25, 606
Access to money		69, 473
No access to money	55.0%	38, 206
Access to money	45.0%	31, 267

Justification of abuse		64, 484
No justification of abuse	43.9%	30, 525
Justification of abuse	56.1%	38, 959
Previous exposure to violence		64, 379
No previous exposure to violence	81.9%	52, 720
Exposure to violence	18.1%	11, 659
Husband's Variables		
Age	37.4 (SD=9.0)	65, 406
Educational Attainment		68,862
No Education	23.1%	15, 895
Primary	15.6%	10, 773
Secondary +	61.3%	42, 194
Employment Status		69,272
Unemployed	1.8%	1, 248
Employed	98.2%	68, 024
Alcohol Consumption		69, 415
Does not drink alcohol	62.7%	43, 513
Does drink alcohol	37.3%	25, 902

Household Variables		
Region		69, 484
South	19.5%	13, 560
Northeast	16.7%	11, 626
West	13.1%	9, 066
Central	17.9%	12, 400
North	17.9%	12, 400
East	15.0%	10, 432
Place of Residence		69, 484
Urban	43.9%	30, 522
Rural	56.1%	38, 962
Wealth Index		69, 484
Poorest	14.0%	9, 734
Poorer	16.0%	11, 117
Middle	19.5%	13, 551
Richer	23.1%	16, 051
Richest	27.4%	19, 031
Religion		69, 484
Hindu	74.4%	51, 660
Muslim	12.4%	8. 597
Christian	8.2%	5, 714

Other	5.1%	3.513 69, 484
Number of Living Children	2.42 (SD=1.6)	

5.2 Results by Research Questions

5.2.1 To what extent have ever-married women in India experienced IPV?

Utilizing the CTS (Straus, 1996), participants' experience with physical, sexual, emotional, and any lifetime experience with IPV were calculated. Fifty-two women were excluded from analyses due to missing values, bringing the sample size from 69, 484 to 69, 432. Among ever-married women who participated in the NFHS-3 domestic violence module: 31% (31.1%) reported experiencing physical violence, 8% (8.3%) reported experiencing sexual violence, 14% (14.1%) reported experiencing emotional violence. More than 35% (35.3%) reported experiencing some form of violence.

Table 7: Extent of Intimate Partner Violence Among Ever-Married in India (N=69, 432)

Variable	**Percentage**	**Number reporting (N)**
Physical IPV	31.1%	21, 600
Sexual IPV	8.3%	5, 778
Emotional IPV	14.1%	9. 814

5.2.2 What are the risk and protective factors for IPV among married women in

India?

In Table 7 models are presented showing the association between physical, sexual, and emotional violence and the individual and household-level factors of married women in India. Older age is a slight protective factor against sexual violence (OR: 0.99; CI: 0.99-0.99), while it is a slight risk factor for experiencing emotional violence (OR: 1.01; CI: 1.00-1.04). Higher educational attainment is a protective factor against all three types of violence: physical (OR: 0.94; CI: 0.94-0.95), sexual (OR: 0.98; CI: 0.96-0.98) and emotional violence (OR: 0.97; CI: 0.94-0.99). Interestingly, the predicted odds of employed women experiencing physical, sexual, and emotional violence were 25%, 23%, and 29% higher than their unemployed counterparts (respectively).

The predicted odds of women who endorsed the use of violence experiencing physical, sexual, and emotional violence were 45%, 32%, and 35% higher than their counterparts who did not endorse the use of violence (respectively). Additionally, previous exposure to violence as a child significantly increased the odds of women experiencing all types of violence: women who were aware that their fathers abused their mothers were two to three times more likely to experience IPV than their counterparts who were not aware of their father abusing their mothers.

While higher educational attainment was a protective factor for women, the higher educational attainment of the husbands was not protective factor. Women whose husbands had at least a primary education were 14% (OR:1.14; CI:1.08-1.21) and 17% (OR: 1.08-1.28) more likely to experience physical and sexual violence than their counterparts whose husbands did not have any formal education. Additionally, the

husbands' attainment of a secondary education and higher were not significant protective factors against IPV. Women whose husbands consumed alcohol were much more likely to experience all types of IPV compared to women whose husbands did not consume alcohol (see Table 7 for OR and CIs).

Women from South India were less likely to experience almost all forms IPV than their counterparts from all other regions. The only exception was in regard to physical violence; women in North India were 9% less likely to experience physical violence compared to their South Indian counterparts (OR: 0.91; CI:0.85-0.97). Additionally, coming from a household that observes Christianity and other faiths (e.g., Sikhism, Jainism, and Buddhism) were protective factors against experiencing IPV (relative to women from Hindu households), while coming from a Muslim household was a risk factor for experiencing every type of IPV compared to women from Hindu households. Additionally, wealth is a protective factor against experiencing all forms of IPV

Table 8: Odds Ratios (OR) for the Likelihood of Experiencing Intimate Partner Violence: Physical, Sexual, and Emotional (IPV) (N=69,432)

Variable	Physical Violence		Sexual Violence		Emotional Violence	
	OR	95% CI	OR	95% CI	OR	95% CI
Individual Level						
Women's Variables						
Age	0.99	0.99-1.00	0.99***	0.99-0.99	1.01***	1.00-1.04
Educational Attainment	0.94***	0.94-0.95	0.98***	0.96-0.98	0.97***	0.94-0.99
Employment Status						
Not working (reference)						
Working	1.25***	1.21-1.31	1.23***	1.15-1.31	1.29***	1.23-1.35

Access to Money						
Does not have access (reference)						
Has access	0.99	0.96-1.08	0.99	0.93-1.05	0.99	0.94-1.04
Justification of abuse	1.45***	1.40-1.51	1.32***	1.24-1.41	1.35***	1.29-1.43
Previous exposure to violence	3.00***	2.86-3.13	2.23***	2.09-2.38	2.28***	2.14-2.34
Husband's Variables						
No education (reference)						
Primary Education	1.14***	1.08-1.21	1.17*	1.08-1.28	1.04	0.97-1.12
Secondary +	0.99	0.94-1.05	1.10	0.95-1.13	0.95	0.89-1.01
Alcohol Consumption						
Does not consume alcohol						

(reference)						
Consumes alcohol	2.50***	2.40-2.60	2.15***	2.02-2.29	2.23***	2.12-2.34
Household Variables						
Region						
South (reference)						
Northeast	1.04	0.98-1.11	3.13**	2.76-3.51	1.13**	1.04-1.23
West	1.08*	1.00-1.15	1.21*	1.05-1.41	1.72***	1.58-1.87
Central	1.76***	1.66-1.88	2.60***	2.31-2.92	1.75***	1.63-1.89
North	0.91**	0.85-0.97	2.50***	2.21-2.82	1.15**	1.06-1.26
East	1.41***	1.31-1.50	5.12***	4.59-5.72	1.44***	1.32-1.57
Religion						
Hindu (reference)						
Muslim	1.43 ***	1.36-1.52	1.60***	1.46-1.74	1.43 ***	1.32-1.54
Christian	0.63***	0.58-0.69	0.40***	0.35-0.47	0.95	0.86-1.05

Other	0.97	0.88-1.07	0.58***	0.50-0.69	0.87***	0.79-0.98
Wealth Index	0.85***	0.84-0.87	0.91***	0.88-0.94	0.87***	0.85-0.90
Number of Living Children	1.10***	1.09-1.12	1.01	0.99-1.04	0.99	0.97-1.12

Wald χ^2	9, 005.09***	3,371.63***	3, 835.52***
Max-rescaled R^2	0.23	0.13	0.11
C	0.79	0.75	0.79

*p<.05, **p<0.01, ***p<0.001

5.2.3 What proportion of survivors seek services and from whom?

Of the 24, 513 women that reported receiving services, 5, 968 (24.3%) women reported seeking IPV-related sources. 25% (25.7%) of survivors reported seeking IPV-related help from informal sources (e.g., family, friends), while only 3% (2.8%) of survivors sought IPV-related help from formal sources (e.g., police, social service organizations, lawyer).

Table 9: Use of IPV-related services by survivors (N=5, 968)

Variable	Percentage	Number reporting (N)
Informal	25.7%	5, 873
Formal	2.8%	633

When survivors sought services, they mostly sought services for physical violence 26% (25.6%), followed by emotional violence (14.2%), and lastly, sexual violence (8.1%).

Table 10: Type of service sought by IPV type (N=5, 968)

	Physical	Sexual	Emotional
Informal	5,754 (25.2%)***	1,794 (7.9%)***	3,178 (13.9%)***
Formal	594 (2.6%)	227 (1.0%)***	346 (1.5%)***

*p<.05, **p<0.01, ***p<0.001

5.2.4 What are predictors of service utilization?

Two logistic regression models were run to determine the predictors of informal and formal service utilization (see Table 10). Older women were more likely to utilize formal services than their younger counterparts (OR: 1.03; CI: 1.02-1.04); however, age was a not a significant predictor for informal service utilization. Surprisingly, educational attainment was not a significant predictor in either type of service utilization. Women who were employed and had access to household income were 14% and 16% more likely to utilize informal sources; however, employment status and access to money were not significant predictors of formal service utilization.

As expected, women who endorsed the use of violence were less likely to utilize either type of services compared to their counterparts who did not endorse the use of violence (informal- OR:0.93; CI:0.90-0.97; formal- 0.80; CI: 0.67-0.96). While women who were previously exposed to violence were more likely to seek help from informal sources (OR: 1.17; CI: 1.14-1.20), they were less likely to seek services from formal sources (OR: 0.76; CI: 0.63-0.91).

Women from South India were much more likely to go to informal sources of support than their counterparts from every other region. In regard to formal service utilization, women from West India were 63% more likely to seek services than their South Indian counterparts (OR: 1.63; CI: 1.27-2.11). Women from Christian households and households of other faiths were 24% (OR: 1.24; CI: 1.20-1.25) and 47% (OR: 1.47; CI: 1.26-1.70) more likely to seek help from informal sources than their Hindu counterparts; religious affiliation of the household was

not a significant predictor of formal service utilization. Women who had more children were less likely to seek any type of services.

Table 11: Odds Ratios (OR) for the Likelihood of Survivors Utilization of IPV Services

Variable	**Informal Services (N=20,458)**		**Formal Services (N=20, 458)**	
	OR	95% CI	OR	95% CI
Individual Level				
Women's Variables				
Age	1.01	0.99-0.99	1.03 ***	1.02-1.04
Educational Attainment	1.00	0.94-0.95	1.02	.99-1.04
Employment Status				
Not working (reference)				
Working	1.14***	1.21-1.31	1.06	0.88-1.27
Access to Money				
Does not have access (reference)				
Has access	1.16***	1.08-1.2	1.18	0.99-1.41

Justification of abuse	0.93*	0.90-0.97	0.80**	0.67-0.96
Previous exposure to violence	1.17***	1.14-1.20	0.76*	0.63-0.91
Household Variables				
Region				
South (reference)				
Northeast	0.47***	0.98-1.11	0.90	0.68-1.19
West	0.70***	1.00-1.15	1.63*	1.27-2.11
Central	0.75***	0.66-0.88	0.25***	0.17-0.36
North	0.70***	0.65-0.97	0.63*	0.46-0.87
East	0.58***	0.31-0.60	0.83	0.63-1.09
Religion				
Hindu (reference)				
Muslim	0.96	1.36-1.52	0.82	0.62-1.08
Christian	1.24*	1.20-1.25	0.73	0.50-1.06
Other	1.47***	1.26-1.70	0.80	0.53-1.20
Wealth Index	0.98	0.84-0.87	1.00	0.92-1.10
Number of Living Children	0.96**	1.09-1.12	0.92*	0.87-0.98

Wald χ^2	402.50***	200.99***
Max-rescaled R^2	0.03	0.05
C	0.59	0.68

*p<.05, **p<0.01, ***p<0.001

5.3 Limitations

First, the data are eleven years old and some of the results may not be relevant to the current landscape of IPV in India. Additionally, data collection for the NFHS-3 ended prior to the implementation of India's National Domestic Violence Act in 2006, which expanded the legal definition of IPV and the availability of formal service provisions for survivors (e.g., social services, legal assistance).

Second, the Max-rescaled R^2 for the models were modest and especially weak for the models pertaining to service utilization. The weak r-squares and the low c values (under .70) suggest limited predictive abilities of the models. Therefore, findings should be interpreted with caution. Future studies may consider adding other important and relevant predictor variables to increase the r-square values and the predictive ability of the models. Some predictor variables, which were not available in the present data set, but would have been important and relevant to include are: experiences with coercive control and other experiences that constitute previous exposure to violence (e.g., child abuse, non-partner sexual violence).

Additionally, according to Rodriguez and colleagues (2009), there are numerous client-level and provider-level barriers that serve as barriers to formal service utilizations; these factors may explain the low levels of service utilization among survivors in India. Client-level barriers include sociopolitical factors (e.g., feelings of shame, guilt, or fear; lack of familiarity with

formal systems; partner intrusion in help-seeking; language barriers); cultural factors (e.g., stigma associated with help-seeking; values that emphasize family and secrecy); and financial factors (i.e. lack of financial resources to afford services and/or costs related to service utilizations such as transportation) (Rodriguez et al., 2009). Clinician-level barriers include lack of screening and discriminatory practices (e.g., caste-based, religion-based) directed towards survivors (Rodriguez et al., 2009). Future studies may consider understanding the extent to which these factors affect survivors' decision making regarding service utilization.

Third, the NFHS-3 was subject to several measurement issues. The NFHS-3 employed the CTS-2; as a result, violence was situated in the context of settling disputes, which implicitly discourages respondents from sharing their experiences with abuse that is control-based or that arises from an unknown cause not (DeKeseredy & Schwartz, 1998). Additionally, the CTS-2 does not reveal the motivation for the abuse; therefore, it is unclear if the abuse was the result of control, self-defense, or some other factor (DeKeseredy & Schwartz, 1998). Lastly, the CTS-2 does not ascertain the meaning that women attributes to their experiences with abuse, which has implications for the psychological and emotional wellbeing of survivors.

Another measurement issue was the way in which previous exposure to violence was operationalized. In the present study, previous exposure to violence was operationalized as witnessing parental IPV. However, previous exposure to violence encompasses a variety of acts in addition to witnessing parental IPV, including non-partner physical, sexual, and/or psychological abuse and community violence.

Additionally, though the study asked about the source of help, the study did not specifically ask what type of assistance the survivors received and their satisfaction with the help

they received. Therefore, the researcher was unable to determine the utility of these resources for women experiencing IPV.

Lastly, the data were cross-sectional. Therefore, causation cannot be established. The researcher cannot conclude that findings were caused by predictor variables explored.

Despite these limitations, the NFHS data provided invaluable insight that guided the collection, analysis, and interpretation of the primary data, especially in regards to the informal and formal help-seeking behaviors of survivors. The help-seeking behaviors of survivors in India are relevant to understand the help-seeking behaviors of survivors of Indian origin who migrated to the United States. Additionally, the NFHS data provided insight into regions in India where women may be particularly vulnerable to IPV and may require extra outreach when they immigrate to the United States.

VI. Primary Data Results

6.1 Primary Quantitative Survey Participant Demographics (N=125)

The final sample derived from the quantitative survey was 125 women from New Jersey, New York, and Connecticut. On average, the women in the sample were approximately 40-years-old (SD=12.8). Most of the participants were United States citizens (82.4%). A majority of the participants (85.6%) were of Indian origin and 57% (56.7%) were born in India and immigrated to the United States. The sample consisted of highly educated women with almost 93% reporting that they had at least a Bachelor's Degree and approximately 71% (71.2%) of the sample was employed at the time of the survey.

Most of the women in the sample were married or formerly married (69.6%) and most of these marriages were arranged (55.2%). Approximately 56% of the sample reported having children and the average number of children the women in the sample had was almost 2 (SD=1.8). Most of the women in the sample were acculturated (3.7, SD=0.9) and most of the sample reported having social support. Additionally, 99% of the sample rejected the use of IPV. Almost 20% (19.2%) of the sample stated that they were aware of their father physically abusing their mother. See Table 11 below for full demographics of the participants and their partners.

Table 12: Quantitative Survey Participant Demographics (N=125)

Variable	Sample Mean(SD)/ %	Number reporting
Individual Level		
Women		
Age	39.5 (SD=12.8)	125

US Citizen		125
No	17.6%	22
Yes	82.4%	103
Country of Origin		125
India	85.6%	107
Bangladesh	6.4%	8
Pakistan	6.4%	8
Other	1.6%	2
Country of Birth		125
United States	35.3%	44
India	56.7%	68
Pakistan	2.4%	3
Bangladesh	2.4%	3
Other	4.0%	5
If India, region		68
South	47.1%	32
West	33.8%	23
North	14.7%	10
Central	4.4%	3
Age at immigration		125
Did not immigrate	35.2%	44
12 or under	12.8%	16
13 or over	52.0%	65

Religion		125
Hindu	75.2%	94
Muslim	13.6%	17
Christian	2.4%	3
Other	8.8%	11
Educational Attainment		125
High School of Less	4.0%	5
Some College	3.2%	4
Bachelors	32.0%	40
Graduate	60.8%	76
Employment Status		125
Unemployed	9.6%	12
Employed	71.2%	89
Student	12.0%	15
Retired	7.2%	9
Marital Status		125
Married	64.0%	80
Dating	19.2%	24
Single	11.2%	14
Other (divorced/separated/widowed)	5.6%	7
Type of Marriage		87
Arranged	55.2%	48
Love Marriage	44.8%	39

Acculturation Score	3.7 (SD=0.9)	116
Social Support		125
Family in close proximity		125
No	36.8%	46
Yes	63.2%	79
Can depend on family		125
No	20.8%	26
Yes	79.2%	99
Friends in close proximity		125
No	4.8%	6
Yes	95.2%	119
Can depend on friends		125
No	10.4%	13
Yes	89.6%	112
Justification of Abuse		107
No justification of abuse	99.0%	106
Justification of abuse	1.0%	1
Previous Exposure to Violence		
No previous exposure	80.8%	104
Previous exposure	19.2%	84
Partner		20
Age	42.9 (SD=14.7)	114
US Citizen		114

No	20.2%	23
Yes	79.8%	91
Country of Birth		114
United States	29.6%	37
India	51.2%	64
Bangladesh	2.4%	3
Pakistan	1.6%	2
Other	6.4%	8
Race/Ethnicity		114
South Asian	78.1%	89
White	14.0%	16
Other	7.9%	9
Religion		109
Hindu	62.4%	68
Muslim	9.2%	10
Christian	14.7%	16
Other	13.8%	15
Educational Attainment		111
High School or Less	1.8%	2
Some College	3.6%	4
Bachelors	26.1%	29
Graduate	68.5%	76
Employment Status		111

Unemployed	4.5%	5
Employed	82.4%	91
Retired	5.4%	6
Student	8.1%	9
Number of Living Children	1.83 (1.0)	70

6.2 Results by Research Questions

6.2.1 To what extent have South Asian women in New Jersey, New York, and Connecticut experienced IPV?

Of the 125 women who comprised the primary quantitative sample, 107 women completed the questions pertaining to experiences with IPV and help-seeking behaviors. There were 18 missing observations in the sample. As a result, the demographic characteristics of the women who completed the survey were compared to the demographic characteristics of women who did not complete the survey; there were no significant differences between both populations. As a result, the missing values were attributed to random error and not systematic error.

Of the 107 women who completed the questions pertaining to experiences with IPV, 14% (n=18) of the women indicated that they experienced physical violence in their lifetime and 3% (n=4) indicated that they experienced physical violence in the 12-months prior to the study. Almost 11% of the sample (n=10.8%) indicated that they experienced sexual violence in their lifetime and only one respondent indicated that she had experienced sexual violence in the 12-months prior to the study. More than 40% (n=51) of the sample indicated that they have

experienced emotional violence in their lifetime and 20% (n=25) indicated that they experienced emotional violence in the 12 months prior to the study.

Table 13: Extent of Intimate Partner Violence among South Asian Women in New Jersey, New York, and Connecticut

Variable	Percentage	N=107 (Total Respondents)
Physical Violence		
Lifetime	14.4%	18
12-months prior	3.2%	4
Sexual Violence		
Lifetime	10.8%	11
12-months prior	.80%	1
Emotional Violence		
Lifetime	40.8%	51
12-months prior	20.0%	25

In total, 47% (n=51) of the women who completed the IPV related questions (n=107) had experienced physical, sexual, and/or emotional violence in their lifetime. Following the sets of questions pertaining to endorsing the experience of physical, sexual, and emotional violence, participants were explicitly asked: "Have you ever experienced physical, sexual, and/or emotional violence from a current or former husband/spouse/partner?" Only 43% of women (n=22) acknowledged that they had experienced IPV from a current or former partner/spouse.

Of the 22 women who acknowledged that they had experienced some form of IPV, 77% (n=16) had experienced a combination of physical, sexual, and emotional violence and 3% (n=5) experienced only emotional violence, and one woman experienced only physical violence.

On the other hand, 57% (n=29) of the women who experienced IPV from a current or former partner/spouse did not acknowledge that they had in fact experienced IPV. Of these women, 86% (n= 25) had experienced emotional violence and 14% (n=4) had experienced a combination of physical, sexual, and emotional abuse.

6.2.2 What the predictors of IPV among South Asian women in New Jersey, New York, and Connecticut?

In Table 14 models are presented showing the association between physical, sexual, and emotional violence and the individual and household-level factors of married women in India. Only predictor variables that were significantly associated with the outcome variables at the bivariate level were included in the models.

At the bivariate level, there were only two statistically significant associations across all three models. One was the association between a participant being able to depend on her family for help and her experience with physical violence. Women who indicated that they could count on their family for help were significantly less likely to experience physical IPV than their counterparts who stated that they could not count on their family for help (OR: 0.20; CI: 0.06-0.61).

The other statistically significant association was between a woman's experience with sexual violence and her husband/partner's citizenship. Women who indicated that their husbands

were United States citizens were significantly less likely to experience sexual violence than women whose husbands are not United States citizens (OR: 0.26; CI: 0.07-0.94).

Table 14: Odds Ratios for the Likelihood of Experiencing Intimate Partner Violence: Physical, Sexual, and Emotional (IPV) among South Asian Women in New Jersey, New York, and Connecticut (n=107)

Variable	Physical Violence		Sexual Violence		Emotional Violence	
	OR	CI	OR	CI	OR	CI
Individual-Level						
Women's Variables						
Age					1.03	0.97-1.08
Region in India						
South India (reference)						
Other (North, East, Northeast, West, Central)					0.41	0.14-1.19
Religion						
Hindu (reference)						
Other (Muslim, Christian, Jain, Buddhist)					0.43	0.06-3.22
Social Support						
Can depend on family for help						

No (reference)						
Yes	0.20**	0.06-0.61	0.94	0.47-1.86		
Friend live in close proximity						
No (reference)						
Yes						
Can depend on friends for help						
No (reference)						
Yes	0.30	0.08-1.20				
Acculturation Score	0.90	0.51-1.58				
Partner/Spouse's Variables						
US Citizen						
Not a citizen (reference)						
Citizen			0.26*	0.07-0.94	0.63	0.15-2.77
Wald χ^2	12.01**		4.49*		4.04*	
c	0.70		0.72		0.68	

*p<0.05, **p<0.01, ***p<0.001

6.2.3 What proportion of survivors seek services and from whom?

Of the 51 women total who have experienced some form of IPV in their lifetime, 35% (n=18) sought help from informal sources. The women were asked to indicate all of the informal sources that they sought help from: 16 indicated that they told their friends, seven told their siblings, six told their parents, four told their husband/partner's family, three told their children, and three told their neighbors.

Additionally, almost 20% (n=10) of the women who experienced IPV in their lifetime stated that they sought help from formal sources. Participants were asked to indicated all of the formal sources that they sought help from and nine indicated women's organizations, six indicated the court/legal system, three indicated social services, three indicated the police, two indicated a hospital/clinic, and two indicated that they sought help from a priest.

Interestingly, eight women stated that they have been injured as a result of the violence perpetrated by their partner and only two women stated that they received healthcare as a result of the injuries. Further, neither of the two women indicated that they disclosed the real cause of their injury to their healthcare worker.

Furthermore, participants were asked to indicate the reasons that prompted them to seek formal help: seven women stated that they were encouraged by their friends and family, nine indicated that they could no longer endure the abuse/feared for their lives, and two indicated that it was affecting their children's lives.

Qualitatively, participants were asked to explain what was the most useful form of help that they received either from formal or informal sources. Of the responses (n=12), most participants discussed support from informal sources (e.g., friends and family) and counseling from formal organizations. One woman stated: "The counselor helped me come up with a plan to come out…"

Additionally, women were asked to qualitatively indicate what the least useful form of help was that they received and from whom. Of the responses (n=8), most women stated the lack of acknowledgement of the abuse from their family (both natal and in-laws) and the encouragement to stay in the abusive relationship. One woman stated that the least useful form of help she received was from her counselor. This woman stated: "My counselor spent a lot of time trying to get me to disengage from my partner. The problem wasn't wanting to disengage, but not having a place to go."

Women were asked to indicate the reasons that they did not seek help: two indicated that they were afraid that their partner would leave them, two stated that they were afraid they would bring a bad name to their family, and four stated that they were embarrassed/ashamed/afraid that nobody would believe them.

Women were asked to indicate if they ever left, even for the night, because of the IPV: 11 women indicated that they left and four indicated that they stayed with their neighbors, two with their relatives, two went to a hotel, one stayed on the street, and two said other but did not specify where. Furthermore, women were asked to indicate all of the reasons they returned or stayed with their perpetrator: four indicated that they forgave their partner, two thought their partner could change, two indicated that their family encouraged them to stay, two said there was

nowhere to go, one indicated the "sanctity of marriage" kept her from leaving, and four indicated other.

6.2.4 What are the predictors of service utilization

Formal and informal service utilization were examined at the bivariate level using Fishers Exact Test. The only significant associations were between service type (formal and informal) and whether or not the participant felt that she could depend on her family for help.

Table 15: Bivariate Associations between Service Type and Women's Individual and Household Characteristics (Fisher's Exact)

Variable	Formal Services (n=10)	Informal Services (n=18)
	%/N; p-value	%/N; p-value
Individual Level		
Women's Variables		
Age	38.3 (SD=9.2); p=0.76	40.7 (SD=13.3); p=0.91
United States Citizenship		
Not a citizen (reference)	20.0%	22.2%
Citizen	80.0%; p=0.33	77.8%; p=0.33
South Asian country of origin		
India (reference)	100%	27.8%
Other	0%; p=0.33	72.2%; p=0.29
Location of Birth		

United States (reference)	30.3%	36.4%
South Asia	69.7%; p=0.26	63.6%; p=0.26
Region in India		
South India (reference)	42.9%	70.0%
Other	57.1%; p=0.23	30.0%; p=0.15
	p=0.76	p=0.34
Age at immigration		
Did not immigrate (reference)	30.0%	27.8%
12 years or younger	20.0%	22.2%
13 years or older	50.0%	50.0%
Religion		
Hindu (reference)	60.0%	66.7%
Other (Muslim, Christian, Jain, Buddhist)	40.0%; p=0.26	33.3%; p=0.23
	p=0.65	p=0.63
Educational attainment		
Some college or less (reference)	0.0%	0.0%
Bachelor's Degree	30.0%	38.9%
Graduate Degree	70.0%	61.1%
Employment Status		
Unemployed (reference)	30.0%	66.7%
Employed	70.0%; p=0.30	39.3%; p=0.29
Marital Status		

Unmarried (reference)	60.0%	50.0%
Married	40.0%; p=0.16	50.0%; p=0.14
Type of marriage		
Arranged (reference)	37.5%	61.5%
Love	62.5%; p=0.69	38.5%; p=0.14
Social Support		
Family lives in close proximity		
No (reference)	70.0%	44.4%
Yes	30.0%; p=0.69	55.6%; p=0.38
Can depend on family for help		
No (reference)	70.0%	44.4%
Yes	30.0%; p=0.06	56.6%; p=0.38
Friends live in close proximity		
No (reference)	70.0%	44.4%
Yes	30.0%; p=0.00**	55.6%; p=0.04*
Can depend on friends for help		
No (reference)	0.0%	0.0%
Yes	100.0%; p=0.80	100%; p=0.64
Acculturation Score	3.7 (SD=0.6); p=0.33	3.5 (SD=0.7); p=0.30
Previous exposure to violence		

No previous exposure (reference)	75.0%	75.0%
Exposure	25.0%; p=0.67	25.0%; p=0.71
Household Level		
Number of living children	1.0 (SD=0.8); p=0.98	0.9 (SD=0.9); p=0.98

*p<0.05; **p<0.01; ***p<0.001

6.2.5 What are the perceptions of SAWO service providers regarding IPV in the South Asian community?

Qualitative interviews were conducted with 12 service providers. The average age of the service providers was 37.9 (SD=12.2) and providers been with their respective agencies for approximately 4 years. The shortest amount of time reported was one month and the longest amount of time was 25 years. Fifty-eight percent (n=7) had graduate degrees and 42% (n=5) had bachelors level degrees. All of the providers were of South Asian origin (83% Indian and 17% Pakistani). Pseudonyms are used below to protect the anonymity of the service providers.

Demographic Characteristics of Clients

SAWO service providers from New Jersey, New York, and Connecticut were asked to comment on the demographic characteristics of the clients served by their respective organizations. Providers reported that most of their clients are married women between the ages of 26 and 45. The organizations in New Jersey and New York noted a recent trend, within the past year, of younger (18-22), unmarried women in dating relationships. Providers noted that their respective organizations have served women from all South Asian backgrounds. However,

the organizations in New Jersey and Connecticut reported that most of their clients are of Indian origin, while the organization in New York reported that most of their clients are of Bangladeshi origin.

Providers reported that the majority of their clients are immigrants who came to the United States after marriage. Most clients served have been in the United States long enough to obtain legal citizenship, while others are legal permanent residents or conditional or permanent green card holders. Although the vast majority of clients served are immigrants from South Asia, providers noted that they also serve clients who were born and raised in the United States or others parts of North America.

Providers from New Jersey and Connecticut reported that most of their clients are upper-middle class, well-educated, and highly proficient in English. Providers from New York reported more socio-economic diversity in their client population citing a sizable population of poor, un/undereducated women with limited English speaking abilities.

Factors that increase vulnerability to IPV

Every service provider cited patriarchal cultural values as a salient contributor to IPV in the South Asian community, primarily among immigrant families. Two areas that providers discussed extensively were patriarchal gender norms/expectations for men and women and the prominence placed on family.

Gender Norms/Expectations

All service providers noted patriarchal gender norms and expectations as a contributor to IPV in the South Asian community. Most providers explicitly commented on expectations of

South Asian women to derive worth and value from their roles as "good" wives and mothers. Oftentimes, providers used the words "submissive," "accommodating," and "dependent" to describe what being a "good" wife and mother entails. Providers overwhelmingly discussed the expectation of South Asian men to be the "head of the household" and "provider"/"breadwinner" in their families. Some providers even used the word "control(ing)" to describe South Asian men in these roles.

Providers attributed these gender norms and expectations to creating immense pressure on women to maintain/"keep together" the home and family that their husbands (financially) provide. Providers explicitly commented on how this pressure contributes to environments conducive to IPV and women's tolerance of it.

Seetha, a service provider, said:

> "In the South Asian culture, you get married and stayed married. When…if there is violence, it's on her [woman]. She has to be the one, the one to tolerate… to adjust because it is her 'husband'..."

Renu, another provider, echoed this sentiment, adding:

> "…women have this pressure… as if they did something to cause this [violence]…so they need to accommodate or fix what they are doing…"

The following provider, Zaara, mentioned women's tolerance of violence for the sake of her children and being a "good" mother":

> "…they are willing to put up with the worst of the worst to keep their kids safe and I think that's just like what they think what a good mother… that's what they do…"

Almost all providers discussed the role of immigration to the United States in the reinforcement of gender roles, especially women's financial dependency on their spouse.

Nassim, another provider, shared the common experiences of her immigrant clients who come to the United States on dependent visas:

> "A lot of South Asians come through visas and the spouses [women] come on the dependent visa. So ultimately these women are financially dependent on their spouses. And I…I can honestly tell you that a lot of the women I've worked with are highly accomplished in their native country. They're doctors, lawyers, and engineers and you know women who could absolutely support themselves financially but cannot work legally here... So they are completely dependent on their spouse…"

Some providers also noted that even when women work, they do not necessarily have control of their own income. Radhika noted:

> "The man is the head of the household. He controls the finances...even hers when she makes her own… "

A few providers described experiences with clients who had limited/no knowledge about household finances (e.g., how to access bank accounts, how to pay for bills) due to women's financial dependence on their husbands. Most providers discussed how women's financial dependence often leaves them confined in abusive relationships. The following provider, Sameera, stated:

> " So when the relationship gets into violence, there are only so many options for the women, right? Like if he controls all of the money…"

Renu added:

> "…that's part of the reason why they stay in these relationships so long. It is more the threat of withholding finances for the children… I am not going to pay for the school trip or college…"

Family

Providers discussed the emphasis placed on family in the South Asian culture and its role in perpetuating IPV. Almost every provider shared that their clients sought support and/or advice from their family before seeking services from their respective organizations. Some providers

acknowledged the benefit of women seeking support from their families. For example, Latha noted:

> "When a woman is suffering, she will have the emotional support… it is support because they [her family] are not alienating her."

However, providers cautioned that familial support has potential to be problematic when IPV occurs. Providers stated that families often instill and reinforce gender norms that tend to normalize abuse and encourage women to tolerate violence.

Latha also explained:

> "Culture has such a strong hold… Families give support, but it is toxic. It is wrong. They tell her that he is her husband, you know? They tell her it will be okay… that she should just do better and try not to make him upset…"

Seetha added:

> "I've had clients and their own mothers, who have probably experienced it [violence] say 'Kanna (dear), adjust…he is that way."

Several providers discussed the salience of marriage to South Asian families and its implications for women experiencing IPV.

Nassim explained:

> "In the South Asian culture, marriage is not between two people; it is two families getting together…So, when a woman experiences violence, she is told to tolerate it because…it's not just her. There are others invested…"

Sameera added:

> "They [women] can't think about themselves. They have to think, well, they are conditioned to think about what it means for everyone else—their kids, their husband, their in-laws... Every action, will affect everyone in her family…so, she just suffers…"

Several providers discussed that South Asian women often avoid seeking help for violence because of the "shame" it could cast on them and their families. Providers mostly discussed how divorced women /single mothers in the South Asian community are blamed for the dissolution of their family.

One provider, Priya, said:

> "Divorced women in the South Asian community, I hate to say it, are like pariahs…What's wrong with her? Why did he leave her?"

Radhika added:

> "The children are huge for these women and that is why they stay most of the time. When she leaves, it's like 'what about her kids?' because the father is important in the children's' lives too..."

Providers noted that even in cases where women's families are accepting of their divorce/decision to leave their abusive husband, women are not always welcomed back to live with them in their natal country.

Barriers to Formal Services

Providers identified numerous barriers that South Asian women encounter when accessing formal IPV-related services. The biggest barrier to formal service utilization that providers noted was lack of awareness. However, one provider explicitly discussed discrimination faced by survivors by formal (non-SAWO) institutions.

Lack of Awareness

Several providers noted lack of awareness about what IPV is and what it entails as a barrier, especially among older immigrant women. Providers stated that even when women are able to identify IPV, it is mostly limited to physical violence and most providers attributed the lack of awareness to cultural values and norms that promote wifely submission. For example,

providers shared that women often do not identify unwanted sexual advances and/or acts perpetrated by their husbands as sexual violence. Instead, providers stated that women believe it is their "wifely duty" to sexually satisfy their husbands even if they are not interested in participating.

Additionally, many providers discussed the lack of awareness regarding the availability of services. Providers shared that many South Asian women do not know that there are services available to help them address IPV, especially culturally-relevant services offered by SAWOs. Almost every provider noted that this lack of awareness is exacerbated by immigrant status. In particular, providers noted the following access problems: linguistic barriers (limited English-speaking capabilities), limited geographic mobility and/or access to public transportation, and lack of social networks in the United States separate from their abusive partners.

Discrimination

One provider discussed discrimination as a barrier to formal service utilization. Their commentary was specifically focused on the experiences of immigrant women. Latha discussed experiences her client had accessing community resources:

> "One thing, the Asian accent isn't sexy here… So take my personal experience because I go on court accompaniments... I like go out into the community with these women to help them secure resources to… that are owed to them and I find that these women get no respect from anybody."

Latha continued:

> "It's a big problem because these women are victimized over and over again in marriages and relationships. And when they finally get the courage to seek for help they're faced with a barrier after barrier because you don't like the way that they talk? I just don't understand that."

Survivors' Experiences with SAWOs

Providers were asked about their perceptions of clients' experiences accessing services at their respective organizations. Providers' responses focused on two major areas: client's' initial contact with the SAWO and the therapeutic alliances formed between the providers and clients.

Client's Initial Contact with SAWO

Most providers shared that their clients reached out to their respective SAWOs through word of mouth (e.g., informal sources). However, providers also said that some, especially younger first-generation South Asian Americans, reached out to their organizations via the internet (e.g., SAWO website, social media).

Most providers shared that the impetus for women seeking services at their respective SAWOs was the effect the violence had on their children; some of these effects include partners withholding financial support for the children and a decline in the children's academic performance. Additionally, providers stated that clients generally approach SAWOs for legal consultation centered around topics related to separation/divorce from abusive partners, including citizenship, child custody and support, and alimony. Most providers noted that although clients initially contact SAWOs for legal issues, eventually, they uncover the years of IPV women have endured.

For example, Zaara explained:

> "I mean I think to be honest with you I don't think I've ever had a case where a woman reached out for… like usually, it is financially motivated and then through that then we uncover all of this years of abuse."

Additionally, providers stated that many women seek services at their agencies after years of enduring abuse. Providers stated that women typically tried to "work it out" and see if the abuse would stop.

Renu explained:

> "Women come at the "end" stages… well, is there ever really an end? But, generally they had enough. They try and they say 'I tried to work it out… I tried to see if it could change…'"

Therapeutic Alliance

Providers were asked to discuss their goals when working with clients. While acknowledging that they tailor their services to every client's unique circumstance, every provider said their goal is to "empower" their clients. To that end, providers generally discussed how clients are the experts on their own situations.

Nassim said:

> "They know that they know their situations better than anyone else... They know their weaknesses and strengths…"

Seetha shared:

> "Want them to make them to make decisions for themselves even if that means for them to stay"

Every provider identified as a South Asian woman and stated that the shared culture between them and their clients was beneficial to the therapeutic alliance. Priya explained:

> "I connect with my clients. Even if I cannot relate with them with the abuse, I get it… Like one client told me that her parents paid a dowry. I understand. I am not going to judge…"

Sameera added:

> "Having the shared culture is very helpful. The clients do not need a background story because I am South Asian… I understand…"

Yet, some clients stated that there are challenges with having the same culture as their clients. For example, Radhika said:

> "They won't skip over details of abuse, but they skip over

> implications of abuse on them… on family and society…because they think that I get it because I am South Asian…"

Additionally, some providers noted that generation differences pose challenges to the therapeutic alliance with their clients. For example, the following provider, Saara, explained:

> "I feel like most of the people I help are from a different generation... The strong influence of the South Asian culture has on them is… it's big. But, it hasn't had that strong of an influence on my life… I was born and raised here [United States]..."

Some providers also discussed how cultural values of women's submissiveness and dependence often serve as a barrier to the therapeutic alliance with clients. Latha stated:

> "I mean you could tell them six million times that this abuse…and they will agree with you because they are conditioned to obedience. And so it's very difficult to push that.."

Nassim added:

> "We have clients that ask us, they want us to tell them what to do because they've always been told what to do."

Role of the Community

The providers were asked to discuss the role, if any, of the South Asian community in preventing IPV. Most providers, especially those who have been with SAWOs for many years have acknowledged the progress that has been made in acknowledging the existence of IPV. Yet, overwhelmingly, providers stated that there is still much progress that remains. Zaara explained:

> "We still have a long way to go… I see conversations happening. people talking about it more. But, we need more open discussion…"

Saara added:

> "Difference between talking about it and having open platforms, I don't see as a community people coming together saying 'let's create something to address it' that is key to allowing women to come out and talking about."

Ultimately, providers expressed that it is crucial for the South Asian community to accept the pervasiveness of IPV in order to address it.

Radhika stated:

> "More prevalent than you would think. Might be happening to you, but you don't know. You normalize it."

Latha added:

> "We went to this conference and one of the presenters said that domestic violence is like cancer it's like the great equalizer because it doesn't care what how old you are, what color you are, if you are going to get cancer, you are going to get cancer. It doesn't matter what your job is it doesn't matter where you were born or what kind of house you lived in and you can be affected by it. "

6.3 Limitations

The primary data collection portion of the dissertation was subject to several limitations. First, the researcher was only able to attain a sample of 125, of which, only 107 filled out the domestic violence and subsequent help-seeking questions. As a result, the results of this study cannot be generalized to all South Asian women in the United States.

Second, the sample was not obtained through random sampling. As a result, there were many inherent biases in the primary sample; a limitation of previous studies conducted with this population (Mahapatra, 2013; Raj and Silverman, 2002; Adam, 2000). The vast majority of the women in the primary sample were highly educated, employed, and acculturated. Additionally, the survey required women to be proficient in English and computer literate. As a result, this survey precluded non-English speaking women and women from lower socio-economic backgrounds.

This study also employed the CTS-2. Similar to the limitations of the secondary data analysis, this study was unable to determine the subjective meaning that survivors attributed to their experiences with violence. Additionally, there were not enough participants recruited from all four regions in India to detect whether patterns seen in the secondary analyses were consistent in the primary data.

Lastly, the qualitative component of the dissertation study only captured the perceptions of SAWO service providers from three different agencies on the East Coast. Therefore, the study results may not be representative of SAWO service providers' perceptions in other parts of the United States. Additionally, the perceptions of the providers may or may not accurately reflect the experiences of women who do not seek services.

Despite these limitations, this study has many strengths and potential for contributions to this field. Despite the small sample size, the data highlights the prevalence of IPV among highly educated, employed, and acculturated South Asian women. In particular, the data suggests that South Asian women may not necessarily perceive certain acts of sexual and emotional violence as violence. This is important pilot data that could be used to guide future exploration into these forms of violence.

Additionally, this study is one of the few existing studies that specifically examined the help-seeking behaviors of South Asian survivors in the United States (Mahapatra, 2013; Yoshioka, 2003; Silverman & Raj, 2002). Again, despite the limited sample size, this study provided survivors with the opportunity to quantitatively and qualitatively describe their decisions to seek (or not) IPV related services and their relative satisfaction with the services received. This is an area that can be expanded upon in future studies.

Lastly, this is one of very few studies (Abraham, 1995; Radrappa, 2004) and the only recent study to examine SAWO service providers' perceptions of IPV in the community and the subsequent help-seeking behaviors of survivors. SAWO service providers have been providing services to South Asian women and their families across the United States with services for 30 years. As such, they possess valuable insight that can be utilized to design future studies and prevention/intervention programs.

VII. Discussion

This dissertation study combined secondary data analysis of the NFHS-3 from India and primary mixed methods data collection and analysis to understand the experiences of South Asian women in the United States with IPV and the help-seeking. Below, major findings from the secondary and primary data analyses are synthesized and reflected upon in the context of South Asian women's experiences in the United States.

7.1 Risk and Protective Factors for IPV

Consistent with previous literature, the data from India suggests that the relationship between educational and economic empowerment of women and IPV are complex (Ackerson et al., 2008; Dalal, Rahman & Jansson, 2009; Jewkes, 2002). While increased educational attainment was a protective factor against IPV, being employed and having access to money was a risk factor. Extant literature suggests that women's economic empowerment may challenge gender role structures that emphasize men's role as the breadwinner and head of the household; as a result, IPV may be utilized as a mechanism to maintain power and control over women (Koenig et al., 2003; Rocca et al., 2008; Vyas & Watts, 2008).

In the United States sample of South Asian women, educational attainment and employment status were not significantly associated with IPV. The sample was mostly comprised of highly educated and employed Indian women. Yet this is not an unexpected finding. According to Chakravorty and colleagues (2017), Indian-born residents are the best-educated group in the United States; roughly three times more India-born residents have college degrees than the general population. Additionally, Indian-American households have the single highest income level of any other group in the country, more than twice as high as the general population (Chakravorty et al., 2017). Future studies may consider paralleling the educational

attainment of women in India to Indian women in the United States to determine the extent to which women's experiences with IPV are similar.

Previous studies have documented partners' educational attainment as a protective factor against IPV (Ackerson et al., 2008; Boy & Kulczyki, 2008; Boyle et al., 2009). Surprisingly, women in India whose husbands had a primary education were more likely to be victimized than women whose husbands had no education. It is important to note that all socio-demographic questions pertaining to the respondents' husbands, including educational attainment, were obtained through the respondents' self report. Additionally, it is unclear whether or not women who indicated that their husbands had no education meant that their husbands had zero years of education or had completed a few years of education, but not completed the requisite number of years for primary school. Future research should verify the husbands' educational attainment and determine if primary educational attainment is in fact a risk factor for IPV.

Women in India who reported that they were exposed to parental IPV were significantly more likely to be victimized themselves; this finding is consistent with existing literature that has documented the strong association between childhood exposure to IPV and future victimization (Söchting, Fairbroth- er & Koch, 2004). In the United States sample, however, childhood exposure to parental IPV was not significantly associated with future victimization. It is possible that exposure to parental IPV is not as salient among the sample in the United States because IPV may be perceived as less socially acceptable than in India. Furthermore, legal consequences in the United States may serve as deterrents to the use of IPV.

More than half of women in India justified the use of IPV and these women were 40 percent more likely to be victimized than their counterparts who did not justify the use of IPV.

Interestingly, women in the United States sample, most of whom were Indian immigrants, overwhelmingly disagreed with the use of IPV (99%). This finding may also be attributed to the use of IPV being perceived as less socially acceptable than in India.

Specific to the experiences of South Asian women in the United States, perceived familial social support was the only significant protective factor against physical IPV. Women who indicated that they could depend on their family members were less likely to report physical IPV than women who indicated that they could not depend on their family members. This finding is supported by existing literature that have demonstrated that social support is a protective factor against IPV and instrumental in mitigating the deleterious mental health implications of IPV (Baumgartner, 1993; Klien & Milardo, 2000).

Additionally, the only protective factor against sexual IPV for the United States sample was the partners' citizenship status. Women who reported that their partners were United States citizens were less likely to report sexual IPV than women who reported that their partners were not United States citizens. Extant literature suggests that women from countries that emphasize patriarchal gender norms are often more likely to be tolerant of marital rape (Mildarsky, 2006; Dasgupta, 2000). It is possible that immigration to the United States and subsequent acculturation to the United States culture facilitates more egalitarian views towards sex and gender; this may explain why partners' citizenship status served as a protective factor against sexual IPV.

Lastly, findings from both the qualitative interviews with service providers and qualitative responses from survivors highlighted socio-cultural factors that contextualized South Asian women's experiences with violence. The socio-cultural values gleaned from survivors and

service providers included the importance of family and normative gender role expectations of men and women; these findings are consistent with existing studies (Dasgupta, 2000; Dasgupta and Warrier, 1996; Ayyub, 2000).

7.2 IPV-Related Help-Seeking

Help-seeking is a coping strategy that is associated with lower levels of distress among abused women (Ahmad, Driver, Mcnally & Steward, 2009; Kemp, Green, Hovanitz, & Rwlings, 1995; Mitchell & Hodson, 1983). Yet, delayed help- seeking plagues abused women from all backgrounds (Reidy&VonKorff, 1991). Survivors in India and South Asian survivors in the United States rarely sought help for IPV and when they did, they typically sought help from informal sources such as family and friends.

According to Liang and colleagues (2005), many abused women avoid or delay seeking help from formal sources as a result of anticipated and/or actual negative experiences with formal institutions. Negative experiences that serve as deterrents to formal help seeking include: lack of validation, trivialization of survivors' experiences, and racial and/or religious stereotyping (Liang, 2005; Wolf et al., 2003).

Additionally, qualitative interviews with service providers highlighted the unique barriers that immigrant South Asians survivors encounter at the intersection of their race, class, immigrant status, and acculturation level when attempting to access formal services. Providers discussed how these barriers are exacerbated by cultural norms that emphasize privacy, familialism, and rigid gender norms (Dasgupta, 2000; Abraham, 1995). In order for formal services to increase accessibility and effectively meet the needs of South Asian survivors, future

studies should examine survivors' perspectives regarding barriers to formal service utilization and the perceived relevance of formal services to their needs.

Survivors in India and South Asian survivors in the United States who experienced sexual violence were least likely to seek either type of help, formal or informal. The reticence to seek help for sexual IPV may be due to cultural norms that either prevent South Asian women from recognizing such acts as violence or encourage women to tolerate such abuse. According to the qualitative interviews with service providers and findings from extant studies (Dasgupta, 2000; Bhattacharjee, 1992), South Asian women are often socialized to be submissive to their partners. Therefore, women may perceive sexual acts as their "wifely duty," as opposed to something that is pleasurable for them and that they have agency over.

Sexual violence is associated with numerous adverse physical and mental health outcomes including unintended pregnancies (Miller et al., 2010), sexually transmitted infections and diseases (Campbell, 2002), post-traumatic stress disorder (Clum et al., 2000; Kilpatrick & Resnick, 1993; Rothbaum et al., 1992), and depression (Acierno et al., 2002; Clum et al., 2000; Winfield et al., 1990). In order to mitigate the harmful effects of sexual violence and move towards a preventative approach, future studies should examine ways in which sex education targeted towards South Asian women could be enhanced to be more culturally relevant, yet safe and empowering.

Lastly, this study provided insight into regional variations in regards to IPV prevalence and help-seeking behaviors. Data from the NFHS-3 suggested that women from Northeast and East India were particularly vulnerable to IPV and the least likely to seek help. On the other

hand, women from South India were the least likely to experience IPV and the most likely to seek help.

Women in Northeast India are often assumed to enjoy a more elevated status compared to their counterparts in other regions of the country due to the presence of matrilineal systems (Islam, 2014). In the state of Meghalaya, where the Khasi and Garo tribes are located, women have greater decision-making power and inheritance rights to family property, which typically follow a female line (Sun, 2002). However, despite the elevated status offered by matrilineal systems, the Northeastern region of India is marred by low levels of women's literacy and educational attainment and high levels of female child mortality that have undermined the socio-economic well being of women (Kar, 2002).

South India, on the other hand, is often noted for high levels of literacy and educational attainment among women compared to all other regions in India (Atal, 2009). Kerala is a matrilineal state and unlike their counterparts in the Northeast, women in Kerala have high rates of female literacy, educational attainment, life expectancy, and a favorable sex ratio (Ammu, 1999). In fact, Kerala has a sex ratio of 1.08, which is higher than that of the rest of India and is the only state where women outnumber men (Tharamangalam, 2005).

More research is needed to elucidate additional regional nuances that serve as risk factors for and protective factors against IPV. This information may provide insight into where additional outreach and resources need to be allocated for women in India and for women who immigrate to the United States in India.

VIII. Implications for Social Work Practice, Policy, and Research

Culture profoundly affects how women conceptualize, identify, and address violence in their lives. The results from both the secondary and primary components of this study suggest that in order to successfully intervene and address IPV among South Asians in the United States, it is imperative to understand the antecedents to violence, cultural values that foster the tolerance and perpetuation of violence, and factors that serve as deterrents to help-seeking. Below are social work practice, policy, and research implications derived from this study that will help practitioners, policy makers, and researchers better understand this phenomenon and more effectively intervene.

8.1 Implications for Social Work Practice

8.1.1 Social Services for South Asian Women

Both the secondary and primary data demonstrated that IPV among South Asian women spans socio-economic characteristics on the individual and household levels. Even women who were educationally and financially empowered experienced IPV at high rates. This may be reflective of the salience of cultural values and norms that promote women's submission to their partners/spouse. While these cultural values and norms may not be equally prominent in the lives of all South Asian women, it is important for service providers to be cognizant of these values and how they may shape a woman's experience with and response to violence. In order to prevent imposing adherence to these cultural values and norms on all South Asian survivors, providers may consider asking clients how their culture has shaped their experiences with violence. In doing so, providers will be better equipped to understand the client's experience with violence and how better to help them in a culturally sensitive and relevant manner.

The data suggested that South Asian women may have a limited awareness regarding the breadth of IPV and/or cultural values may encourage women to tolerate certain acts of violence (e.g., sexual violence, emotional violence). For example, women who experienced sexual IPV were the least likely to seek help from either informal or formal sources. This reticence to seek help for sexual IPV may be reflective of cultural values that promote women's submissiveness to their partner/spouse (Dasgupta, 2000; Bhattacharjee, 1992). As a result, targeted outreach efforts are needed to educate South Asian women about the different forms of IPV, its manifestations, and implications. Additionally, it is imperative for these efforts to be culturally relevant yet empowering.

The findings from the primary data demonstrated that South Asian women tend to place importance on their roles as mothers, often putting the health and wellbeing of the children ahead of their own (Dasgupta, 2000). Due to the priority that South Asian women place on their children and the empirically documented deleterious implications of childhood exposure to IPV, this may be an area for outreach and prevention/intervention efforts to emphasize. Additionally, targeted efforts to raise awareness among this population may be more effective if done in conjunction with other systems that South Asian women interact with (e.g., religious institutions, cultural organizations).

SAWOs have made significant contributions in addressing IPV in the South Asian community, even in the face of limited funding for services. Findings from the qualitative interviews suggest that SAWOs offer culturally relevant services that ease the burden of explaining and justifying cultural values of survivors. However, as providers discussed, service provision runs the risk of becoming too solution-focused without offering survivors the opportunity to reflect on the implications of experiencing IPV and the role of culture. Providing

survivors with the space and opportunity to process and make meaning of the abuse that they endured is a crucial learning opportunity to help prevent future victimization.

While SAWOs offer survivors with vital, culturally relevant services, it is imperative for mainstream domestic violence/sexual assault organizations to be equipped to serve the needs of South Asian women as they are a growing demographic in the United States. As discussed extensively in this dissertation, cultural norms and gendered relations serve as barriers to help-seeking behaviors. Barriers are further exacerbated by immigration status (e.g., language, fear of deportation, child custody). To provide culturally relevant services, mainstream providers must be cognizant of the ways in which South Asian women's multiple identities are contextualized by larger social, cultural, and religious values that shape their experiences with violence.

8.1.2 Collaboration with other systems of care

The needs of survivors of IPV clearly span the spectrum of formal systems of care (e.g., mental health, medical, legal). Both the secondary and primary data demonstrated that South Asian survivors rarely seek formal services and when they do, it is mostly for physical violence. In the primary sample of South Asian women, eight women reported being physically injured by their partner/spouse, however, only two sought medical services. Neither of the two women disclosed the cause of injury to their health professional.

Mental health professionals and/or domestic violence service providers could provide trainings to their colleagues situated in other formal institutions on how to appropriately screen for IPV and refer survivors to relevant resources. Although the CDC-P and numerous medical associations (e.g., the American Medical Association, the American College of Obstetrics and Gynecology) have advocated for the routine screening of IPV in medical settings (Bhandari et al., 2009), healthcare workers do not routinely screen for IPV even when treating injuries

(D'Avolio, 2011). Failure to screen for IPV and appropriately intervene may have fatal implications (Sprague et al., 2012). According to Davis (2008), 44 percent of IPV related homicide victims had presented to an emergency department within two years of their death.

One promising strategy to increase routine IPV screening by health professionals is the integration of the Kaiser Permanente (KP) Systems Model (Miller et al., 2015). The Systems Model essentially utilizes the entire healthcare environment to integrate IPV screening in everyday care (Miller et al., 2015). According to Miller and Colleagues (2015):

> "[EMR support clinicians] role is clear and limited: ask, affirm, assess, document, and refer. On-site services are provided by behavior health clinicians who triage for mental health needs and begin the safety planning process. Robust community linkages ensure access to essential DV crisis and ongoing advocacy support services. At each medical center, a multidisciplinary team, led by a physician champion, provides leadership and oversight of systems model implementation. Quality improvement metrics, including IPV identification and referral rates, are communicated quarterly to departments and medical centers" (p.4)

The implementation of the Systems Model has been associated with a six-fold increase in IPV identification between 2000 and 2011 in KP's Northern California Region; the majority of those identified received mental health follow-up care (Miller et al., 2015). Therefore, this model may be a promising strategy to increase the routine screening and intervention for IPV.

Additionally, SAWO service providers could provide cultural sensitivity trainings to their colleagues in other systems of care to explain the cultural/linguistic factors that serve as barriers to service utilization. Although only one service provider explicitly discussed discrimination encountered by survivors when accessing services, SAWOs could use such trainings as an opportunity to address and dispel myths and stereotypes pertaining to South Asians and South Asian survivors.

However, underutilization of formal services may not be symptomatic of lack of awareness or accessibility. Rather, underutilization may be due to the lack of relevance to the unique needs and circumstances of South Asian survivors. As provider interviews indicated, family is paramount in the South Asian culture. The needs, wants, and desires of the family unit are often prioritized over those of an individual family member. Therefore, formal services that solely utilize an individualistic approach (i.e. focusing only on the individual survivor herself) and do not incorporate the perspective of the broader family unit may not adequately and appropriately attend to the needs of South Asian survivors.

Furthermore, as service providers described, South Asian women's identities are often tied to their roles as wives and mothers. As such, divorce and single motherhood are often viewed as an affront to these normative gender role expectations and are therefore, stigmatized. If formal services for IPV are oriented towards, or perceived to be oriented towards, solely encouraging survivors to leave their abusive partners, South Asian survivors may not view formal service use as a viable option. Indeed there may be circumstances where, regardless of culture, leaving an abusive partner is an appropriate counsel. However, it is important for service providers to pay credence to the options available to survivors and their cultural relevance. Additionally, it is not clear how available services are for batterers in this community. This may be an important component to support alternatives to leaving an abusive relationship.

Service provider interviews provided invaluable insight into the experiences of South Asian survivors accessing services. However, the perspective of the survivors themselves, those who utilized services and those who did not, were not accounted for in the present study. Therefore, future studies are needed to examine survivors' experiences utilizing or not utilizing

services; the insight gained can be utilized to ensure that formal services are accessible and culturally relevant to the needs of survivors.

8.1.3 Community Engagement

According to the World Bank (2016), programming for IPV has traditionally centered on secondary and tertiary prevention, also known as response programming, which includes support services for survivors across multiple sectors (e.g., legal, medical). Though secondary and tertiary prevention programming are associated with positive outcomes (e.g., mental health, treatment of physical injuries), there is limited evidence that suggests that these programs alone lead to significant reductions in the rates of IPV (World Bank, 2016; WHO, 2010). As such, many countries around the world have shifted to primary prevention efforts to curtail the prevalence of IPV (World Bank, 2016). According to the CDC-P, primary prevention efforts seek to address the root causes of IPV and target communities as opposed to individuals.

The present dissertation study highlighted the critical role that the South Asian community plays in perpetuating and sustaining IPV. Survivors in both the secondary and primary components of the dissertation study indicated that when they sought help for violence, they sought help from informal sources. However, these informal sources often reinforce cultural norms and values that emphasize women's submission to their partners and encourage women to tolerate IPV. According to Heise and Kostadam (2015), harmful social norms (e.g., norms justifying male authority over female behavior, norms justifying wife abuse) are strongly and significantly associated with IPV. As a component of prevention, service providers should consider community engagement and education as a mechanism to address cultural norms and values that may promote and sustain IPV in the South Asian community. Such engagement,

however, requires attention to approach. Such norms are often difficult to challenge as they are codified through social and institutional laws and policies, which also may require change.

Community mobilization is a promising strategy that has been utilized internally to address harmful gender norms (Michau, 2012). Community mobilization is:

> "a highly systematic approach that involves all levels of a community over an extended period of time. It requires engaging, inspiring and supporting a diverse range of community members, groups, and institutions. It elicits critical thinking, develops skills and inspires action to replace negative norms perpetuating violence against women with positive norms supporting safety, non-violence and the dignity of women and men" (p. 32).

Community mobilization, as per the World Bank (2016), is "not itself a strategy, but the desired outcome of several strategies aimed at social change" (p. 34). Strategies of community mobilization include: local activism with families and communities; media dissemination that target public perceptions on gender norms; advocacy at the local, state, and national levels, and interactive training to explore gender norms in-depth (World Bank, 2016).

Based on lessons learned from successful community mobilization programs targeting harmful gender norms that perpetuate IPV, the World Bank (2016) formulated the recommendations for IPV service providers. These recommendations may be helpdul for providers of IPV services to South Asians in the Untied States:

> "cutting across and collaborating with multiple sectors (e.g., legal, medical); involving multiple stakeholders (e.g., community members of all socio-demographic statuses, cultural/religious leaders); challenging the acceptability of violence among communities through creating constructive and culturally sensitive dialogues about harmful gender norms and unbalanced power dynamics; supporting participants in developing new skills to empower them to make healthy choices and improve conflict resolution skills; and investing in implementing the intervention over a prolonged period of time" (p. 11).

8.2 Implications for Social Work Research

8.2.1 Surveillance of IPV

The true prevalence of IPV among South Asian women in the United States remains unclear. National studies conducted in the United States suggest that Asian women have the lowest prevalence rate of IPV (Black et al., 2011). However, regional studies (WHO, 2013), country-level studies like the NFHS-3 India, and community-based studies conducted in the United States (Mahapatra, 2012; Raj & Silverman, 2002) suggest that South Asian women experience violence equally, if not more, than other ethnic/minority women.

National surveillance studies could assist in elucidating the prevalence of IPV among South Asian women by addressing certain methodological and measurement issues. For example, the Centers for Disease Control and Prevention's (CDC-P) National Intimate Partner and Sexual Violence Survey (NISVS) currently aggregates all Asian women into one category (Black et a., 2011). Separating South Asian women from other Asian women (i.e. East Asian) would address important regional differences in Asia and therefore provide a more accurate prevalence rate.

Additionally, national surveillances could utilize different strategies to garner higher response rates from South Asian women. Random-digit-dialing was the only method used to recruit participants in the NISVS (Black et al., 2011). However, such methods preclude the participation of South Asian women who do not have access to a phone/computer and/or who do not speak English. The present study and previous studies examining IPV among South Asian women in the United States (Mahapatra, 2012) relied heavily on the internet to recruit participants.

National surveillance of IPV could employ alternative methods of gathering data such as in-person interviews conducted by trained field staff similar to the NFHS-3 India data used in the secondary analysis. Additionally, national surveillances could make the telephone surveys accessible to women who speak a South Asian dialect. The CDC-P may consider partnering with South Asian Women's Organizations (SAWOs) in the United States to assist with data collection as SAWOs have access to South Asian populations throughout the United States and the cultural/linguistic capabilities to conduct interviews.

In addition to addressing methodological concerns with the current surveillance of IPV, it is imperative to address measurement issues that may underestimate and/or hinder South Asian women from disclosing abuse. The CTS-2 is the most widely used measure of IPV nationally and internationally (DeKeseredy & Schwartz, 1998) and was utilized to ascertain IPV prevalence in the secondary and primary components of the present study. However, the CTS-2 has many limitations including its inability to delve into the social construction and cultural meaning of some abusive behaviors and survivors' responses to abuse (Raj & Silverman, 2002; Yoshihama, 2002).

According to Crenshaw (1994), how women define, experience, and address IPV is shaped by the intersection of their multiple identities (e.g., race, class, religious affiliation). Ethnic/minority women, specifically immigrant women, often have differing histories (e.g., collective and personal experiences of displacement, racism, class, caste) in their country of origin, en route to their new countries, and then later in settlement, integration, and assimilation (Mason et al., 2008). As such, it is unclear whether or not universal definitions of IPV hold across diverse communities and cultures.

According to a study conducted by Mason and colleagues (2008) examining IPV among immigrant Tamil women in Canada, findings suggested that definitions of IPV are not culturally specific; rather the manifestations of IPV are. When participants were probed to describe their experiences with psychological IPV, the examples that were provided included dowries, expectations of wives, and the role of in-laws and the extended family in married couple's lives (Mason et al., 2008). Universal definitions of forms of violence in IPV (e.g., psychological, physical, sexual, etc.) may be applicable across populations, countries, and communities, but how and why the abuse occurs and the mechanisms that support it may vary widely. Similarly the survivor's emotional response and actions may also vary by culture and immigration status.

8.2.2. Regional Nuances in India

Most South Asians in the United States are Indian immigrants (Census, 2010). The secondary data from the NFHS-3 revealed that Indian women face IPV at high rates. Additionally, the secondary data revealed regions in India where women are more vulnerable to experiencing IPV and less likely to seek help (Central, East, and Northeast India). Future research is needed to clarify the regional nuances that contribute to women's vulnerability to experiencing IPV and their decision to seek or not seek IPV-related services. This information may provide insight into where additional outreach and resources need to be allocated once women immigrate to the United States from India.

8.2.3 Community Needs Assessment

To effectively address IPV and enact social change, formative research is needed to understand IPV in each respective community, South Asian or otherwise. According to the World Bank (2016), formative research should aim to clarify the following questions (p.28):

1. What types of violence occur in the community? Who are most often the perpetrators and victims? How does violence affect men, women, boys, and girls differently? What are the most common forms of violence? In what kind of circumstances does this violence occur? Where? When?
2. How do families and communities respond to survivors of IPV?
3. What types of resources, such as health, legal, security, safety, religious, cultural institutions, are available to survivors of IPV? Which entities provide these services? How are they accessed, if at all? What reasons are cited for accessing or not accessing available resources? Do the services refer survivors to other appropriate service providers?
4. What are the political and legal frameworks for addressing IPV at the national and local levels? What are the main achievements and challenges of policies targeting women's rights and IPV?
5. What other organizations are working on IPV prevention in a specific context? What do these programs entail? How do different participant groups describe these programs?

By answering these questions, researchers, providers, and policy makers can better understand the scope and magnitude of IPV in a community and what is needed to effectively address IPV and enact social change.

8.3 Implications for Policy

8.3.1 Enhancement of existing policy

In 2015, holders of H4 visas who are typically the dependents (i.e. wives) of H1B visa holders were granted the ability to legally obtain jobs in the United States. The mere existence of this policy does not guarantee that these individuals will gain employment. Additionally, in cases where individuals are able to secure a job, this policy does not guarantee a decent paying job and/or that the individuals will have access to their wages.

Though this policy is not directly targeted at women experiencing IPV, there are enhancements that could be made to the H4 visa to benefit survivors of IPV.

Even when adequate employment is obtained, this may not equate to financial independence. The women who comprised the primary sample for this study were overwhelmingly highly acculturated, educated, and employed. However, as indicated by service

providers, it is not uncommon for South Asian women who are gainfully employed to still be economically dependent on their spouses, often relinquishing their wages to their spouses. As a result, women experiencing IPV may not have the financial resources to address the violence that there are experiencing (e.g., seek medical help, legal help).

To better serve H4 visa holders who may be experiencing violence, the current policy could be revised to include job training and financial and legal literacy programming. Job training could provider H4 visa holders, especially those who are less acculturated and/or less educated, with skills and knowledge required to obtain a job in the United States (e.g., verbal and written communication skills, resume writing, professional development workshops). Financial literacy programming would equip H4 visa holders with skills such as: opening a checking/savings account, saving money, budgeting money, and safety planning in the event of IPV; skills that even highly educated and acculturated women who are economically dependent on their spouses may not possess. Additionally, legal literacy would educate H4 visa holders with knowledge of how to obtain legal counsel for issues (e.g., divorce, custody, property disputes) without their spouse's permission or knowledge.

8.3.2 Liaisons to help navigate formal systems

As previously noted, the needs of South Asian survivors span the spectrum of formal institutions. However, cultural and/or linguistic barriers may serve as deterrents to survivors seeking services.

Qualitative interviews with SAWO service providers revealed that survivors often approach their respective organizations with legal needs. While SAWOs provide court accompaniments and facilitate legal clinics with local lawyers, policy enhancements could be made to more effectively meet the needs to survivors. For example, courts could appoint special

liaisons to assist survivors in navigating the legal system and completing necessary paperwork to file a complaint; tasks that may be especially overwhelming to women who are unfamiliar with these processes. This simply policy addition may enable more survivors to seek services.

8.3.3 Joint advocacy initiatives between SAWOs and other South Asian Organizations in the United States

South Asians in the United States are a rapidly growing demographic, with a current population of 3.4 million (US Census, 2010). The preparation leading to the design and implementation of the primary component of the study revealed the strong presence of South Asian social, cultural, political, and religious organizations in the United States. One of the most prominent South Asian organizations is South Asian Americans Leading Together (SAALT) a national, nonpartisan, non-profit organization that fights for racial justice and advocates for the civil rights of all South Asians in the United States. SAALT coordinates the National Coalition of South Asian Organizations, a network of community-based organizations throughout the United States that works to convene, organize, and advocate for South Asians in the United States.

The National Coalition of South Asian Organizations could partner with the over 25 SAWOs in the United States to raise awareness about the IPV in the South Asian community. Additionally, this partnership could be leveraged to advocate on the state and federal level for more funding and service provisions for this rapidly growing population.

8.4 Conclusion

South Asians are some of the most recent immigrants in the United States and they are one of the fastest growing ethnic groups with a current population of 3.4 million (US Census, 2010). To effectively attend to the emerging needs of this rapidly growing population, it is

imperative to understand the landscape of social issues confronting this population and their experiences accessing and utilizing social services. This includes understanding how country of origin, immigration experiences, and generational differences shape the development and maintenance of social issues like IPV.

The present study was the first of its kind to integrate secondary data from the Indian National Family Health Survey to provide the contextual basis to understand the IPV experiences of South Asian women who have immigrated to the United States, as well as typical informal and formal help seeking behaviors. This information about IPV and women in India was compared and contrasted with a small survey of South Asian women residing in the United States as well as a qualitative study with providers of services to South Asian IPV survivors in the United States. The study findings highlight the importance of both culture of origin and adaptation to the cultural norms in the United States. Additionally, this study highlighted the unique perspective of service providers in regards to cultural norms that perpetuate and sustain violence in this community that suggests an important role for community awareness and engagement in the prevention of IPV in the larger South Asian community.

This study also raised many questions for future quantitative and qualitative research with the community. For example, there is a need to explore the experiences of survivors with services directly as compared to relying on provider reports. There is a need for larger studies that can include sufficient numbers of women from different regions of India to see if the regional differences seen in the India study persist following immigration. There is a need for larger studies that can compare experience of recent immigrants to first and second generations born in the United States to see how cultural norms and perceptions may shift over time. Finally, there is a need to understand the male perspective on IPV within the South Asian population,

including how services and awareness programs might be developed for this group. It is hoped that this study will encourage more research into this population to better inform prevention, intervention and policy solutions for IPV within the South Asian population.

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Appendix A: Quantitative Survey

South Asian Women in New Jersey, New York, and Connecticut NEEDED!

Welcome

Dear potential participant:

Women aged 18 years or older of South Asian origin living in New Jersey, New York, or Connecticut are invited to participate in a research study conducted by Vithya Murugan, a doctoral candidate from Washington University St. Louis' George Warren Brown School of Social work. The study is about South Asian women's life experiences including views on the relationships between men and women. The survey will ask about demographics, social support, acculturation, isolation, other social factors, any experiences of intimate partner violence, and help sought when intimate partner violence occurs and other social factors.

The entire survey will take 30 minutes to complete. Participation is voluntary and confidential (private) and used for research purposes only. The survey will not ask for any identifying information from the participants; therefore, no one can link your answers with you personally.

To participate in the study, you must: (1) be 18 years of age or older, (2) either born in South Asia (India, Pakistan, Bangladesh, Nepal, Sri Lanka, Bhutan, or Maldives or born to a parent or parents from South Asia, (3) have had an intimate relationship with a man (spouse/partner, live-in mate, boyfriend), (4) lived or currently lives in New Jersey, New York, or Connecticut.

The decision to participate or not in this study is entirely up to you. If you choose to participate, no one will know your name or identity; you will remain anonymous. You might experience some

discomfort in answering the questions, for example, if the questions remind you of a time when you may have experienced poor treatment from an intimate partner. However, the survey will also give you an opportunity to anonymously provide information about these situations that can help in better understand the situation of South Asian women in the United States and resources they may need to improve their lives. Your responses may also help prevent intimate partner violence.

To protect any woman taking the survey who might be experiencing intimate partner violence, I kindly request that you not share information about the survey with others. If you think that taking the survey might pose any threat to your safety, then you should not take the survey.

If you start the survey, you can stop any time or skip any question you don't want to answer. By answering the survey, you indicate that you have read the information and have decided to participate in the study.

If you think you need help with intimate partner violence, you can call the following numbers:
South Asian Specific Organizations:
- Manavi is a nonprofit organization based in New Brunswick, New Jersey. The Help Line and Office Line is +1 732-435-1414. http://www.manavi.org/

- Sakhi is a nonprofit organization based in New York, New York. The Help Line and Office Line is +1 212-868-6741. http://www.sakhi.org/

- Sakhi is a nonprofit organization based in New York, New York. The Help Line and Office Line is +1 212-868-6741. http://www.sakhi.org/

- SNEHA is a nonprofit organization based in New Haven, Connecticut. The Help Line and Office Line is +1 860-537-0795. http://www.sneha.org/

The National Domestic Violence Hotline number is 1-800-799-SAFE (7233) or TTY 1-800-787-3224. Help is 24 hours a day, 365 days a year, with crisis intervention, safety planning, information and referrals to agencies in all 50 states. Assistance is available in more than 140 languages. Visit: http://www.ndvh.org/

If you need any more information about me, or about the study, please feel free to contact me at vmurugan@wustl.edu. If you know someone who meets the eligibility requirements for the study, then please pass this email on to them. Thank you.

South Asian Women in New Jersey, New York, and Connecticut NEEDED!

Respondent and Her Community

I would like to start by asking you questions about yourself. Please write in or click your answer.

1. How old are you?

2. What South Asian country are your parents/relatives from? India

Pakistan Nepal Bangladesh Sri Lanka Maldives Bhutan Other

3. Are you a US citizen? Yes

No
No answer

4. Were you born in the United States? Yes

No

South Asian Women in New Jersey, New York, and Connecticut NEEDED!

5. Where were you born? India

Pakistan Nepal Bangladesh Sri Lanka Maldives Bhutan Other

South Asian Women in New Jersey, New York, and Connecticut NEEDED!

6. If you were born in India, what state were you born in?

7. What age did you immigrate to the US? 12 years old or younger
13 years old or older

8. With whom did you immigrate with? Husband/partner

Parents Children Other

9. What religion are you? Hindu

Muslim Christian Jain Jewish Other

10. Have you ever attended school? No

Yes

South Asian Women in New Jersey, New York, and Connecticut NEEDED!

11. What is the highest level of school you have completed or the highest degree you have received? Less than high school degree
High school degree or equivalent (e.g., GED)
Some college but no degree

Associate degree Bachelor degree Graduate degree

12. What is your employment status? Employed

Looking for work/unemployed Retired
Student

13. Do any of your family members live close by that you can easily see/visit them? Yes

No

14. How often do you see or talk to a member of your family of birth? At least once a week

At least once a month At least once a year Never (hardly ever)

15. When you need help or are having a problem, can you usually count on family members for support? Yes

No

16. Do any of your friends live close by that you can easily see/visit them? Yes

No

17. How often do you see or talk to your friends? At least once a week

At least once a month At least once a year Never (hardly ever)

18. When you need help or are having a problem, can you usually count on friends for support? Yes

No

19. Have you ever been married? Yes

No

20. What is your current relationship status? Currently married

Living with partner (not married)
Has a partner, but not living with them Single
Divorced
Separated
Widowed

21. Was the divorce/separation initiated by you, by your husband/partner, or did you both decide that you should separate?

Respondent Husband/Partner Other

22. Does anybody else live with you and your husband/partner? Nobody

Children Respondent's parents Partner's parents Relatives
Other

23. How old were you when first got married?

24. Was your marriage an arranged marriage? Yes

No

25. Before your marriage, were you asked whether you wanted to marry him or not? Yes

No

South Asian Women in New Jersey, New York, and Connecticut NEEDED!

Respondent's Health and Behavior

Now I would like to ask you a few questions about your health.

26. How would you rate your overall physical health? Excellent

Good Fair
Poor
Very Poor

27. How would you rate your overall mental health? Excellent

Good Fair
Poor
Very Poor

28. Do you currently smoke? Daily

Occasionally Not at all

29. How often do you drink alcohol? Every day or nearly every day
Once or twice a week
1-3 times a month

Less than a month Never

30. Have you ever been pregnant? Yes

No

31. How many children do you have?

South Asian Women in New Jersey, New York, and Connecticut NEEDED!

Respondent's current/most recent partner

I would now like to ask you about your current or most recent husband/partner.

32. How old is your husband/partner?

33. Is your husband/partner of South Asian origin? Yes

No

South Asian Women in New Jersey, New York, and Connecticut NEEDED!

34. What is your husband/partner's race/ethnicity? White

Black
East Asian
Hispanic Native/Pacific Islander Other (please specify)

South Asian Women in New Jersey, New York, and Connecticut NEEDED!

35. What country does your husband/partner trace his origins from? India

Pakistan Nepal Bangladesh Sri Lanka Maldives Bhutan Other

36. Is your husband/partner a US citizen? Yes

No
No answer

South Asian Women in New Jersey, New York, and Connecticut NEEDED!

37. Was your husband/partner born in the United States? Yes

No

South Asian Women in New Jersey, New York, and Connecticut NEEDED!

38. Where was your partner born? India

Pakistan Nepal Bangladesh Sri Lanka Maldives Bhutan Other

South Asian Women in New Jersey, New York, and Connecticut NEEDED!

39. If your partner was born in India, what state was he born in?

40. What age did he immigrate to the US? 12 years old or younger
13 years old or older

41. What religion is your husband? Hindu

Muslim Christian Jain Jewish Other

42. Did he ever attend school? Yes

No

South Asian Women in New Jersey, New York, and Connecticut NEEDED!

43. What is the highest level of school that your husband/partner completed or the highest degree he received?

Less than high school degree
High school degree or equivalent (e.g., GED) Some college but no degree
Associate degree
Bachelor degree
Graduate degree

44. What is your partner's employment status? Employed

Looking for work/unemployed Retired
Student

45. How often does your husband/partner drink? Every day or nearly every day
Once or twice a week
1-3 times a month

Occasionally, less than once a month Never

46. In the past 12 months, have you experienced any of the following problems due to your partner's drinking?

Money problems Family problems Other
None

South Asian Women in New Jersey, New York, and Connecticut NEEDED!

Respondent's level of acculturation

47. In general, what language(s) do you read and speak? Only native language
Native language more than English
Both Equally

English language more than native language Only English

48. What was the language(s) you used as a child? Only native language
Native language more than English
Both Equally

English language more than native language Only English

49. What language(s) do you usually speak at home? Only native language
Native language more than English
Both Equally

English language more than native language Only English

50. In which language(s) do you usually think? Only native language
Native language more than English
Both Equally

English language more than native language Only English

51. What language(s) do you usually speak with your friends? Only native language
Native language more than English
Both Equally

English language more than native language Only English

52. In what language(s) are the T.V. programs you usually watch? Only native language
Native language more than English
Both Equally

English language more than native language Only English

53. In what language(s) are the radio program you usually listen to? Only native language
Native language more than English
Both Equally

English language more than native language Only English

54. In general, in what language(s) are the movies, T.V. and radio programs you prefer to watch and listen to?

Only native language
Native language more than English
Both Equally
English language more than native language Only English

55. You prefer going to social gatherings/parties at which the people are: Only South Asians

More South Asians than other racial/ethnic groups Half and half
More of other racial/ethnic groups than South Asians Only of other racial/ethnic groups

56. The persons you visit or who visit you are: Only South Asians

More South Asians than other racial/ethnic groups Half and half
More of other racial/ethnic groups than South Asians Only of other racial/ethnic groups

57. If you could choose your children's friends, you would want them to be: Only South Asians

More South Asians than other racial/ethnic groups Half and half
More of other racial/ethnic groups than South Asians Only of other racial/ethnic groups

South Asian Women in New Jersey, New York, and Connecticut NEEDED!

Respondent's attitudes towards gender roles

In this community and elsewhere, people have different ideas about families and what is acceptable behavior for men and women in the home. For the following statements, please indicate your level of agreement.

58. A good wife obeys her husband even if she disagrees Strongly Agree

Agree
Neutral
Disagree
Strongly Disagree

59. Family problems should only be discussed with people in the family. Strongly Agree

Agree
Neutral
Disagree
Strongly Disagree

60. It is important for a man to show his wife/partner who is the boss. Strongly Agree

Agree
Neutral
Disagree
Strongly Disagree

61. A woman should be able to choose her own friends even if her husband disapproves. Strongly Agree

Agree
Neutral
Disagree
Strongly Disagree

62. It is a wife's obligation to have sex with her husband even if she does not feel like it. Strongly Agree

Agree
Neutral

Disagree
Strongly Disagree

63. If a man mistreats his wife, others outside of the family should intervene. Strongly Agree

Agree
Neutral
Disagree
Strongly Disagree

64. A man has good reason to hit his wife/partner if she doesn't complete the household work to his satisfaction.

Strongly Agree Agree
Neutral
Disagree
Strongly Disagree

65. A man has good reason to hit his wife/partner if she disobeys him. Strongly Agree

Agree
Neutral
Disagree
Strongly Disagree

66. A man has good reason to hit his wife/partner if she refuses to have sex with him. Strongly Agree

Agree
Neutral
Disagree
Strongly Disagree

67. A man has good reason to hit his wife/partner if he suspects that she is unfaithful. Strongly Agree

Agree
Neutral
Disagree
Strongly Disagree

68. A man has good reason to hit his wife/partner if he finds out that she has been unfaithful. Strongly Agree

Agree
Neutral
Disagree
Strongly Disagree

69. A woman can refuse sex if she doesn't want to have sex. Strongly Agree

Agree
Neutral
Disagree
Strongly Disagree

70. A women can refuse sex if her husband/partner is drunk. Strongly Agree

Agree
Neutral
Disagree
Strongly Disagree

71. A woman can refuse sex if she is sick/not feeling well. Strongly Agree

Agree
Neutral
Disagree
Strongly Disagree

72. A woman can refuse sex if her husband/partner mistreats her. Strongly Agree

Agree
Neutral
Disagree
Strongly Disagree

73. In general, how often do you and your husband/partner discuss things that happened with him during the day?

Often Rarely Never

74. In general, how often do you and your husband/partner discuss things that happened with you during the day?

Often Rarely Never

75. In general, how often do you and your husband/partner discuss your worries or feelings? Often

Rarely Never

76. In general, how often do you and your husband/partner discuss his worries or feelings? Often

Rarely Never

77. Does your husband/partner try to keep you from seeing/talking to your family? Yes

No

78. Does your husband/partner try to keep you from seeing/talking to your friends? Yes

No

79. Does your husband/partner insist on knowing where you are at all times? Yes

No

80. Does your husband/partner ignore you or treats you indifferently? Yes

No

81. Does your husband/partner get angry when you speak with another man? Yes

No

82. Does your husband/partner get suspicious that you are unfaithful? Yes

No

83. Does your husband/partner expect you to ask his permission before seeking healthcare? Yes

No

South Asian Women in New Jersey, New York, and Connecticut NEEDED!

Experience with violence

The next questions are about things that happen to many women, and that your current or any other partner may have done to you.

I want you to tell me if your current husband/partner or any other partner, has ever done the following things to you.

84. Has your current husband/partner or any other partner ever insulted you or made you feel bad about yourself?

Yes No

South Asian Women in New Jersey, New York, and Connecticut NEEDED!

85. Has this happened in the past twelve months? Yes

No

South Asian Women in New Jersey, New York, and Connecticut NEEDED!

86. In the past 12 months, would you say this has happened: Once

A few times Many times

87. Before the past 12 months, would you say this has happened: Once

A few times Many times

South Asian Women in New Jersey, New York, and Connecticut NEEDED!

88. Has your current husband/partner or any other partner ever belittled or humiliated you in front of other people?

Yes No

South Asian Women in New Jersey, New York, and Connecticut NEEDED!

89. Has this happened in the past twelve months? Yes

No

South Asian Women in New Jersey, New York, and Connecticut NEEDED!

90. In the past 12 months, would you say this has happened: Once

A few times Many times

South Asian Women in New Jersey, New York, and Connecticut NEEDED!

91. Before the past 12 months, would you say this has happened: Once

A few times Many times

92. Has your current husband/partner or any other partner ever did things to scare or intimidate you on purpose? (e.g., threatening stares)?

Yes No

South Asian Women in New Jersey, New York, and Connecticut NEEDED!

93. Has this happened in the past twelve months? Yes

No

South Asian Women in New Jersey, New York, and Connecticut NEEDED!

94. In the past 12 months, would you say this has happened: Once

A few times Many times

95. Before the past 12 months, would you say this has happened: Once

A few times Many times

96. Has your current husband/partner or any other partner ever threatened to hurt you or someone you care about?

Yes No

South Asian Women in New Jersey, New York, and Connecticut NEEDED!

97. Has this happened in the past twelve months? Yes

No

South Asian Women in New Jersey, New York, and Connecticut NEEDED!

98. In the past 12 months, would you say this has happened: Once

A few times Many times

South Asian Women in New Jersey, New York, and Connecticut NEEDED!

99. Before the past 12 months, would you say this has happened: Once

A few times Many times

100. Has your current husband/partner or any other partner ever slapped you or thrown something at you that could hurt you?

Yes No

South Asian Women in New Jersey, New York, and Connecticut NEEDED!

101. Has this happened in the past twelve months? Yes

No

South Asian Women in New Jersey, New York, and Connecticut NEEDED!

102. In the past 12 months, would you say this has happened: Once

A few times Many times

South Asian Women in New Jersey, New York, and Connecticut NEEDED!

103. Before the past 12 months, would you say this has happened: Once

A few times Many times

104. Has your current husband/partner or any other partner ever hit you with his fist or something else that could

hurt you??

Yes No

South Asian Women in New Jersey, New York, and Connecticut NEEDED!

105. Has this happened in the past twelve months? Yes

No

South Asian Women in New Jersey, New York, and Connecticut NEEDED!

106. In the past 12 months, would you say this has happened: Once

A few times Many times

South Asian Women in New Jersey, New York, and Connecticut NEEDED!

107. Before the past 12 months, would you say this has happened: Once

A few times Many times

108. Has your current husband/partner or any other partner ever pushed you or shoved you? Yes

No

South Asian Women in New Jersey, New York, and Connecticut NEEDED!

109. Has this happened in the past twelve months? Yes

No

South Asian Women in New Jersey, New York, and Connecticut NEEDED!

110. In the past 12 months, would you say this has happened: Once

A few times Many times

111. Before the past 12 months, would you say this has happened: Once

A few times Many times

112. Has your current husband/partner or any other partner kicked you, dragged you, or beaten you up? Yes

No

South Asian Women in New Jersey, New York, and Connecticut NEEDED!

113. Has this happened in the past twelve months? Yes

No

South Asian Women in New Jersey, New York, and Connecticut NEEDED!

114. In the past 12 months, would you say this has happened: Once

A few times Many times

South Asian Women in New Jersey, New York, and Connecticut NEEDED!

115. Before the past 12 months, would you say this has happened: Once

A few times Many times

116. Has your current husband/partner or any other partner threatened to use or has actually used a gun, knife or other weapon against you?

Yes No

South Asian Women in New Jersey, New York, and Connecticut NEEDED!

117. Has this happened in the past twelve months? Yes

No

South Asian Women in New Jersey, New York, and Connecticut NEEDED!

118. In the past 12 months, would you say this has happened: Once

A few times Many times

South Asian Women in New Jersey, New York, and Connecticut NEEDED!

119. Before the past 12 months, would you say this has happened: Once

A few times Many times

120. Has your current husband/partner or any other partner physically forced you to have sexual intercourse when you didn't want to?

Yes No

South Asian Women in New Jersey, New York, and Connecticut NEEDED!

121. Has this happened in the past twelve months? Yes

No

South Asian Women in New Jersey, New York, and Connecticut NEEDED!

122. In the past 12 months, would you say this has happened: Once

A few times Many times

South Asian Women in New Jersey, New York, and Connecticut NEEDED!

123. Before the past 12 months, would you say this has happened: Once

A few times Many times

124. Has your current husband/partner or any other partner forced you to do something sexual that you found degrading or humiliating?

Yes No

South Asian Women in New Jersey, New York, and Connecticut NEEDED!

125. Has this happened in the past twelve months? Yes

No

South Asian Women in New Jersey, New York, and Connecticut NEEDED!

126. In the past 12 months, would you say this has happened: Once

A few times Many times

South Asian Women in New Jersey, New York, and Connecticut NEEDED!

127. Before the past 12 months, would you say this has happened: Once

A few times Many times

128. Has your current husband/partner or any other partner force you to have sexual intercourse you did not want because you were afraid of what he might do?

Yes No

South Asian Women in New Jersey, New York, and Connecticut NEEDED!

129. Has this happened in the past twelve months? Yes

No

South Asian Women in New Jersey, New York, and Connecticut NEEDED!

130. In the past 12 months, would you say this has happened: Once

A few times Many times

South Asian Women in New Jersey, New York, and Connecticut NEEDED!

131. Before the past 12 months, would you say this has happened: Once

A few times

South Asian Women in New Jersey, New York, and Connecticut NEEDED!

132. Have you ever experienced physical, sexual and/or emotional violence from a current or former husband/spouse/partner?

Yes No

South Asian Women in New Jersey, New York, and Connecticut NEEDED!

133. Was there ever a time when you were physically assaulted by you current and/or former partner while you were pregnant?

Yes No

134. Have you ever been injured as a result of violence/abuse by you current or former husband/partner? Yes

No

South Asian Women in New Jersey, New York, and Connecticut NEEDED!

135. In your life, how many times were you injured by your husband/partner? Once/twice

Several (3-5 times)
Many (more than 5 times)

136. Has this happened in the past 12 months? Yes

No

137. Did you ever receive healthcare for your injuries? Yes- sometimes

Yes- all of the time No

South Asian Women in New Jersey, New York, and Connecticut NEEDED!

138. Did you disclose to your healthcare work (doctor, nurse, etc) the real cause of your injury? Yes

No

139. Are there any particular situations that tend to lead to violence? (Circle all that apply) No particular reason

When husband/partner is drunk Money problems
Difficulty at work Unemployment

Problems with his or her family You are pregnant
He is jealous
You refuse sex

You are disobedient

140. For any of the incidents of physical violence, were your children present or did they overhear you being beaten?

Never
Once or twice
Several times Many/most of the time Don't know

South Asian Women in New Jersey, New York, and Connecticut NEEDED!

Help-Seeking

The next set of questions ask about your experiences seeking help for the violence you experienced.

141. Who have you told about the violence that you have experienced? (Circle all that apply) No one

Friends
Parents
Brother/Sister
Aunt/Uncle Husband/Partner's Family Children

Neighbors Police Doctor Priest Counselor Other

South Asian Women in New Jersey, New York, and Connecticut NEEDED!

142. Did any of the following try to help you? (Circle all that apply) No one

Friends
Parents
Brother/Sister
Aunt/Uncle Husband/Partner's Family Children

Neighbors Police Doctor Priest Counselor Other

143. Did you ever go to any of the following for help? (Circle all that apply) Police

Hospital or clinic Social services Legal advice center Court

Shelter
Women's organization (e.g., Manavi, Women Aware) Priest/religious leader

144. What were the reasons that made you go for help? (Circle all that apply) Encouraged by friends/family
Could not endure more
Badly injured/fear for life

He threatened or tried to kill you
He threatened or actually hit the children Saw children suffering
Thrown out of home

Afraid you would kill him
Other

145. If you sought help from anyone, what was the most useful form of help that you received and from whom?

146. If you sought help from anyone, what was the least useful form of help that you received and from whom?

147. What were the reasons that prevented you from seeking help? (Circle all that apply) Don't know/No answer
Fear of threat/consequences
Violence is normal/not serious

Embarassed/ashamed/afraid you would not be believed or that you would be blamed Know of other women who have not been helped
Afraid partner would end the relationship
Afraid you would lose the children

Afraid you would bring a bad name to the family

148. Did you ever leave, even if only overnight, because of the violence? Yes

No

149. Where did you go the last time you left? Your relatives

His relatives
Your friends/neighbors Hotel/lodging
Street
Temple/church
Shelter
Other

150. Why did you return/stay? (Circle all that apply) Didn't want to leave the children
Sanctity of marriage
Didn't want to bring shame on my family

Love him
Didn't want to be single
Family said to stay
Forgave him
Thought he would change Threatened me and/or the children Nowhere to go
Other

151. To your knowledge, was your mother ever abused by your father? Yes

No

Appendix B: Qualitative Interview Guide

Interview Guide

On the day of the interview, the PI will be responsible for collecting the data. The PI will present the study, go through the informed consent form and emphasize the anonymous and voluntary nature of the study. After getting the participants' signed informed consent or electronically signed consent document, the participant will receive a copy of the details of the study for their records. Finally the PI will let the participants know that the session will start and that if they choose to not to participate they are free to leave the room at any time.
The PI will then start audiotaping the session.

The PI will then proceed to state the following prompt:

Thank you for agreeing to participate. Today's interview is part of a larger dissertation study examining intimate partner violence amongst South Asian women in the United States.

For the purpose of today's interview, I would like to generally hear your thoughts on intimate partner violence amongst South Asian women in the United States. As a n IPV related service provider, I believe that you offer unique insight into this issue.
To facilitate this discussion, I have prepared a few questions.

6. How common/prevalent do you think IPV is amongst South Asians in the United States?
    a. Is it more or less common compared to other groups (e.g., Whites, Blacks, other ethnic/minority groups)?
    b. What do you think causes/contributes to IPV?
    c. Is there anything that makes South Asian women more or less vulnerable to IPV? (e.g., cultural norms)
7. Aside from your agency, what are other resources available to women experiencing IPV?
    a. Please tell me about them.
    b. Where did you learn about these resources?
8. Do you believe there are any challenges that South Asian women (in particular) face when trying to get help for IPV?
    a. If so, please describe the challenges?
    b. What can be done to address those challenges?

9. Do you think something needs to be done to address IPV in the South Asian community?
    a. If so what?
10. Who do you think is responsible for addressing IPV in the community? (Individuals? Community members? Law enforcement? Government?)
    a. To what extent?

This concludes the interview. Thank you so much for your participation today. I really appreciate your time and your willingness to share your thoughts with me.

Appendix C: Letter of Support

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March 20, 2016

Vithya Murugan, MSW
Doctoral Student
George Warren Brown School of Social Work
Washington University, St. Louis, MO 63130

Dear Ms. Murugan,

Manavi is pleased to offer a letter of support to collaborate on your project *"Intimate Partner Violence among South Asian Women: Prevalence and Help-Seeking Behaviors."*

Manavi is a New Jersey based women's rights organization committed to ending all forms of violence and exploitation against South Asian women living in the United States. Established in 1985, Manavi was the first organization to focus on issues of violence against women in the South Asian American community. Manavi's work entails providing advocacy and direct services to victims of intimate violence. At the same time, it endeavors through organizing and education to shift community norms to render violence against women unacceptable and enhance support for victims as well as accountability of perpetrations of violence. Another aspect of Manavi's goal is to increase cultural competency of mainstream practitioners, institutions, and organizations in the U.S., so that they may serve the South Asian community more effectively. Manavi's ultimate objective is make sure that women of South Asian descent may exercise their fundamental right to live a life of safety and dignity.

Manavi supports this important proposal that seeks to examine IPV and service utilization among South Asian women. We at Manavi believe that this research is crucial to understanding IPV among South Asian women and that it will inform the creation and enhancement of new and existing services. Given our current presence and experience in Middlesex County and the state of New Jersey as a whole, we believe that Manavi will be a very valuable partner to this project.

Below is the broad outline of tasks that Manavi will collaborate with you in the successful completion of this project:

- Collaborate in the pilot testing and finalizing of the questionnaires and interview guide.
- Translate the questionnaire into at least one South Asian language (i.e. Hindi) (if you, the researcher, are able to procure funding).
- Assist with recruitment by: