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A qualitative study of Arab American perspectives on intimate partner violence in Dearborn, Michigan

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Abstract

Few studies explore how intimate partner violence (IPV) affects Arab Americans. Through focus groups with stakeholders from an Arab-centered health organization and semi-structured interviews with Arab American, female clients (18–65 years), we explore how IPV affects Arab American women and factors that impede and facilitate their access to support services. We find that IPV is a critical concern among Arab Americans and that generational status, educational attainment, and support from family, friends, or religious leaders were perceived to influence access to IPV support services. This study has implications for developing culturally sensitive IPV interventions for Arab American women.

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Keywords

Arab Americans; intimate partner violence; immigrant health; women's health

INTRODUCTION

About 3.6 million Arab Americans live in the United States (U.S.) (Demographics - Arab American Stories, n.d.). Like other immigrant groups, the Arab American population is growing and has diverse ancestral, cultural, and linguistic roots that trace back to at least one of 22 Arab countries, different religions, and unique migration and resettlement journeys (Demographics - Arab American Stories, n.d.; El-Sayed & Galea, 2009). Yet, the health challenges among this immigrant population are largely underrepresented in public health research (El-Sayed & Galea, 2009). Intimate partner violence (IPV), which is recognized as a serious and preventable public health problem by the Centers for Disease Control and Prevention (CDC) (National Center for Injury Prevention and Control, Division of Violence Prevention, 2018), is an area of health that has been explored among Arab Americans only in a limited capacity. Most research on IPV in the Arab American community focuses on causes of IPV and barriers to seeking IPV-related health and social services. In contrast, few highlight facilitators to accessing IPV support services for Arab Americans.

Abuelezam et al.'s (2018) review of Arab American health reported three studies that examined causes of IPV or barriers to IPV-related service utilization. Two studies from the review reported that dependence on male relationships for stability and safety after migrating to the U.S., patriarchal cultural norms, lack of cultural support for seeking marital help outside of the family, family honor, and victim blaming were structural causes of IPV for Arab American women (Kulwicki & Miller, 1999; Kulwicki et al., 2015). Additionally, fear associated with discrimination, lack of culturally sensitive help and trust of providers were barriers to utilizing IPV support services (Barkho et al., 2011; Kulwicki et al., 2010). Past studies also report that traditional beliefs regarding gender roles, particularly in the context of marriage, influence Arab American women's experience with IPV and may prevent them from seeking formal IPV support services (Aswad & Gray, 1996; Kulwicki, 2000; Raj & Silverman, 2002; Crabtree-Nelson et al., 2018). Among the few studies that report prevalence of IPV among Arab Americans, one study in Dearborn, Michigan found that 28% of local arrests for acts of domestic violence involved Arab Americans (Abu-Ras, 2007). Another study found high prevalence of physical IPV or controlling behaviors (93%) among Iraqi immigrants in Metro Detroit (Barkho et al., 2011).

While past studies examine causes of IPV and barriers to support services among Arab American survivors, few have explored if Arab Americans perceive IPV to be a critical issue in their cultural community. Additionally, existing research scarcely discusses factors that facilitate access to appropriate and necessary IPV health and social services for Arab American IPV survivors. Therefore, we designed a needs-assessment study that explores the perceived prevalence and norms of IPV among Arab Americans and sociocultural assets of the community that facilitate access to support services.

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MATERIALS AND METHODS

Setting

The study was conducted in Dearborn, Michigan, an urban city in southeast Michigan with the largest and oldest local concentration of Arabs outside of the Middle East, primarily from Lebanon, Iraq, Palestine, Jordan, and Yemen (Arab American Community in Detroit Michigan, n.d.; Baker et al., 2006). Three-quarters of the Arab population in this area are born outside of the U.S. (Baker et al., 2006). The majority of the Dearborn's Arab population is Muslim while only 5% are Christian (Baker et al., 2006). Sixteen percent of the population is under the age of 25, 59% are between 26–55, and 25% are fifty-five or older (Baker et al., 2006). Over half of the local Arab American population report annual incomes below $50,000 (Baker et al., 2006). Eighty percent of the local Arab (and Chaldean) population speak English very well, 90% speak a second language at home, and 80% are U.S. citizens (Baker et al., 2006). The size and diversity of the local Arab American community made Dearborn an appropriate setting for this study. The study was conducted in partnership with the Arab Community Center for Economic and Social Services (ACCESS), which is the largest Arab American human services nonprofit in the U.S. (Our Roots, n.d.). ACCESS serves the community with over a hundred services and has delivered over 400,000 health, social, and employment and training client services to a diverse (60% Arab; 60% female), and primarily underserved, low-income population (*ACCESS - Annual Reports*, 2020).

Study design

The current study reports findings from the exploratory qualitative phase of a needs-assessment conducted between October 2016 and October 2017. The study included two focus groups (n=21) conducted in English and semi-structured interviews (n=15) conducted in either Arabic or English. Eligibility criteria for focus groups included being a provider or staff member of ACCESS or member of ACCESS's domestic violence task force[1]. Eligibility criteria for the semi-structured interviews included being a self-identifying Arab American woman between the ages of 18–65 and an ACCESS client. All participants of the focus groups are referred to as stakeholders and all participants of the semi-structured interviews are referred to as clients from this point forward. All participants were recruited through convenience samples; a community partner from ACCESS recruited stakeholders from ACCESS by word of mouth or email and the interviewer recruited clients from ACCESS waiting rooms and ACCESS-sponsored community events.

The focus groups were co-facilitated by one university researcher and one community partner trained in focus group facilitation, and one research assistant took notes. Each focus group had 8–13 stakeholders (18 providers or staff from ACCESS and 3 members of the domestic violence task force) and lasted fifty minutes. Stakeholders provided verbal consent for participation and audio-recording, and were compensated with a $50 cash incentive. The incentive value for stakeholders was recommended by our ACCESS community partners.

[1]ACCESS's domestic violence task force was a voluntary group of local professionals with an expertise in working with the local Arab American community or individuals who self-identify as Arab Americans and have a demonstrated interest in participating in local domestic violence prevention efforts.

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One interviewer (a case manager at ACCESS) conducted the face-to-face semi-structured interviews in English (n=7) and Arabic (n=8) based on the preference of the client. Interviews lasted 12–31 minutes. Informed consent to participate in semi-structured interviews was obtained through a written form on which clients checked a box to consent to participate and another box to consent to audio-recording. Consent forms also contained the signature of the interviewer and the date that the interview was conducted. Thirteen of the 15 semi-structured interviews were audio-recorded and two were conducted without; the interviewer took detailed notes of client responses from the two interviews conducted without audio-recording. Clients were compensated with a $20 cash incentive, based on the recommendation of our ACCESS community partners.

Discussion topics of the focus groups and semi-structured interviews included perceived prevalence and community norms around IPV, feedback and recommendations for a quantitative needs-assessment survey, and future IPV intervention designed for Arab Americans (see Appendix A. Focus Group Guide and Appendix B. Semi-structured Interview Guide). The study procedures were approved by the Institutional Review Board (IRB) at the University of Michigan and the ACCESS Community Health and Research Center.

Analysis

Four research assistants (RAs) (authors: AK, NE, LB; additional RA: KM) transcribed and translated the focus groups and semi-structured interviews. Three RAs (NE, LB, and KM) who had native proficiency in speaking, reading, and writing Arabic, translated the interviews conducted in Arabic, and one research assistant who was not fluent in Arabic conducted the initial transcriptions of the focus groups and semi-structured interviews that were conducted in English. All focus groups and interviews were deidentified to maintain confidentiality of all study participants. Two RAs (NE and AK) with graduate-level qualitative training and additional consultation from an associate professor of public health and qualitative methods (EK), conducted inductive, data-driven coding of the focus groups using an open-coding process. For the semi-structured interviews, researchers began with set of *a priori* codes established from the focus groups and created new codes in an inductive manner as they emerged in the interview texts. In order to establish inter-rater reliability, all coders independently coded the focus group transcripts and met to compare and agree upon assigned codes and refine code definitions. The following codes were applied to focus groups and interviews: IPV type (emotional, physical, and sexual), IPV response norms (normalization, victim-blaming, disclosure, pressure (to accept), and influencers of IPV-related support seeking (marital status, generational differences, family and community, culture, education, religion). Coding was conducted using NVivo software and coding scripts from NVivo were organized into code reports in Microsoft Word.

RESULTS

The following four themes emerged across the focus groups with stakeholders and interviews with clients: 1) perceived prevalence of IPV in the community, 2) perceived norms related to IPV in the community, 3) differential IPV experiences by marital status,

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and 4) access to IPV support services in the community. Sample characteristics of the stakeholders and clients are described in Table 1 and overarching themes, subthemes, and exemplar quotes from clients and stakeholders are reported in Tables 2, 3, 4, and 5. The findings reflect the perceptions of stakeholders and clients, however, any divergence in these perspectives are explicitly discussed in the sections that follow.

Theme 1: Perceived prevalence of IPV in the community

IPV was perceived to be prevalent, but prevalence varied by type (emotional, physical, sexual) among Arab Americans.

Emotional IPV—Several stakeholders and nearly half (n=7) of the clients perceived emotional IPV to be the most common form of IPV, with verbal abuse, threats, blackmail, manipulation, insults, and isolation from friends and family being the most common forms of emotional IPV toward Arab American women. At least three stakeholders and one client felt that emotional IPV was a precursor to physical IPV.

"I think the hitting is the last resort…it starts with…disrespect, which is insults and, uh, abusive language. If you're able to look at your partner that you so call love…say such… vulgar words, then your next up is just to lead to something physical." (Client)

Physical IPV—While stakeholders did not discuss physical IPV in detail, 67% (n=10) of the clients reported that they heard of physical IPV occurring between intimate partners within the Arab American community, but that it was not openly discussed. Only one client reported that they did not perceive physical IPV to be an issue in the Arab American community reporting that physical touch between individuals of the opposite gender is uncommon.

Sexual IPV—Almost 75% of clients (n=11) reported they had either never heard of sexual IPV incidents in the local Arab American community or that sexual IPV was not openly discussed due to a lack of openness around discussing sexual relationships.

Theme 2: Perceived norms related to IPV in the community

Six stakeholders and six clients reported that IPV is widely accepted, ignored, normalized, or dealt with privately in the Arab American community. One focus group participant noted, "I've seen it be brushed aside or…people turning the other cheek," while a client mentioned that Arab American women may accept IPV in order to avoid larger conflicts. Additionally, at least four clients and some stakeholders agreed that Arab American women who face IPV often experience victim-blaming from within their immediate and extended families. One stakeholder reported "the family and the husband and his family, they're not going to look at it like it's his fault or he did anything. They're going to look at it like 'ok, this is her'." Furthermore, one client stated that IPV survivors in the Arab American community may be perceived as rebellious and are dismissed if they disclose IPV. Two clients expressed personal views that blamed survivors for IPV experiences and four clients felt that survivors should have the strength and resilience to endure IPV.

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Theme 3: Differential IPV experiences by marital status

Stakeholders and at least four clients discussed the differences in challenges that unmarried and married IPV survivors in the Arab American community may face in seeking IPV support services. Clients and stakeholders noted that married women in the community may not disclose IPV because they would face consequences for tarnishing their spouse's reputation, feel pressured to keep the marriage intact, and fear that their family would be shamed in the community. One stakeholder noted that for married IPV survivors, leaving an abusive partner can be a prolonged process with great pushback from the partner while one client reported that pushback may come from within a survivor's own family. Children were perceived to bring additional challenges for mothers who were facing IPV. For example, one client noted that married women in the community may have a child with an abusive partner believing that a pregnancy will put an end to the abuse. Additionally, women in the Arab American community who are married may choose not to leave an abusive partner because they are worried about the impact leaving would have on their children. One client explained:

> "In the end, she's [the woman is] scared about the future of her daughter, that they will tell her about what happened, that your mother did this and that to your father. And this is the hardest thing for the mom…it's about what's best for the children."

Unmarried IPV survivors in the Arab American community were perceived to experience different challenges. For example, one stakeholder reported incidents in which abusive male partners "will take advantage of…someone trying to protect their reputation," and will blackmail their female partner into staying silent about IPV with threats, such as "'if you tell anybody then I'll post pictures of [you] on the internet [and] tell everyone about our relationship."

Theme 4: Access to IPV support services in the community

Generational status, educational attainment, and support from family, friends, or religious leaders were perceived to influence access to IPV support services for Arab Americans.

Generational Status—There were perceived differences in how the younger, 1.5- and second-generation Arab Americans supported IPV survivors compared to older, first-generation Arab immigrants. While an older, first-generation immigrant client felt that IPV in the Arab American community was handled better when resolved exclusively between partners, younger clients and providers felt the community was evolving and survivors could obtain support from their families or friends or even religious leaders when family was unsupportive.

> "And I feel like a big thing we have to look at too, is generations. Back when my mother was younger, some of her, you know, for my grandmother's sisters and brothers it was like, when the mom gets abused don't say anything, stay with your husband. And then with my mom and all her generation that still went on. But now it's all of their children, if that man beats you, you get the hell out. So, I feel like depending on how long they've been in the country, the generation, all that plays a huge factor." (Stakeholder)

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Education—Clients and stakeholders believed that Arab American IPV survivors with high educational attainment had the tenacity to obtain IPV resources and leave abusive partners more easily than their counterparts with low educational attainment, as the former were perceived to have more knowledge of their legal rights. For example, one client reported that "the women are more educated, she knows she can go to the court and ask for divorce."

Support—Family and close friends were perceived to play an essential role in supporting Arab American IPV survivors. Just over a quarter of the clients (n=4) reported that IPV survivors in the Arab American community often turn to trusted family or friends for support in managing conflict or leaving a violent intimate partner. One client noted that there are several cases where families intervene for a survivor, though the same client noted that this may not be the case for everyone. Another client reported a personal experience of disclosing IPV to her family only when she could no longer hide bruises left by her partner because she was concerned how the abuse would influence the reputation of her family in their community. When family was not supportive, clients felt that friends played an integral role in supporting Arab American IPV survivors.

Sheikhs and imams, religious leaders of the Muslim community, were perceived to be critical first resources for Muslim Arab American IPV survivors and their families. One client reported that often women and an elder male of the family, such as the father, seek help through a local mosque.

> "From my understanding…the majority of people…they go to the mosque, their dad will take them to the mosque, or their parents or somebody…My cousin was in an abusive relationship and her dad took her to the mosque right away and he wanted to get his, like, he wanted her daughter to divorce the guy, right away." (Client)

Three stakeholders reported that in recent years religious leaders have also been promoting IPV awareness through lectures and sermons at Islamic centers, "the mosques have been doing a great job advising…in [Friday] prayer they'll say something about domestic violence and honestly ask." However, at least one stakeholder reported an experience in which a religious leader in the community was not a supportive or dependable advocate for an IPV survivor.

> "Everything was set, the last minute the sheikh needed to come in, they bailed out, she was alone, no family in this country, young woman with like two kids, her husband was beating her up every day. The police had to go by her house every single day just to make sure she's alive and then at the end of the day they [the sheikh] bailed."

Furthermore, one stakeholder noted that IPV survivors may lack trust in religious leaders of the local Arab American community and may not be comfortable turning to them.

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DISCUSSION

This study highlights perspectives of Arab American women who were clients of an Arab-centered community health organization and the perspective of their healthcare providers and key stakeholders in the community on how IPV affects the Arab American community. We found four themes pertaining to perceived prevalence of IPV in the community, norms related to IPV, differential IPV experiences by marital status, and factors that may facilitate access to IPV support services in this community.

Perceived prevalence of IPV in the community

Perceived prevalence of IPV in the Arab American community varied depending on the type of IPV, where emotional IPV such as threats, insults, blackmail, and manipulation were perceived to be the most common form of IPV among Arab American survivors and thought to be a precursor to physical IPV. This is similar to findings from past studies on incidence of IPV among Arab American women (Abu-Ras, 2007; Barkho et al., 2011). Incidences of sexual IPV were less known among the Arab American female clients; providers felt that this was due to the taboo nature of discussing sexual relationships in Arab American communities. Similar findings are reported in past studies on the role of Arab women and expectations of appropriate behavior (Kulwicki et al., 2010). Subsequently, inability to openly discuss sexual relationships has impeded discussion of sexual IPV.

Perceived norms related to IPV in the community

Most stakeholders and clients felt that IPV was ignored or accepted in the community, that victim-blaming was common, and that survivors should be strong and resilient against IPV. Kulwicki et al. (2010, p. 728) reported that among Arab American women, domestic violence continues to be a “silent crisis.” Silent acceptance of IPV in the Arab American community may be due to fear of exacerbating negative ethnic stereotypes, preserving family honor, maintaining privacy in family affairs, lack of low-cost or culturally tailored services, fear of deportation, unwillingness to go to the police or shelters, and lack of trusted, professional Arab American providers (Abu-Ras, 2007; Abu-Ras & Abu-Bader, 2008; Kulwicki, 1996; Kulwicki, 1996; Kulwicki et al., 2010).

Differential IPV experiences by marital status

Married and unmarried Arab American survivors were perceived to have different experiences with IPV and support seeking. Stakeholders and clients reported that married Arab American IPV survivors faced challenges due to obstacles created by abusive spouses, family members, and at times, religious leaders. Crabtree-Nelson and colleagues (2018) also found that strong cultural forces play a role in reinforcing a women’s responsibility to be follow what her husband says and has led to women not disclosing abuse to her family. Furthermore, Arab family values play a large role in how Arab Americans navigate separation and divorce (Barakat, 1993). Additionally, clients and stakeholders felt that the decision to leave an abusive partner became more complicated if children were involved, which is similar to past studies that discuss the challenges that mothers face, particularly mothers from racial or ethnic minority backgrounds. These mothers face cultural pressures of upholding their role as a “good” wife and mother and worry about the financial

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constraints of providing for their children on their own (Ateah et al., 2019; Barrios et al., 2020; Kelly, 2009; Khaw et al., 2018; Semaan et al., 2013). Stakeholders reported that unmarried IPV survivors in the Arab American community are afraid to disclose violence in their relationships because partners will threaten to expose their relationship, which can damage the reputation of a woman and her family in the community. This was expected given past research on Arab cultural values of honor and shame associated with premarital sex and flirting (Abu-Ras, 2003).

Access to IPV support services in the community

Generational status was one factor that was perceived to influence access to IPV support services for Arab American women survivors. First- and 1.5- or second-generation Arab immigrants had different views of the appropriate family and community response to IPV. Past studies discuss the role of acculturation on immigrants and children, where ideologies of gender roles become more egalitarian over generations (Raj & Silverman, 2002). Furthermore, studies of Asian and Arab immigrant communities indicate that changes in gender role ideology occur more quickly for women than for men (Kulwicki & Miller, 1999; Raj & Silverman, 2002). As ideologies change, women may be less willing to conform to norms of IPV acceptance, which could gradually shift the community response to IPV among 1.5- and second-generation Arab Americans.

Arab American IPV survivors with high educational attainment were also perceived to have greater awareness of IPV resources and their legal rights compared to those with lower educational attainment and more tenacity to leave an abusive partner. This is similar to findings from a review of violence against women from immigrant backgrounds, which found that among Asian and Latino women, having limited English proficiency, education, and work skills made immigrant women doubt their ability to function in U.S. society without their partners (Haile-Mariam & Smith, 1999; Perilla, 1999; Raj & Silverman, 2002; Supriya, 1996).

Finally, support from family, friends, and religious leaders were perceived to influence access to IPV support services. Family and friends were also viewed as critical support systems for Arab American IPV survivors. However, some did not feel that family and friends were always supportive. This is similar to findings from a study conducted in Jordan in which supportive families were found to be protective against IPV, but not all families were found to be effective support (Clark et al., 2010). Although Arab families may not always be fully supportive of IPV survivors, they are also often the “only natural support network” in this community (Kulwicki et al., 2010, p. 733); though at times they may play a role in perpetuating IPV, they can also be instrumental in breaking the chain (Crabtree-Nelson et al., 2018).

Sheikhs and imams were considered effective spokespersons for raising awareness about IPV and mediating IPV among Muslim Arab Americans. Studies among Arab women in the Middle East and U.S. found that IPV survivors prefer mediation through relatives or local religious leaders (Haj-Yahia, 2000, 2002; Shalhoub-Kevorkian, 1997, 2000) and often the faith community is the first point of contact for help-seeking (Abu-Ras et al., 2008). Though sheikhs and imams may not be formally trained counselors, they are considered to

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be equipped to assist IPV survivors in the Arab American community due to their familiarity with cultural and religious values of the community (Abu-Ras, 2007). However, the response from Muslim religious leaders was not always perceived to be supportive toward Arab American IPV survivors in the current study. Another study found that religious leaders may encourage Arab women to tolerate IPV and discourage them from seeking support services or leaving abusive partners (Kulwicki et al., 2010). In the current study, stakeholders noted that the response and advocacy from sheikhs and imams for Muslim American IPV survivors has changed in recent years from an approach that used to be more corrective to one that is more empathetic. Noting this shift in attitudes, providers and violence prevention researchers should continue to engage with Muslim religious leaders as liaisons of IPV awareness and conflict management for Muslim Arab Americans and connect them with local, culturally sensitive and structured IPV support resources for survivors.

LIMITATIONS

One limitation of this study is that findings are limited to Arab American women in an urban setting with a significant Arab American presence. The findings may not be generalizable to Arab Americans who are more isolated, however, our findings are similar to past studies on Arab American women who have survived IPV and live in an area with a large concentration of Arab Americans in a large metropolitan area (Crabtree-Nelson et al., 2018). While there is a necessity for further exploration of the IPV experiences of Arab American residing in areas with smaller concentrations of immigrant-origin populations, there are important implications of this study for Arab Americans residing in other cities with significant Arab Americans populations including New York, Dearborn, Los Angeles, Chicago, and Washington D.C. (Arab American Institute Foundation, 2018). Additionally, stakeholders and clients who participated in the focus groups and semi-structured interviews came from non-random convenience samples and were recruited through ACCESS. This sampling method may contribute to selection bias and limits generalizability; however, the researchers felt it was important to work with a community organization that already worked with the local community on Arab American healthcare needs, as this would foster trust between participants and researchers.

Another limitation of this study is that though clients came from diverse backgrounds, the thematic analysis did not highlight perceived differences in IPV experiences and norms by country of origin, religious affiliation or sect, or immigrant resettlement context. Still, this study highlights differences in IPV experiences based on factors perceived to be critical in the Arab American community and offers providers and researchers insight on ways to intervene on IPV in this population. Future studies should also examine differences in IPV experiences based on the ethnic and religious diversity within the Arab American community. Finally, though clients were asked to reflect on their perception of IPV in the community, some also disclosed personal experiences. Stakeholders and clients who discussed personal experiences of IPV or experienced distress during the focus groups or interviews were offered the option to skip questions, end an interview, or leave a focus group discussion, along with a list of relevant resources. Despite the limitations, this study makes important contributions in understanding how Arab Americans in large urban setting feel their community responds to IPV and aids survivors.

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CONCLUSION

This exploratory qualitative study examines IPV perceptions among Arab American female clients from an Arab-centered community health organization, their providers, and community experts. The study demonstrates that IPV is a public health concern among Arab Americans and that more programming and research that addresses IPV is a priority of the community. The study is also unique in highlighting community assets that may facilitate Arab American IPV survivors' access to formal and culturally sensitive support services. This study reinforces an urgent need for more empirical evidence of Arab American IPV experiences and offers critical insights for researchers and providers working with Arab Americans. Such insights can be used to improve trust and promote cultural-sensitivity in cross-collaboration between research institutions and develop IPV interventions tailored to the needs of Arab Americans.

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Mona Makki is the Director of the ACCESS Community Health and Research Center, where she oversees over 70 programs in healthcare, mental health and public health divisions. An impassioned proponent of rights for underserved members of the community, Mona has fearlessly advocated against crime and domestic violence for over a decade and committed herself to improving and empowering the lives of individuals and families

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who suffer from domestic and sexual abuse, chronic diseases and behavioral health issues. She has worked tirelessly to collaborate with judges, faith leaders, schools and police departments in the fight against such abuse.

Madiha Tariq is the Deputy Director of the ACCESS Community Health and Research Center, a role in which she oversees health promotion and disease prevention programs with a focus of immigrant and refugee health. She is a co-chair of the Arab Health Summit, the only platform for ground-breaking research on Health Issues in Arab Communities, a project director on several complex federal grants, and a Robert Wood Johnson Foundation Interdisciplinary Research Leadership Program Fellow. She holds a Master of Public Health degree from George Washington University in Washington, D.C. and a Bachelor of Arts from Middlebury College in Vermont.

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APPENDIX

Appendix A. Focus group guide

Questions

I. Needs-assessment

A. Can you tell us about how intimate partner violence is usually addressed in the local Arab American community?

B. What barriers exist for Arab American women who are in violent relationships in terms of their access to healthcare, and contraception specifically?

[PROBES:]

- Stigma
- Family
- Religion

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- Culture
- Lack of willingness of providers/leaders to address IPV

II. Approach

A. Where would be the best setting for disseminating this survey?

B. Who would be the best individual to administer the surveys (e.g., healthcare provider, a trained interviewer) or would it be better to make the surveys self-administered?

C. Would asking women about IPV experiences face-to-face elicit honest answers (as opposed to questions on a paper form or through web-based surveys)?

[PROBES:]

- Should the survey dissemination only be done at ACCESS or should it be more widespread?
- Would CCRT members be able to offer their work settings or community settings as locations to deliver the surveys?
- In what language should we deliver the surveys? Should someone also deliver the surveys orally in English or another language?
- Would it be better to administer questions orally to elicit honest answers, or would it be better to do administer the questions in paper/pencil or web-based survey form?

D. Are there any questions from the survey that stood out to you?

III. Future intervention

A. Based on the needs of your community, what do you think an effective intimate partner violence and reproductive health intervention would look like?

[PROBES:]

- Should an intervention be housed at ACCESS?
- Should the intervention address violence and reproductive coercion?
- Should it be individual, group classes, partner counseling, or all of these options?
- Should the intervention address contraception, e.g., counseling women about and giving them a contraceptive method that would be more under their control?
- Should an intervention involve religious or community leaders? Should these leaders be trained in IPV response and counseling or family planning?

B. Have we missed anything that you would like to add before we end today?

This discussion has been very helpful and we want to thank everyone for participating in this conversation. If you have any questions or feedback after you leave today, please feel free to contact us. I will also be available for a few minutes right now if anyone has other comments they weren't able to share. Thank you all and have a great day!

Appendix B. Semi-Structured Interview Guide

Questions

I. Introduction

A. Tell me a little bit about yourself.

أخبريني قليلاً عن نفسك

B. Tell me about your experiences with ACCESS.

أخبريني قليلاً عن تجاربكِ مع ACCESS

[PROBES]

a. How well does ACCESS serve your needs?

ما مدى حُسنْ قيام ACCESS بخدمة احتياجاتكِ؟

b. What do you feel ACCESS could do a better job of addressing?

ما هي الأشياء التي تظنين أنه بإمكان ACCESS القيام بعمل أفضل في معالجتها؟

II. Needs Assessment

Today we would like to talk about how couples within the Arab American community make decisions about having children. We also want to discuss how disagreements related to pregnancy and delaying having children are handled.

نودّ أن نتحدّث اليوم عن كيف يتخذ المتزوجين أو الشركاء الذين في علاقة حميمة في الجالية العربية الأمريكية القرار بشأن إنجاب الأطفال. كما نريد أن نتحدّث أيضًا عن كيفية التعامل عادة مع الخلافات المتعلقة بالحمل وتأخير إنجاب الأطفال.

A. Can you talk about how decisions about when to have children are made among Arab American women?

هل يمكنكِ أن تتحدثي عن كيفية اتخاذ القرارات حول متى يتوجّب إنجاب الأطفال بين نساء الجالية العربية الأمريكية؟

[PROBES:]

a. Who is involved in the decision-making process to have children (e.g., family members, in-laws, cultural or religious community pressure, religious leaders)?

مَنْ يُشارك في عملية اتخاذ القرار لإنجاب الأطفال (على سبيل المثال، أفراد الأسرة، أو أبويّ الزوجين أو الجالية الثقافية أو الدينية، قادة الدين)؟

b. How do you think that culture may have an influence?

كيف ترين أن الثقافة قد يكون لها تأثير على ذلك؟

c. How do you think that religion may have an influence?

كيف ترين أن الديانة قد يكون لها تأثير على ذلك؟

d. Are there any other factors you can think of that influence the decision to have children?

هل هناك أي عوامل أخرى قد تخطر على بالك من شأنها أن تؤثر على اتخاذ قرار إنجاب الأطفال؟

B. If a married woman in this community wanted to wait to have children, what would the community think about that?

إذا أرادت امرأة متزوجة في هذه الجالية الانتظار حتى تنجب أطفالاً، فما سيكون نظرة أهالي الجالية حول ذلك؟

[PROBES:]

a. How hard would it be for her to do this?

ما مدى الصعوبة التي تواجهها تلك المرأة في عمل ذلك؟

b. Why would it be hard (e.g., family, community, education, knowledge of methods and appropriate services)?

لماذا يكون هذا الأمر صعباً (على سبيل المثال، الأسرة، الجالية، درجة التحصيل الدراسي، معرفة الوسائل والخدمات الملائمة)؟

c. How may religion or culture play a role in her decision?

كيف يمكن أن تلعب الديانة أو الثقافة دوراً في قرارها؟

We are going to change topics now. We are also interested in understanding how violence and abuse may occur between married couples or people who have been in a relationship. The following questions will focus on understanding how this community responds to that violence and abuse.

سننتقل الآن إلى موضوع آخر. نهتم أيضاً في فهم كيف يمكن أن يحدث العنف وسوء المعاملة بين المتزوجين أو بين الذين في علاقة حميمة. ستركّز الأسئلة التالية على فهم كيف تكون ردّة فعل واستجابة هذه الجالية لذلك العنف وسوء المعاملة.

A. What have you heard about abuse among couples in the Arab American community?

ماذا سمعتِ عن سوء المعاملة بين المتزوجين أو بين الذين في علاقة حميمة في الجالية العربية الأمريكية؟

[PROBES:]

a. What about kicking or hitting between partners?

ماذا عن الرفس أو الضرب بين الشريكين؟

b. What about insults or abusive language between partners?

ماذا عن الشتائم أو اللغة البذيئة بين الشريكين؟

c. What about one partner forcing the other to have sex when they did not want to?

ماذا عن شريك يُغصب الآخر على الجماع الجنسي، عندما لا يريد الآخر القيام بذلك؟

B. How are issues of violence among couples usually handled in the Arab American community?

كيف يتمّ التعامل عادة مع قضايا العنف بين المتزوجين أو بين الذين في علاقة حميمة في الجالية العربية الأمريكية؟

[PROBES:]

a. How have you seen violence between couples handled in the past?

b. How do family members, friends, and or other community members find out about the violence, it at all?

كيف يعرف أفراد الأسرة والأصدقاء وغيرهم من أفراد الجالية عن العنف، إذا كان ذلك ممكنًا على الإطلاق؟

c. How is help seeking approached (by these individuals, their family, and friends)?

كيف يتم تقديم المساعدة (من قبل هؤلاء الأفراد، وأسرتهم وأصدقائهم)؟

C. Why may it be hard for Arab women who are in violent relationships to access to healthcare?

لماذا قد يكون صعبًا على النساء العربيات اللواتي يكنّ في علاقات متسّمة بالعنف الوصول إلى الرعاية الصحية؟

[PROBES:]

a. How may these challenges be different from generation to generation?

لماذا قد يكون صعبًا على نساء الجالية العربية الأمريكية اللواتي يكنّ في علاقات متسّمة بالعنف تأخير حملهن؟

b. Why may be it hard for Arab American women who are in violent relationships to delay pregnancy?

لماذا قد يكون صعبًا على نساء الجالية العربية الأمريكية اللواتي يكنّ في علاقات متسّمة بالعنف تأخير حملهن؟

c. How may religion or culture play a role in her ability to access health services to delay pregnancy?

كيف يمكن أن تلعب الديانة أو الثقافة دورًا في قدرة المرأة إلى الوصول للخدمات الصحية لأجل تأخير حملها؟

D. What have we missed that you would like to add before we move on to the next part of the interview?

ما الأشياء التي لم نذكرها وتودّين إضافتها قبل أن ننتقل إلى الجزء التالي من المقابلة؟

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I. Approach

We also wanted to get your input for a survey we are creating. These surveys will give us a better understanding of Arab American women's health. That said, the next few questions will be about how willing you think women in this community would be to completing the survey and how we can tailor the survey to reflect their needs.

نريد أيضًا أن نأخذ آرائك بشأن استطلاع الآراء الذي نقوم بإنشائه. ستحسّن هذه الاستطلاعات من فهمنا لصحة النساء في الجالية العربية الأمريكية. ومع ذلك، ستتناول الأسئلة القليلة التالية آرائكِ حول مدى استعداد نساء هذه الجالية في استكمال الاستطلاع وكيف يمكننا أن نصممه ليعكس احتياجاتهن.

A. How willing do you think women in this community will be to complete a survey about their decisions to have children and when to have children?

ما تظنين مدى استعداد نساء هذه الجالية في استكمال استطلاع حول قراراتهن لإنجاب أطفال ومتى يتوجّب إنجاب الأطفال؟

[PROBES:]

a. What about for women who have experienced physical, sexual, or emotional abuse in their relationship?

ماذا عن النساء اللواتي عانينَ سوء معاملة وانتهاكًا بدنيًا أو جنسيًا أو عاطفيًا في علاقاتهن؟

b. What might help them be more willing?

ما الأشياء التي قد تساعدنهن ليكنّ أكثر استعدادًا لتقبّل الاشتراك في الاستطلاع؟

c. What may keep women from wanting to complete this survey?

ما الأشياء التي قد تقللّ من همّة النساء وتُبعدهن عن استكمال هذا الاستطلاع؟

B. How do you think we can best find women to invite to fill out the survey?

ما رأيك حول أفضل طريقة لإيجاد نساء لدعوتهن لتعبئة الاستطلاع؟

[PROBES:]

a. ACCESS or elsewhere?

هل تظنين أن ACCESS هو مكان مناسب أو أن لديك مكان آخر؟

b. What if we wanted to reach women who are not already coming to ACCESS?

ماذا لو أردنا أن نتصل بالنساء اللواتي لم يسبق لهن المجيء إلى ACCESS؟

c. In what language or languages should the survey be available?

بأي لغة أو لغات ينبغي كتابة الاستطلاع؟

d. Age group?

ما هي فئة العمر؟

e. Should the survey only be for married women or also included unmarried women? Why?

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هل ينبغي على الاستطلاع أن يكون للنساء المتزوجات فقط أو أن يشمل النساء غير المتزوجات أيضًا؟ ولماذا؟

C. What is the best way to delivery the survey?

ما أفضل طريقة لإعطاء الاستطلاع؟

[PROBES:]

a. Who do you think should deliver the survey?

مَنْ تظنين ينبغي إعطاء الاستطلاع؟

b. Where do you think the survey should be delivered?

أين تظنين ينبغي إعطاء الاستطلاع؟

D. How willing do you think women in this community who have experienced violence in their relationship will be to participate in an interview about their experience at a later time? The interviews would be anonymous, and they cannot be linked back to survey responses.

ماذا تظنين مدى استعداد نساء هذه الجالية اللواتي يعانين من العنف في علاقتهن للاشتراك في مقابلة حول تجربتهن في وقت لاحت؟ ستحُفظ هوية المشاركات في المقابلات بصورة مجهولة ولا يمكن ربطهن بإجاباتهن على الاستطلاع.

E. What have we missed that you would like to add before we end?

ما الأشياء التي لم نذكرها وتودّين إضافتها قبل إنهاء المقابلة؟

This discussion has been very helpful and we want to thank everyone for participating in this conversation. If you have any questions or feedback after you leave today, please feel free to contact us. I will also be available for a few minutes right now if anyone has other comments they weren't able to share. Thank you all and have a great day!

كانت المساعدة مفيدة جدًا ونريد أن نشكر كل واحدة منكن للاشتراك في هذه المحادثة. إذا كان لدى أحد منكن أسئلة أو ملاحظات بعد مغادرتكن اليوم، فرجاءً ألا تترددن بالاتصال بنا. سأكون موجودة أيضًا لبضعة دقائق الآن إذا كان لدى أي منكن تعليقات أخرى لم تكن قادرات على مشاركتها. شكرًا لكنّ جميعًا وأتمنى لكل واحدة منكن يومًا عظيمًا!

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Table 1.

Characteristics of the Focus Group and Semi-Structured Interview Sample (N=36)

	Focus Groups (N=21)		Semi-structured interviews (N=15)	
	n	%	n	%
Focus group session				
1	8	38.1		
2	13	61.9		
ACCESS providers or staff	18	85.7		
Taskforce member	3	14.3		
Country of origin				
Lebanon			1	6.7
Iraq			2	13.3
Sudan			2	13.3
Yemen			5	33.3
More than 1 (Lebanese-Palestinian)			1	6.7
Not reported			4	26.7
Age				
18–24			4	26.7
25–31			2	13.3
32–38			2	13.3
39–45			1	6.7
45–65			2	13.3
Not reported			4	26.7
Relationship status				
Single			1	6.7
Married			2	13.3
Separated, divorced, or widowed			5	33.3
Not reported			7	46.7
Children			8	53.3
Not reported			7	46.7

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Table 2.

Overarching Theme 1, Subthemes, and Exemplar Quotes

Theme 1: Perceived prevalence of IPV in the community	
Subtheme	**Exemplar Quotes**
Emotional IPV was perceived as the most common form of IPV among Arab American women and a precursor to physical IPV.	“I think the hitting is the last resort…it starts with…disrespect, which is insults and, uh, abusive language...If you’re able to look at your partner that you so call love…say such…vulgar words, then your next up is just to lead to something physical.” (Client)
Physical IPV is known to occur in the Arab American community.	I heard about some people they beat up their wives. There are some wives they don’t complain about that eh, and they say that their husbands prohibited them from telling others.” (Client)
	“What I hear mostly is like pushing, you know, heated arguments there’s pushing going on.” (Client)
	Exception: [Interviewer:] What have you heard about abuse among couples in the Arab-American community? [Respondent:] “Nothing…no, especially in Arab ways, we don’t, guys don’t touch girls.” (Client)
Sexual IPV was perceived as less common and too sensitive to discuss openly.	“I don’t hear about that more often than abuse and vulgar language only because, um, that’s a sensitive topic that I don’t think most women like to admit.” (Client)
	“I don’t really discuss sexual life with uh, people among, like, the community. But it happens. I’m sure it happens. It happens here and everywhere.” (Client)

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Table 3.

Overarching Theme 2, Subthemes, and Exemplar Quotes

Theme 2: Perceived norms related to IPV in the community	
Subtheme	**Exemplar Quotes**
IPV is typically accepted, normalized, or dealt with privately in the Arab American community.	"Well, for me, I've seen it be ignored or brushed aside or, um, I've seen victim-shaming, people turning the other cheek…I've seen it firsthand." (Stakeholder)
Arab American IPV survivors face victim-blaming and are expected to have the strength and resilience to endure IPV.	"Because a lot of times the family and uh, the husband and his family, they're not going to look at it like it's his fault or he did anything. They're going to look at it like 'ok, this is her'." (Stakeholder)
	"[A woman] is supposed to heal herself and put an end to the situation she is in." (Client)

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Table 4.

Overarching Theme 3, Subthemes, and Exemplar Quotes

Theme 3: Differential IPV experiences by marital status	
Arab American IPV survivors who are unmarried can be blackmailed into accepting IPV if an abusive partner threatens to ruin a survivor's reputation by exposing the relationship to family or in the community.	"Because I was involved in a domestic [violence] situation when I was younger, and the reason it was heightened was because it was a quiet relationship, no one could know about it." (Stakeholder)
	"Sometimes the boyfriends can, will take advantage of you know, someone trying to um, protect their reputation, 'if you tell anybody then I'll post pictures of you on the internet, I'll tell everyone about our relationship', and they have that, uh, power over the young women, because reputation is very important." (Stakeholder)
Arab American IPV survivors who are married struggle to obtain a divorce or feel obligated to stay with an abusive partner due to children.	"…Religiously speaking, when you get married it's a lot harder to get a divorce, religiously versus, you know, just the American court system…Instead of just being about the abuse or trying to get out as quickly as possible it becomes this… prolonged situation where you're trying to get out, but he wants to make it as difficult as possible because he doesn't want that reputation or shame or having his name being kind of tarnished or wronged…so I feel like it becomes a lot harder if you're married." (Stakeholder)
	"And in the end, she's scared about the future of her daughter, that they will tell her about what happened, that 'your mother did this and that to your father'. And this is the hardest thing for the mom. In the end, it's about what's best for the children." (Client)

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Table 5.

Overarching Theme 4, Subthemes, and Exemplar Quotes

	Theme 4: Access to IPV support services in the community
Subtheme	**Exemplar Quotes**
1.5- and second-generation onward Arab Americans are perceived to experience more support from within the community when disclosing IPV compared to first-generation Arab immigrants.	"I feel like a big thing we have to look at too is generations. Back when my mother was younger...when the mom gets abused don't say anything, stay with your husband…but now it's all of their children, if that man beats you, you get the hell out. So, I feel like depending on how long they've been in the country, the generation, all that plays a huge factor." (Stakeholder)
Arab American women with high educational attainment are able to seek IPV resources and leave violent intimate partners more easily than those with low educational attainment.	"I think that the women [who] are more educated, she knows[s] she can go to the court and ask for divorce, if she was educated herself and if she has self-confidence." (Client)
Whether Arab American IPV survivors can turn to family and friends for support varies.	"I would not have reached the point that I did…but because I was afraid of him, and afraid for my parents well-being… I did not talk, but it reached the point…the beatings were showing on me always." (Client)
	"Um, a lot of, uh families, eh, handle it well, where they, they put out into it and they talk to the guy and his family, but some other parents 'oh, go back to your husband, deal with your issues'." (Client)
	"She complain[s] to her parent, [but] they tell her, 'this is your husband, no matter what, maybe you did something to him'." (Client)
	"A friend will play a role…I knew someone, she confided in us so instead of her family, so we ended up going to a social worker to help her in school, so like a, maybe like how you said friends really help out when the…family likes to keep it quiet." (Stakeholder)
Religious leaders have been promoting IPV awareness at Islamic community centers and have advised survivors and their families.	"The mosques have been doing a great job advising…in [Friday] prayer. They'll say something about domestic violence…" (Stakeholder)
	"From my understanding…they go to the mosque and talk to someone there. That's what the majority of people do, they go to the mosque, their dad will take them to the mosque, or their parents or somebody." (Client)