INTIMATE PARTNER VIOLENCE AMONGST WOMEN IN THE SOUTH ASIAN DIASPORA

INTIMATE PARTNER VIOLENCE AMONGST WOMEN IN THE SOUTH ASIAN DIASPORA

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Abstract

Background: Little is known about the perspectives of South Asian mothers with regards to the experience of intimate partner violence (IPV), including risk and protective factors, impacts of exposure, and help-seeking. This thesis is comprised of two sub-studies. In the first study, a scoping review was conducted to identify and map the literature on IPV amongst South Asian women residing outside of South Asia. The second study consists of a qualitative project to explore how IPV is perceived among South Asian mothers living in Ontario, Canada.

Methods: The first study was a scoping review conducted using the 5-stage framework outlined by Arksey and O'Malley, and later advanced by Levac et al. Four health and social science databases, including Embase, CINAHL, Medline, and PsychINFO were systematically searched from inception to June 2020 using the themes "intimate partner violence" and "South Asian." Studies were screened for inclusion based on pre-determined eligibility criteria, and relevant data with regards to study location, journal type, and sample characteristics were abstracted by two independent reviewers. Studies were organized and synthesized into thematic categories. Then a qualitative descriptive study was conducted with a purposeful sample of 6 South Asian mothers from the Greater Toronto and Hamilton Area, recruited from a sub-sample of the SouTh Asian biRth CohorT Study (START). Semi-structured interviews were conducted to explore their perceptions and experiences of IPV in their community. The interview data were analysed using reflective thematic analysis.

Findings: The scoping review revealed that most studies qualitatively explored the experiences and perceptions of IPV amongst women of the South Asian diaspora; however, there was a paucity of quantitative literature to ascertain the impacts of exposure to IPV. Similarly, there was a dearth of literature on the prevention of IPV in this population. Other research gaps included the lack of clinical samples, the underrepresentation of some South Asian ethnicities over others, and the overrepresentation of studies conducted in the USA. The qualitative descriptive study revealed that among this sample of South Asian mothers, they expressed that in-laws play a significant role in contributing to violence from in-laws, which can lead to IPV, and in increasing a woman's risk of experiencing IPV by adhering to traditional gender roles. Participants identified that the IPV can manifest as unequal sharing of responsibilities between partners and women's education can be protective against IPV. Participants believed that their concern for their children's well-being along with cultural expectations of South Asian females, played a key role in the decision to seek help for IPV. Participants identified that physicians could play an important role in helping women who have experienced IPV by asking about IPV and offering resources.

Discussion: This scoping review, which identified and mapped IPV literature, and qualitative study, which investigated the perceptions of IPV amongst South Asian mothers, contribute to the body of IPV literature amongst women in the South Asian diaspora. The findings can help inform future research directions, and can contribute to the general understanding of stakeholders, such as service providers for IPV, about how IPV is understood, experienced, and addressed among South Asian mothers.

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Here's to strong women. May we know them. May we be them. May we raise them.

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Chapter 1: Introduction & Background

The goal of this chapter is to provide, at the global and local Canadian level, an overview of intimate partner violence (IPV) as a type of gender-based violence, including theories of causation of IPV, associated risk factors, and health and social effects associated with IPV. Since South Asian women represent one demographic that is at higher risk of experiencing IPV than other groups, this chapter includes a broad discussion of IPV in South Asian communities, first within South Asia, then in Canada. This chapter concludes with a layout of the present thesis and the positionality statement of the primary researcher.

Gender-based Violence

Gender-based violence describes violence that is committed against someone based on their gender identity, gender expression, or perceived gender[1]. According to the United Nations Economic Commission for Europe, gender-based violence disproportionately affects women, girls, and gender non-binary individuals[2]. Individuals who identify as gender non-binary belong to a gender identity that does not fit the traditional male-female binary. Violence against women and girls, a form of gender-based violence, is any act that results in, or is likely to result in, physical, sexual or psychological harm to women or girls[2]. The World Bank estimates that gender-based violence affects 1 in 3 women in their lifetime[3]. In addition to the devastation caused to survivors and their families, violence against women can cost some countries up to 3.7% of their gross domestic product[3]. Gender-based violence can manifest in various forms. This includes, but is not limited to, child marriage, female genital mutilation, honour killings, sex trafficking, and IPV.

Gender-based violence in Canada

In concordance with the aforementioned global trends as reported by the United Nations Economic Commission for Europe, gender-based violence disproportionately affects Canadian women and girls; for instance, women are at 20% higher risk of violent victimization than men[4], and 47% of all reported sexual assaults in 2014 were committed against women aged 15-24 years[5]. Gender-based violence also impacts Indigenous peoples, LGBTQ and gender non-conforming people, people with disabilities, newcomers, children and youth, seniors, and people living in rural or remote areas[1]. In a report from the Canadian Centre for Justice Statistics, the economic costs of sexual assault and other sexual offenses against Canadian women was found to be $3.6 billion annually[6]. Estimates taken from other costing studies conducted from 1993 to 1994, investigating the economic impact of violence against women, range from $2.05 billion to $5.55 billion (adjusted to 2009 dollars)[7]. Although gender-based violence can manifest in various different forms, one particular type that significantly affects women in Canada is IPV. Police-reported data from 2018 revealed that 45% of all female victims aged 15-89 years experienced IPV[8], representing the most common kind of violence experienced by women and girls. Of all incidents of IPV, women and girls accounted for 8 of 10 victims, highlighting the gendered nature of IPV.

Intimate Partner Violence

The Centers for Disease Control and Prevention (CDC) in the United States define IPV as "physical violence, sexual violence, stalking and psychological aggression (including coercive acts) by a current or former intimate partner."[9] Physical violence refers to the use of physical force such as hitting or kicking to hurt their partner. Sexual violence refers to forced sexual intercourse or sexual coercion, whether physical or non-physical (e.g. sexting). Psychological aggression

refers to the use of verbal or non-verbal communication with the intent to harm a partner psychologically or emotionally. Stalking is a pattern of unwanted attention and contact from a partner that causes concern for one's own safety or that of their loved ones. The definitions of IPV are similar across most health organizations with minor differences. For instance, the definition of IPV offered by the World Health Organization (WHO) explicitly states emotional abuse as a form of IPV, whereas this falls under psychological aggression in the CDC's definition[10]. Although the term domestic violence is often used interchangeably with IPV, this is a broader term that refers to the abuse of any member of a household, for instance, child abuse or elder abuse, and not necessarily violence that occurs between intimate partners[10]. Representing a major public health problem, the WHO estimates that, across WHO regions, 30% (95% CI = 27.8%-32.2%) of ever-partnered women over the age of 15 years have experienced physical and/or sexual IPV in their lifetime[11].

IPV in Canada

In Canada, police-reported data on IPV victimization revealed that the rate of female-victimization by male partners, which was 507 females who experienced IPV per 100,000[8]. This figure represents the most contemporary national prevalence estimate of female IPV victimization; however, since they are police-reported data, they likely underestimate the prevalence at the community level. Police-reported data underestimate the true prevalence of IPV due to a variety of factors such as distrust of the police, learned helplessness syndrome, and the type of abuse present in the relationship[12]. A national population-based survey administered in 2009 identified that, of the 19 million Canadians in 2009 who had a current or former spouse/common-law partner within the past 5 years, 6.4% of women report being physically or sexually victimized[13]. Based on

these prevalence estimates, the economic costs of IPV against Canadian women were valued at $4.8 billion annually in 2009[14]. These figures are generated from self-reported data in the General Social Survey, which collects information on victimization from a random sample of Canadian men and women. The response rate for this survey in 2009 was 61.6%[15] and this survey has not since been administered. The results of this survey are likely more accurate than the aforementioned police-reported data in determining the true prevalence rate due to its use of a community-based sample. However, the definition of IPV used in the General Social Survey did not include those who were in dating relationships, or who experienced IPV other than sexual or physical abuse, such as emotional abuse.

In addition to police-reported and community-based data, other researchers have aimed to determine the prevalence of IPV amongst women in clinical settings. In order to provide recent estimates, only Canadian studies conducted in the past 2 decades (2000-2020) are discussed. In 2006, MacMillan et al. reported that the 12-month prevalence of IPV in various clinical settings in Ontario, Canada (emergency departments, family practice, and women's health clinics) ranged from 4.1% to 17.7%[16]. This study was a cluster-randomized trial designed to determine the optimal method for IPV screening in health care settings by evaluating outcomes such as prevalence, missingness of participant data, and participant opinions of the various screens. The screening methods tested in this study included the computer, written, and face-to-face assessments of the Partner Violence Screen (PVS) and the Women Abuse Screening Test (WAST), compared to the criterion standard, the Composite Abuse Scale (CAS). Prevalence was found to be significantly lower on the WAST than on the PVS, and in family practices and women's health clinics as compared to emergency departments. Another study investigating the prevalence of IPV across

fracture clinics in Ontario reported a 12-month prevalence of 32% (95% CI: 26.4%-37.2%) using the WAST[17]. In a subsection of the same sample, the researchers also investigated the prevalence of IPV using the PVS, which suggested a lower prevalence of IPV as compared to the WAST (PVS = 9.2% vs. WAST = 15.4%); however, this study was not powered to detect significant differences in prevalence using the two scales. Ahmad et al. conducted a prevalence study of IPV within current or recent relationships in primary care settings in [18]. They found that the overall prevalence of IPV in current or recent relationships was 14.6% (95% CI 8.8%-20.3%) using the Abuse Assessment Screen (AAS) and the PVS. Combining both clinical and community prevalence assessments, a 2002 descriptive review on the prevalence of IPV amongst Canadian women found the lifetime prevalence of IPV to be between 8% to 36.4%[19].Taken together, these estimates suggest, that the prevalence of IPV amongst women in clinical settings is higher than in the general population.

IPV occurs in all types of relationships, across different types of couples, such as heterosexual and same sex couples. For example, in 2017, there were 2,327 cases of police-reported IPV amongst same-sex couples, as compared to 69,243 cases amongst opposite-sex couples in Canada[20]. To date, the literature on IPV has largely focused on heterosexual couples, particularly on women who have experienced IPV; however, women may also use violence against their intimate partners. In 2018, a report on police-reported violence in Canada published that the rate of male-victimization by female partners was 134 male victims per 100,000[8]. This is in comparison to 507 female victims per 100,000. In the same year, women represented 79% of all victims of IPV in the same year, which suggests that women are overrepresented as survivors of IPV. Thus, the focus of this work is on women-identifying survivors of IPV in heterosexual relationships.

Theories of IPV Causation

As the scholarly attention on IPV has grown, many theories have been proposed to explain the personal, cultural, religious, and social factors that affect and perpetuate abuse[21]. None of these theories fully explain why IPV occurs, and each is subject to criticism that is based on research findings that do not fit the theoretical model. Still, these theoretical frameworks offer unique lenses through which the problem of IPV and its perpetration can be viewed.

The theory of individual psychopathology posits that abusive behaviours result from the psychological and neurobiological effects of mood/personality disorders, brain injury, and post-traumatic stress disorder (PTSD)[22]. While it potentially captures the physiological aspects of IPV perpetration, this theory is often critiqued for its inability to explain why abusive behaviours are directed at intimate partners[21]. Along the lines of biological theories, evolutionary theories posit that the evolutionary pressures on males to reproduce eventually manifested as extreme jealousy and violent behaviour in order to ensure the survival of their species[23]. However, this theory is met by the criticism that IPV can result in significant morbidity and mortality, thereby reducing opportunities for reproduction[21]. Other theories suggest that alcohol and drug use lead to IPV, through the mechanistic disinhibition of behavioural constraint pathways[24]. However, while alcohol and drug use are known risk factors of IPV perpetration (and, in fact, victimization), this theory is subject to criticism since substance use does not always result in IPV, and, conversely, IPV can occur in the absence of drug and alcohol use[21]. Next, social learning theory posits that abusive behaviours are learned during childhood exposure to violence, reinforced by social norms (i.e. it is permissible for men to be aggressive when they are upset), then imitated in intimate relationships during adulthood[25]. Similar to the critique of the theory of drug and alcohol use, not

all children who experience, whether as a victim of child abuse or a witness of IPV, later become perpetrators, and not all perpetrators of IPV experienced childhood violence. Another theory of IPV causation, and one of the only theories at the level of the family rather than the perpetrator, suggests that IPV is the result of familial imbalances in power, communication, and expectation[26]. This family systems and stress theory posits that usually all members of the family, including the victim, are culpable; however, this theory is criticized for its minimization of the perpetrator's responsibility and exaggeration of the victim's role[26]. Contemporary research identified that women were disproportionately affected by IPV, and this lent support to the formation of feminist theories, which posit that IPV is enabled by patriarchal beliefs that support men's domination over familial, social, and cultural systems[27]. However, while this theory captures the important gender-based nature of IPV, it fails to explain the influence of other factors such as racism and classism, which, although they contribute to IPV, are not necessarily rooted in gender differences[27].

One popular theoretical framework of IPV is the socioecological model. Commonly used by the WHO and the CDC, the socioecological model describes the use of a four-stage intersecting framework to understand the complex interplay of individual, relationship, community, and societal-level factors that contribute to violence[28] (**Figure 1**). This model was first introduced by Bronfenbrenner as a conceptual model for understanding human development in the 1970s, then formalized as a theory in the 1980s[29]. It has since been applied in the field of IPV and family violence by researchers investigating factors that influence various aspects of violence, such as its experience[30], perpetration[31], prevention[32], and severity[33]. It is described in more detail in the following subsection.

Figure 1. The social ecological model. Taken from: Centers for Disease Control and Prevention (CDC).

Risk Indicators

Using the social ecological framework, factors that influence an adult woman's risk for experiencing IPV are discussed here. The present discussion does not include risk factors for IPV perpetration or research on adolescent dating violence. These results are taken from a large systematic review of 228 studies investigating risk factors for IPV victimization, conducted by Capaldi and colleagues in 2012[34], and supplemented with evidence from more recent reviews, where possible. The risk indicators discussed in this section are summarized in **Table 1**.

Table 1. Risk Indicators organized by levels of the social ecological framework.

Level of Social Ecological Framework	Risk Indicator
Individual	Younger Age Unemployment Low Income Lower Parental Education Level African American/Hispanic Ethnicity Acculturation Stress Alcohol Consumption Childhood Maltreatment Infertility/Subfertility/Unplanned pregnancy
Relationship	Peer-like relationship with parents/child as caretaker for parents Single/divorced/separated/widowed/previously married status

	Co-habiting Increased frequency of relationship or marital disagreement Hostility in disagreement style Female- or male-dominance Low relationship satisfaction Social support (tangible resources)
Community	Social disorganization Collective efficacy/social cohesion Socioeconomic standing Community violence
Societal	Cultural gender norms and patriarchal attitudes Membership in ethnic minority Foreign-born status

Individual Level

Individual level risk factors describe those that are biological or personal in nature, such as age, sex, or education. This level can also include an individual's personality traits and their personal history with abuse[28]. A systematic review-meta analysis of prospective-longitudinal studies conducted by Yakubovich and colleagues, found that being older was significantly associated with a 4% reduction in IPV (OR = 0.96, 95% CI 0.93-0.98)[35]. Age was analysed as a continuous variable in this review. With regards to education, socioeconomic status, and employment, Capaldi et al. report that unemployment and low income are stronger predictors of IPV than education level[34]. While Yakubovich et al. found that parent's education level was significant predictor of female IPV victimization, the findings reported by Capaldi and colleagues suggest that the relationship between education and IPV is dissipated when proximal factors, such as relationship conflict, are controlled. Race and ethnicity have also been found to affect IPV victimization. For instance, amongst studies conducted in the USA, studies found that African American and Hispanic ethnicity was associated with higher levels of IPV relative to Euro American couples, however this effect may be mediated by other factors, such as age, marital status, and income. A topic closely related to race and ethnicity status is acculturation, which refers to the cultural modification

of a group by adapting or borrowing from traits from another culture. In their review, Capaldi et al only reported acculturation studies amongst Hispanic populations. They concluded that the degree of acculturation did not affect recurrence of IPV. However, after controlling for SES, acculturation stress amongst Hispanic individuals increased the risk of IPV. Additionally, other reviews have identified alcohol consumption amongst women[36], childhood maltreatment[37], and infertility or subfertility[38] as risk factors for IPV. Yakubovich et al similarly found that unplanned pregnancies put women at increased risk of experiencing IPV. Taken together, these results suggest that younger age, unemployment, non-white ethnicity, alcohol consumption, childhood maltreatment, and infertility/subfertility represent individual level factors that affect women's IPV victimization.

Relationship Level

This level examines how relationships that are proximal, or close, to the individual can influence their risk of experiencing IPV. For instance, this can include relationships with a partner, friends, family, and co-workers or peers[28]. Firstly, using longitudinal studies, Capaldi et al reviewed the effect on the type of relationships between parents and their children to assess the risk of IPV victimization. They found that experiencing early childhood abuse, witnessing parental IPV, and parent-child boundary violations, defined as a peer-like relationship between the parents and the child or the child adopting a caretaker role for the parents, was significantly associated with IPV victimization in young adulthood. These findings are robust even when other individual-level variables such as education, employment, ethnicity, and SES are controlled. Several studies suggest that the mechanism through which child abuse or witnessing of IPV in childhood results in IPV victimization in adulthood occurs through antisocial personality disorder. However, this

intergenerational effect can be moderated by a woman's perceived relationship quality with her partner. In terms of relationship dynamics, couples who are co-habiting have been found to be at a higher risk for IPV than dating or married couples. Across other types of relationships, women who were single, divorced, separated, or widowed were magnitudes more likely to experience IPV as compared to women who were married or living with a common-law partner. In fact, formerly married individuals had higher rates of IPV victimization than currently married individuals. In addition to relationship status, variables such as frequency of relationship or marital disagreement and hostility in disagreement style, typically displayed a positive relationship with IPV victimization. To this extent, families in which there is either a female- or male-dominance report higher levels of IPV. IPV is not typically observed in equalitarian relationships. That male-domination was a significant predictor of IPV against females was also observed in a narrative systematic review conducted by Vives-Cases and colleagues[39]. A concept similar to relationship disagreement or discordance is relationship satisfaction; low relationship satisfaction is associated with both relationship conflict and IPV victimization. The presence of social support in the form of tangible opportunities to receive help, as opposed to emotional support, were found to be protective against IPV victimization. However, this may not be true of women with additional, individual level risk factors, such as substance abuse problems. In summary, childhood exposure to IPV or abuse, being previously married or co-habiting, having greater relationship disagreement, and lower relationship satisfaction are factors that are significantly associated with IPV victimization.

Community Level

The third level of the social ecological model accounts for an individual's community context in which social relationships are embedded, and assesses how characteristics of settings like workplaces, schools, and neighbourhoods can influence the risk of IPV[28]. Capaldi et al found that neighbourhood connectedness and support are associated with IPV, and collective efficacy (e.g. community cohesion and willingness to intervene with a neighbour) mediated the relationship between neighbourhood disadvantage and lethal IPV. A review conducted by VanderEnde and colleagues on the community-level correlates of IPV against women identified five major thematic correlates from 27 different community-correlates found across 17 studies[40] . These themes are social disorganization, collective efficacy/social cohesion, socioeconomic standing, community violence, and community gender norms. The results of the latter theme are described in the following subheading. Firstly, most studies found that increased social disorganization, typically measured using indices of concentrated disadvantage (i.e. percentage of single-parent households, non-white/unemployed residents, etc.), was significantly positively associated with physical IPV against women. On the other hand, some studies investigated residential stability as a facet of the concentrated disadvantage construct, measured using the percentage of people that moved versus did not move in the past five years. Residential stability, in addition to immigrant concentration, was not associated with IPV. Findings are mixed with regards to the effect of collective efficacy, a concept which refers to the mutual trust of a community, on IPV, where some studies report a significant, negative association, and others fail to report any association. Another similar concept is social control, which describes a community's capacity to regulate its members. Path analysis studies reveal that there is a direct, significant, and negative association between social cohesion and IPV, but not between social control and IPV. With regards to social cohesion, residents who

have family members living in their neighbourhood had a significant negative association with severe physical IPV, but the same effect was not observed with residents who had friends in the neighbourhood. There is considerable disagreement as to the effect of socioeconomic variables on IPV victimization. This is true of variables such as standard of living, community development, and neighbourhood poverty, studied in the USA, Haiti, and India. Male unemployment appeared to more consistently significantly predict severe physical IPV in Haiti and the USA. However, level of education amongst males and females was inconsistently associated with IPV victimization for females. In India, while individual-level education did not influence the likelihood of experiencing IPV, women living in communities with an intermediate level of female literacy were significantly more likely to experience IPV as opposed to women living in communities with the highest tertile of female literacy. Similarly, females were also more likely to experience IPV if they lived in communities with the lowest tertile of male literacy. This relationship was not observed in the USA. Community-level perceptions and behaviours with regards to non-intervention norms for violence were strong predictors of IPV victimization. The relationship between IPV and beliefs of non-intervention (i.e. the belief that fighting between family is nobody else's business) is moderated by collective efficacy. Hence, as non-intervention norms increase, collective efficacy is less useful in reducing IPV. Additionally, there are some associations between female IPV, and the level of physical punishment used typically used against children in the community. Women are more likely to experience higher levels of physical and emotional IPV, but not sexual IPV, in communities where moderate, but not high, levels of physical punishment are used against children. Finally, while non-intervention beliefs were significant predictors of IPV, these associations were not observed between intolerance of deviant behaviours, such as fighting, and IPV.

Societal Level

At the societal level, factors such as cultural, political, or religious norms are examined to understand how they may influence IPV. It also includes economic and social policies that shape or contribute to inequalities in key domains such as education, employment, and health[28]. VanderEnde and colleagues report that a women's acceptance of partner mistreatment, but not her attitudes towards traditional gender roles, was a significant predictor of IPV[40]. However, these studies were only conducted in India and Bangladesh.

One review by Okeke-Ihejirika and colleagues summarized the literature on IPV amongst immigrant communities in Canada, including, but not limited to, South Asian (including Guyanese), Portuguese, Japanese, Nigerian, and Brazilian immigrants[41]. The researchers identified four themes. The first theme referred to the different perceptions and experiences of IPV amongst immigrant women and highlighted the consistent findings that immigrant women are likely more vulnerable to abuse due to the added stress of immigration. They also reported that, while immigrant women from various cultures might hold a universal definition of IPV, they have important cultural differences in its interpretation, particularly with regards to the degree to which violent behaviours are tolerated. Secondly, under their theme of coping with IPV, the authors report that immigrant women were more likely to utilize passive, non-confrontational, and private strategies as opposed to Canadian-born women, who were more likely to use active, problem-oriented strategies (i.e. disclosure of violence and accessing formal support). This apparent dichotomy is mediated by several factors that are unique to immigrant women, such as lack of knowledge of available supports, fear of deportation, and cognitive restrictions in terms of education and fluency in English. Another theme identified by Okeke-Ihejirika and colleagues was

the inadequacy of services and policies to meet the needs of immigrant women. With regards to policy, they identified the paucity of work at the intersection of immigration and IPV. They also reported the barriers posed by mandatory charging laws that preclude immigrant women, many of whom are financially dependent on their partners, to disclose abuse and thereby access support. This is especially true of women whose immigration is sponsored by their partners. With regards to community services, the authors suggested that providers should empower women to make choices that are in line with their needs as opposed to imposing decisions (i.e. separation, involving law enforcement) that do not necessarily align with immigrant women's value systems. This understanding is considered a facet of cultural competence. Finally, the authors noted in their fourth theme that although providers and researchers tend to pathologize the culture of immigrant women as one that enables IPV, host countries play an important role in establishing egalitarian relationships, especially by mitigating cultural barriers to access for IPV-related services.

In addition to this review, there are several individual studies that have demonstrated that membership in a racialized group can affect a woman's exposure to and understanding of IPV. As defined by the government of Canada's Employment Equity Act of 1995, ethnic minorities are "persons, other than Aboriginal peoples, who are non-Caucasian in race or non-white in colour"[42]. Some studies have shown that the rate of IPV victimization is higher amongst women who belong to ethnic minorities as compared to white Caucasian women; the National Violence Against Women Survey of 1995 reported that the lifetime estimates for physical IPV amongst African women was 26.8%, as compared to 21.3% for White women[43]. Other studies demonstrated that the type of violence (i.e. physical, emotional, sexual) experienced by women who belong to ethnic minorities may differ as compared to other groups. For instance, one study revealed that although

the lifetime, 5-year, and past-year prevalence of IPV did not differ significantly between Latina and non-Latina women, Latina women were significantly more likely to experience physical abuse within the past 5 years[44]. One retrospective study reported that, after controlling for neighbourhood income, victims of intimate partner femicide (IPF) were twice as likely as non-IPF victims to be foreign-born[45]. These results add an additional layer of complexity which suggests that immigrants may be at higher risk of femicide than US-born women, although it is not clear whether the researchers controlled for ethnic minority status in this study. Additionally, in a study comparing perspectives about IPV amongst a national sample of Whites, African Americans, Latinas, and Asians, Asian women were least likely to categorize vignettes of violent interactions (e.g. a man yelling/beating his wife) as intimate partner violence[46]. These results suggest that a woman's conception and understanding of IPV are influenced by cultural norms, which in turn, are shaped by her membership in a minority ethnic group. Taken together, these results suggest that belonging to an ethnic minority can influence a woman's perception and likelihood of experiencing IPV, and the type of violence that she experiences.

IPV Amongst South Asians

One particular ethnic group that is vulnerable to higher rates of IPV are South Asians, defined by the WHO as people who originate from the Indian subcontinent, which consists of the nations of India, Pakistan, Bhutan, Bangladesh, Sri Lanka, Nepal, and the Maldives. Although other definitions include individuals from Afghanistan, the present research uses the former definition for consistency with WHO data. A systematic review performed by the WHO of the global and regional prevalence estimates of IPV in WHO regions, based on data extracted from 79 countries and 2 territories, reveals that the lifetime prevalence of IPV among women living in South Asia is

estimated to be 37.7% (95% CI = 32.8%-42.6%)[11]. Amongst low- and middle- income WHO regions, the prevalence was highest in South Asia (37.7%) and lowest in the Western Pacific at 24.6% (95% CI = 20.2%-29.2%), followed by the European Region at 25.4% (95% CI = 20.1%-29%). The prevalence estimates in the Western Pacific and European Regions are comparable to high income regions at 23.2% (95% CI = 20.2%-26.2%). This review was performed by conducting a systematic search across 26 medical and social science databases in several languages. These estimates are based on data extracted from 79 countries and 2 territories, which included census data and large cohort studies such as the WHO multi-country study on women's health and domestic violence against women[47], the International Violence Against Women Surveys (IVAWS, 8 countries)[48], and GENACIS: Gender, alcohol and culture: an international study (16 countries)[49]. Although this study represents one of the most robust investigations into the prevalence of IPV amongst South Asians, most research to date has focused on white Caucasians, African Americans, and Hispanic populations. In addition, prevalence studies regarding IPV amongst South Asian women largely focus on those living within South Asia.

Interestingly, although most investigations about IPV in this population have been prevalence studies, the results are conflicting in terms of their estimates[50–54] and therefore limited in their interpretability. For instance, a multinational study which recruited 2945 women attending orthopedic surgery clinics included 137 self-identified South Asian women (4.7% of the sample) across India, North America, and Europe, and found that the past year prevalence of IPV was 18%[50]. This prevalence from a clinical sample is considerably lower than estimates generated by studies that recruited women from a community sample. To this effect, studies show that 40% of South Asian women from Boston had experienced IPV from a current partner[52], 54 % of Nepali

women living in New York had ever experienced emotional abuse and 36% had experienced physical abuse in their lifetime[53].

IPV Amongst South Asians in Canada

According to the 2016 Canadian census, South Asians are the largest Canadian racialized group, representing 5.6% of the national population[55]. The provinces with the highest proportion of South Asian residents are Ontario and British Columbia, representing 8.7% and 8% of the provincial population, respectively[55]. In keeping with their status as the largest ethnic minority group, Okeke-Ikejirika and colleagues report that the literature on IPV amongst immigrant communities largely consists of investigations within the South Asian population[41]. One study estimated that the past year prevalence of IPV amongst South Asians living in Southern Ontario was 19.3%[54]. This is comparable to the aforementioned past year prevalence rate of 18% in orthopedic clinics across India, North America, and Europe[50]. However, these comparisons should be drawn with caution since South Asians only represented 4.7% of the total sample in the latter study, which was conducted in a clinical setting, while the former estimate is drawn from a community sample.

It is useful to examine the IPV prevalence estimate from the START (SouTh Asian biRth cohorT) study. START is a prospective cohort study consisting of 1,012 South Asian women aged 18-30 years and their offspring, recruited during pregnancy from the Peel Region in Ontario from July 2011 to November 2015[56]. A secondary analysis of data from the START study was conducted by the primary author of this thesis to determine the prevalence of IPV, which revealed that 1.75% reported experiencing at least one occurrence of abuse measured using the Humiliation, Afraid, Rape, and Kick (HARK) scale. The START study is discussed in detail in Chapter 4. There is

considerable discrepancy between the prevalence rates of IPV in the START cohort (1.75%) and other cited estimates. For instance, a prevalence of 19.3% was reported across a community sample of South Asian women in Southern Ontario[54] while a prevalence of 18% was found across a clinical sample of South Asian women in orthopedic clinics across India, North America, and Europe[50]. Interestingly, the START cohort prevalence is also vastly different from the provincial prevalence of 17.7%. These discrepancies may be attributed to the use of different measurement tools, the recruitment of clinical versus community samples, the type of sample of women (i.e. general population versus young mothers), selection bias, and/or underreporting by participants. Reasons for underreporting may be related to stigmatization, the hesitancy to interact with police authorities, cultural or family values, and fear of hurting or losing their children. This disagreement may also be explained by the fact that some estimates were determined using police-reported data, and IPV is typically under-reported to police authorities. Thus, the already limited literature on this population to date consists of considerable disagreement in prevalence estimates and overall heterogeneity in the methods, reporting, and results.

The Impact of Women's Experiences of IPV

Experiencing IPV has been shown to have both short and long-term effects on women's health and social outcomes. These impacts can generally be categorized into effects on physical health, including sexual and reproductive health, mental health, and familial or social effects, including parenting and employment. These impacts can also be broadly categorized into direct and indirect impacts, where the latter is exemplified by health problems that arise as a result of exposure to chronic stress. The summary of findings in this section is largely taken from WHO's global and

regional estimates of violence against women[11], and supplemented with data from other sources, where appropriate.

Physical Health

One effect of experiencing physical forms of IPV is physical injury. Population-based self-reported data from 31 countries revealed that the prevalence of women who had non-fatal injuries after exposure to IPV was 41.8% (95% CI = 34.0%-49.6%)[11]. Campbell and colleagues, in their review of the health effects of IPV exposure, report that the aftermath of physical abuse can manifest as pain, broken bones, facial trauma, loss of consciousness, and chronic headaches, which may later result in undiagnosed cognitive problems[57]. According to the WHO report, women who were in relationships where IPV was occurring were nearly three times more likely to experience non-fatal injury (OR = 2.92, 95% CI = 2.21-3.63)[11]. In addition, 38% of all murdered women were murdered by an intimate partner, representing the prevalence of fatal injury due to IPV exposure[11]. Similar to the trend of prevalence of IPV, the prevalence of intimate partner homicide was highest in the South-East Asia region at 55%[11]. Similar to the WHO estimates, Canadian police-reported justice data reports that 56% of women who experienced IPV sustained minor physical injuries[8]. Of all women who experienced IPV, only 2% experienced major injuries or death. Other health consequences of abuse that may not manifest immediately include chronic pain, psychosomatic disorders, gastrointestinal disorders, and irritable bowel syndrome[47]. Women who have experienced abuse are also twice as likely to have self-reported poor health and physical health problems.

Reproductive Health

Exposure to IPV also has significant effects on a woman's sexual and reproductive health. Although Canadian police reported data suggests that just above 5% of women who report IPV experience sexual assault[8], other population-based estimates suggest that this figure is closer to 45%[11]. Forced sex has physiological consequences such as increased risk of STDs/HIV, vaginal and anal tearing, bladder infections, sexual dysfunction, and other genitourinary problems. The WHO reports that there is a significant association between IPV and HIV/AIDs OR = 1.52, 95% CI = 1.03-2.23)[11]. In addition to sexual coercion, Campbell and colleagues report that another mechanism for IPV is reproductive coercion, through which an abusive partner is in control of their partner's contraceptive use[57]. Exposure to IPV also has maternal and neonatal effects during the pregnancy and post-partum period. Using data taken from prospective studies, the WHO reports that women who experience IPV are 2.4 times more likely to have an induced abortion (OR = 2.38, 95% CI = 1.93 to 2.84), the occurrence of which is affected by the trimester in which the violence occurred and the accessibility to legal abortion options[11]. Cross-sectional data suggests that there is a significant association between IPV and low birthweight (adjusted OR = 1.16, 95% CI = 1.02-1.29) and preterm birth (adjusted OR = 1.41, 95% CI = 1.21-1.62), but not intrauterine growth restriction[11]. Additionally, one recent meta-analysis investigating the health effects of pregnant women's exposure to IPV found that women who had recent IPV exposure were significantly more likely to experience increased symptoms of subsequent post-partum depression (OR=2.19, 95% CI 1.39 to 3.45)[58]. It is believed that increased stress responses might mediate the relationship between IPV and adverse maternal and neonatal outcomes[59].

Mental Health

Women who have experienced abuse are twice as likely to have self-reported mental health concerns[11]. One of the most common mental health effects of exposure to IPV, identified across several reviews, is depression. The WHO reports a significant association between depression and IPV (OR = 1.97, 95% CI = 1.56 to 2.48). It has been reported that 34.7% of the total IPV disease burden is attributable to depression. This is in comparison to 27.3% of the disease burden attributable to anxiety, 10.7% to suicide, and 0.06% to physical injuries[60]. In fact, survivors of IPV are 4.5 times more likely to die of suicide (OR = 4.54, 95% CI = 1.78-11.61)[47]. In addition to depression, the prevalence of post-traumatic stress disorder (PTSD) amongst women who have experienced IPV is 40%. Survivors are 4.9 (95% CI = 3.8-6.4) times more likely to develop PTSD[61]. The same study also found that women who experienced IPV were 1.8 times more likely to develop anxiety (95% CI = 1.5-2.1). Studies report that the type, severity and frequency of abuse[47], rather than demographic or cultural characteristics, are significant predictors of depression amongst women who have experienced IPV[57]. In addition to the above, exposure to IPV has also been reported to affect health behaviours such as alcohol/drug use and smoking. To this effect, the WHO reports that women who have experienced IPV are 1.8 (95% CI = 1.04-3.18) times more likely to use alcohol[47]. Another meta-analysis found a significant, small to medium effect size describing the relationship between IPV victimization and cigarette smoking (d = 0.41, 95% CI = 0.35-0.47)[62]. Although this analysis included studies which recruited men who have experienced IPV, women were disproportionately represented, reflected in 94.9% (n=34) of effect sizes.

Social Wellbeing

Experiences of IPV have various effects on a woman's professional and social lifestyle, including employment, relationships, and housing. The WHO reports that 13% women who have been

exposed to IPV typically are made to take time off work, missing an average of 7 working days. Women who were exposed to IPV also had a high rate of job turnover (likely due to physical and mental health concerns that affect job performance), had lower personal incomes, and were more likely to receive welfare assistance[28]. These results are corroborated by Wathen and colleagues. In a survey conducted within a Canadian sample, they found that survivors of IPV reported that their exposure to IPV impacted their ability to get to work and negatively affected their job performance[63]. Through qualitative work, Riger and colleagues describe the social effects such as alterations in their relationships with family and friends, such that they became important sources of support through experiences of IPV[64]. Participants in their study also described experiencing a shift in their perceptions of intimate relationships, where some women thought IPV was an inevitable part of future relationships and others felt that they would be able to recognize and end potentially abusive future relationships. Women also felt that a significant social consequence of exposure to IPV was not being able to find stable housing.

For mothers, exposure to IPV has also been shown to have a strong influence on the mother's parenting style and their relationship with their children. Firstly, Campbell and colleagues report that between 40% to 70% of children who enter women's shelters have themselves experienced abuse, usually by their mother's intimate partner, but sometimes by the mother, herself[57]. This figure suggests that there may be considerable overlap between IPV experienced by the mother and child abuse. Similarly, in the same review, Campbell et al report that women who have experienced IPV tend to be more worried about their children's exposure to violence, both at home and in other places, such as at school or in the playground. To this extent, additional studies have reported that mothers who have experienced IPV may be more punitive towards their children[65],

which suggests that a woman's exposure to IPV tends to negatively affect her parenting ability. However, other studies have shown that women can act as emotional anchors for their children during times of stress[66], be warm and responsive towards the needs of their children[67], and mediate the distressing family situations[68], which may, altogether, act as protective factors against the negative social and emotional consequences of a child's exposure to violence in the home[66].

The Interaction of Multiple Effects

As noted by other researchers, the consequences that result from the exposure to violence rarely exist independently[64]. Hence, the physical, mental, and social consequences should be conceptualized as nested domains that are linked to one another. For instance, Levendosky and colleagues report that parenting quality is poorer amongst mothers who experience depressive symptoms as a consequence of exposure to IPV, which in turn, increases the likelihood of distressing behaviours in children[69]. In this way, there is a nesting of the mental health and social effects of exposure to IPV. In another instance, Wuest et al found that the relationship between child abuse severity and chronic pain severity is mediated by PTSD symptom severity, suggesting the interconnectedness of the physical health, mental health, and social wellbeing domains[70]. It should also be noted that the presence and magnitude of these effects can depend on the conditions of the abuse, such as whether the woman has left the abusive relationship and the severity of the abuse. Ford-Gilboe and colleagues report that past IPV exposure exerts a continued negative effect on women's physical and mental health, and this effect is mediated by the severity of the violence[71]. In summary, exposure to IPV can have significant impacts on a woman's physical, mental, and social wellbeing, and these effects can intersect across multiple domains and vary by relationship factors.

Problem Statement

Given the current state of the evidence regarding IPV amongst South Asian women, two apparent research issues were identified. First, although there were several identified systematic reviews of various aspects of IPV amongst South Asian women residing within South Asia, especially those conducted by the WHO, there was a paucity of review literature on IPV amongst South Asian women residing outside of South Asia. South Asians living outside of South Asia are referred to as the South Asian diaspora. While the term 'diaspora' is sometimes used exclusively to refer to people who were forcibly removed from their home countries for enslavement, and their successors, it is used here to refer to all individuals who originate from, but to not reside in South Asia. It is important to investigate IPV within the diaspora since the previously cited literature shows that the prevalence, perception, experience of IPV can be influenced by factors such as ethnic minority status, immigration, and acculturation. The need for a comprehensive review in this population is underscored by the breadth and heterogeneity, in terms of methodology and findings, of research that is done in this field. Second, the large discrepancy in the prevalence of IPV from the START study as compared to other estimates of IPV amongst South Asians in clinical and community settings warranted further investigation. A better understanding of this discrepancy can be established by examining the reasons for the underreport within the START cohort, which may be rooted in the perceptions and beliefs around IPV in this population. As evidenced by the previously cited literature, it is important to understand, especially amongst ethnic minorities, the role of cultural or social norms on the experience of IPV. Thus, the overall purpose of this thesis was to contribute to the understanding of the perceptions and experiences of IPV amongst South Asian women outside of South Asia. This was accomplished through the completion of two related, but independent projects.

Project 1: Scoping Review

To date, the overall evidence on IPV amongst women in the South Asian diaspora has not been comprehensively synthesized, summarized, or interpreted. Hence, the first project was a scoping review to identify and map the literature on IPV amongst South Asian women residing outside of South Asia.

Project 2: Qualitative Descriptive Study

To build upon the evidence base identified in Project 1 and to further investigate IPV within the START cohort, the second project was a qualitative descriptive study of the perceptions and beliefs of IPV held by South Asian mothers in Ontario, Canada.

Positionality

Introduction to Reflexivity & Positionality

A core tenet of rigorous and trustworthy qualitative research is reflexivity, which holds that, because the instrument of qualitative research is the researcher, they must systematically acknowledge and attend to how their personal experiences and assumptions have the potential to influence the research process[72]. Thus, because it is impossible to remain detached from one's research[73], the researcher must be aware of the influence that her values, beliefs, experiences, assumptions, and interests have on the research (the phenomenon under investigation), and also the influence of the research on the researcher[74]. Jointly, these aspects of a researcher's identity shape her position, which is the "stance or positioning of the researcher in relation to the social and political context of the study - the community, the organization or the participant group"[75].

Taken together, engaging in reflexivity through the research process clearly delineates and makes transparent the ways in which a researcher's positionality affects the research[76]. Through a positionality statement, this chapter discusses my position as a researcher as it pertains to the phenomenon of IPV amongst South Asian women.

Positionality Statement

I am a 23-year old female Indian-born-Canadian immigrant and I am undertaking this work as part of my Master's degree at McMaster University, from which I also received a Bachelor's of Science. I view this work from the perspective of an unmarried South Asian, politically liberal, woman-identifying, female who has the privilege of belonging to an upper middle-class home in suburban Ontario. Due to my ethnic Indian identity, I recognize that, often times, when I think of South Asians, I think of Indian and the closely related Pakistani culture, and it is easy for me to neglect other South Asian countries.

I came into this work rarely having thought about IPV or violence against women and girls in the South Asian community, except for my knowledge of the rampant acid attacks in India and the *Nirbhaya* case[77]. However, I held opinions that influenced my conception of the role and treatment of women and girls in the South Asian culture, and these opinions were shaped by my experiences and, at large, by my membership in this group. For instance, I have always seen and believed that the South Asian culture is patriarchal, and it is a widely held belief that women are to be submissive to their male counterparts. My experiences with sexist and racist microaggressions in my community ("You're doing more school? Don't you want to get married?") and outside of my community ("Why do you have a 'white' last name if you're 'brown'?) have shown me the clear

delineation of gender roles in my community, and any threat to that patriarchal order could be met with disapproval. To me, my home has always been a place where women have been seen as equal to men; but I appreciate that this is not the case in everyone's home or communities.

I believed that disapproval in the South Asian community by other members of the community, and by family and friends could result in ostracization, and in immigrant communities, this could come at a grave cost. As an immigrant myself, I remember how closely my parents relied on other Indian, Pakistani, and Sri Lankan families for babysitting, groceries, transportation, emotional support and solidarity. Without their support, our family would not be able to thrive in a foreign country. Thus, a South Asian person's decision-making is largely underscored by the threat of ostracization from their community and choosing to report or seek help for IPV is no exception. Additionally, like many other South Asian women, I am taught that my duty to my family comes first. Thus, South Asian culture prioritizes filial piety amongst its women. That women may not seek help for IPV due to the fear of breaking their family, and thereby not upholding our shared value of filial piety, represented another assumption I brought to this work.

Despite my knowledge of and experiences with these phenomena, my immediate home has never been a place where my identity, aspirations, and worth have been questioned on the basis of my gender. My support network, comprised of my parents, siblings, and friends, many of whom are South Asian, enable me challenge traditional gender roles by supporting my goals of higher education, especially in provocative and charged topics, such as IPV, in lieu of "getting married and settling down". Because I belong to a younger generation and my conceptions of gender are not rooted in the South Asian ideal, I held that IPV was a problem of either older generations or

new immigrants, who might be closer in proximity to this ideal. Having been in Canada for 18 years and having immigrated to Canada when I was just 5 years old, I only knew what it meant to negotiate my identity as an Indian-Canadian but not necessarily an Indian or a Canadian. At times, I worried that my liberal upbringing, punctuated with my Canadian identity, combined with my residence in a predominantly white town, and my inability to converse in the language of my participants, painted me as the "other". I appreciate that despite belonging to the same ethnic group, my participants and I have varying degrees and dimensions of attachment to our shared South Asian culture, which could ultimately inform differences in our interpretation of IPV.

I can comfortably attribute my liberal social and political worldviews to my punctuated Indian-Canadian upbringing. I believe that everyone, including women and girls, should have the right to make their own decisions as they see fit. In terms of the phenomenon under study, these decisions include, but are certainly not limited to, their physical and mental health, sexuality, reproduction, cultural identity, religion, language, and family. However, I appreciate that the autonomy that I idealize is not always accessible due to a myriad of oppressive social, political, and economic factors. For instance, the lack of culturally and linguistically appropriate immigrant job-seeking services may inhibit a woman's financial security, which may lead her to stay with an abusive partner on whom she is financially dependent. I imagine that these issues are further complicated when women have children to support. Raising and bringing up children, of course, also fall under the responsibility of the South Asian woman.

In this study, I employed reflexive journaling through the various phases of research including pre-research, formulation of the research question and qualitative method selection, data collection,

and analysis. Taking frequent inventory of my position through reflexive journal has enabled me to monitor and report the ways in which my "baggage" reflects my research decisions and interpretations.

Chapter 2: Literature Review

The purpose of this chapter is to provide an overview of what is known about IPV among South Asian women living in Canada, including a discussion of risk factors, prevalence estimates, perceptions, experiences, coping strategies, help-seeking, outcomes of exposure to IPV, and the responses of professionals working with South Asian women who experienced abuse. This chapter also includes a discussion on the limitations of the existing literature.

Introduction

To our knowledge, only one review including Canadian South Asian women and IPV has been conducted. However, this review, conducted by Okeke-Ihejirika and colleagues, also included studies that recruited immigrant women from non-South Asian immigrant groups[41]. Since the previously cited literature has demonstrated that various dimensions of IPV (i.e. perception, experience, and help-seeking) can vary with one's cultural background[34], in addition to reviewing the literature across various communities, it can also be valuable to review the literature within ethnic groups. This may help capture nuances specific to South Asian women that may otherwise be lost when their data is pooled with other ethnic groups. Additionally, the review by Okeke-Ihejirika et al. focused solely on immigrant women[41]; however, the present review seeks to broaden this criterion by including studies which recruited South Asian women who may not be first-generation immigrants, in order to capture a greater number of citations. The present review also advances earlier work by including non-family types of IPV, such as adult dating violence. While the aim of the present thesis is to examine IPV amongst South Asian women in the province of Ontario, we anticipated a paucity of literature in this narrow provincial geographical context.

Hence, this literature review was expanded to examine IPV among South Asians in Canada, at large.

Methods

The following databases were searched from inception to July 2020 to identify articles that explored IPV amongst South Asian women in Canada; CINAHL, MEDLINE, EMBASE, and PsychINFO. The search strategy included terms such as "intimate partner violence", "South Asian", "Canada", and associated synonyms terms that were developed with the assistance of a research librarian. The complete search strategy is provided in Appendix 1. Articles were included if they were published in English, had IPV as their main research focus, and recruited South Asian women or service providers to South Asian women. The exclusion criteria consisted of studies that only recruited participants who reside in South Asia or were not peer-reviewed. Following title and abstract screening, full-text articles were screened for inclusion by one reviewer. The reference lists of included articles were hand-searched to capture any relevant citations that may have been missed by the systematic literature search. The results were organized thematically post-priori by examining the included articles for commonalities in research objectives. For instance, studies on risk factors for IPV were considered similar and were reported under one subheading.

Results

Of 60 articles, 12 articles were found that focused on IPV amongst South Asian women in Canada. 8 articles (67%) were qualitative studies, 3 (25%) were quantitative studies (all of which were cross-sectional studies), and 1 (8%) was a mixed methods study. Across the 427 total participants, 416 (97%) were women, and of these, 386 (93%) were South Asian. Three studies used data from

the same participant sample[78–80]; these participants were counted only once. Data on specific South Asian nationality was available for 178 of 386 SA women (46%). Of these 178 women, 97 (55%) were Sri Lankan, 52 (29%) were Indian, 26 (15%) were Pakistani, and 3 (2%) were Bangladeshi. Eleven studies were conducted in the Greater Toronto Area (GTA), Ontario, Canada, and 1 study was conducted in Surrey, British Columbia, Canada. The included studies are described briefly in **Table 2**. Across these studies, the following topics were represented: risk factors for IPV, perceptions, prevalence and experiences, outcomes associated with experiences of IPV, help-seeking, and the responses of health care providers in working with South Asian women who have experienced abuse.

Table 2. Characteristics of included studies.

Study	Participants	Method	Primary objective
Ahmad 2004[81]	47 SA women	Cross-sectional study	Investigates the relationship between South Asian immigrant women's patriarchal beliefs and their perceptions of spousal abuse
Shirwadkar 2004[82]	Service providers & 8 SA women	Qualitative; unspecified method	Explores the problems of Indian immigrant women who face cultural constraints in accessing the benefits of Canadian policies for women exposed to domestic abuse
Mason 2008[78]	63 SA women*	Qualitative; unspecified method	Examines the ways in which immigrant Sri Lankan Tamil women in Toronto understand, define, and experience IPV
Ahmad 2009[83]	22 SA women	Qualitative; unspecified method	Explores why South Asian immigrant women with experiences of partner abuse delay seeking help from professionals
Janssen 2009[84]	6 SA women	Qualitative; unspecified method	Defines a role for obstetrical care providers in assisting women who experience family violence
Hyman 2011[79]	63 SA women*	Qualitative; unspecified method	Explores Sri Lankan Tamil immigrant women's views on factors contributing to IPV
Kanagaratnam 2012[80]	63 SA women*	Qualitative; unspecified method	Explores perceptions of coping with IPV from the perspective of immigrant Tamil women
Guruge 2012[85]	30 SA women & 30	Cross-sectional study	Examines history of violence and impairment of physical and mental health

	Iranian women		amongst Sri Lankan and Iranian immigrant and refugee women
Ahmad 2013[86]	11 SA women	Qualitative; unspecified method	Explores resilience and resource usage among South Asian immigrant women who were survivors of IPV
Madden 2016[54]	188 SA women	Cross-sectional study	Assesses the prevalence of IPV in past year among South Asian women living in Southern Ontario.
Ahmad 2017[87]	6 SA men & 5 SA women	Mixed method; concept mapping	Assesses conceptual variations in defining IPV amongst SA men & women.
Couture-Carron 2017[88]	6 women & 5 men	Qualitative; unspecified method	Examines behaviours/actions in dating relationships that South Asian Muslim women may experience or understand differently
Total	**397 South Asian participants**		

*these studies used the same sample of women

Risk Factors for IPV

In a qualitative study that included a purposeful sample of 63 women who had immigrated from Sri Lanka and were living in Toronto, Canada, Hyman and colleagues explored their perceptions of which factors contribute to IPV in the post-migration context[79]. They conducted 8 focus groups with women of various ages and experiences with IPV; the focus groups were separated into distinct sessions for young women, adult women, women over the age of 65 years, and women who had received counselling services for IPV in the past. They identified several risk factors, such as immigration/acculturation stress, lack of social support in Canada, involvement of in-laws, and gender inequality as factors contributing to IPV in their relationships. The participants that identified immigration stress as a risk factor for IPV referred to financial stress most often; they noted that increasing financial stress in the post-migration context requires women to work outside of the home in order to contribute to the household income. They noted that women are required to balance their employment with the household responsibilities (i.e. cooking, cleaning, caring for

children) that are traditionally ascribed to them. In addition, women believed that there was a lack of social support for daily activities in Canada, which further created an unfair division of household tasks. In contrast, the women referred to the family structure in Sri Lanka as connected, close, and helpful in terms of daily activities. However, they noted that women experienced IPV in Sri Lanka as well as in Canada, but that the manifestation of the IPV was different post-migration. For instance, participants noted that the close proximity of the husband's and wife's families in Sri Lanka mitigated or reduced the occurrence of domestic violence perpetrated by mothers-in-law towards their daughters-in-law. Although this form of domestic violence was commonly experienced pre- and post- migration, women expressed the belief that the proximity of their parents to their marital home in which the abuse occurs, afforded a balance of opinions that mitigated the violence. In the post-migration context, the involvement of in-laws, and mothers-in-law, in particular, manifested in different ways due to their immigration, sponsorship by the husband, or occasional visits. In addition to the harsh criticisms that women endured from their mothers-in-law, they also intervened in child-rearing practices by governing the degree to which a couple, and their children, should acculturate to Canadian culture. A purposeful sample of participants in a study conducted by Janssen et al. stated that mothers-in-law may turn a blind eye to abuse perpetrated by their son towards their daughter-in-law due to the value ascribed to sons in the South Asian community[84]. Finally, women mentioned gender inequality as a contributing factor to IPV. Upon reflecting on their upbringing, women noted that they were raised to be obedient and loyal children, and to be submissive to their husbands. Conversely, males were raised to be dominating, and to eventually become the head of the family. This extreme dichotomy, introduced in childhood, and reinforced throughout one's life, may contribute to both the male and female perceptions of IPV, or in some households, may have normalized IPV. Some participants

also believed that women had a responsibility to prevent violence from occurring by being careful not to provoke their husbands. For instance, some participants believed that women could provoke violence by bringing up issues after their husband had a long day at work or by participating in certain activities (i.e. going out of the house often, wearing certain clothes, having male friends) of which he did not approve. Participants did not mention provocation avoidance in order to take responsibility for their husband's behaviour, rather, it was mentioned as a strategy for maintaining family harmony.

Interestingly, the authors reported contradictory findings with regards to the effect of increased autonomy and freedom experienced by women in the post-migration context on IPV. While some women believed that the greater independence, gender equality, and financial independence afforded to them in Canada made them more susceptible to IPV, others believed that these factors were central to preventing IPV. There was no further discussion on these proposed effects or on their mechanisms.

Prevalence, Perceptions, and Experiences of IPV

Madden and colleagues conducted a cross-sectional study to investigate the 12-month prevalence of IPV amongst South Asian women[54]. Conducted in Southern Ontario, this study recruited a convenience sample of 188 women attending a "Sister's Festival" cultural event. The researchers noted that the women attending this festival largely spoke English or Punjabi. Using bilingual surveys, the researchers asked three IPV prevalence questions taken from the Woman Abuse Screening Tool (WAST), which were, "has your partner ever abused you physically?", "has your partner ever abused you emotionally?", and "has your partner ever abused you sexually?". The

overall prevalence of IPV in the past 12 months was 19.3 % (95 % CI: 13.9–26.1 %). Of the women who indicated exposure to abuse in the past year, 17.1% experienced emotional abuse, 6.2% experienced physical abuse, and 3.3% reported experiencing sexual abuse. Another study conducted by Ahmad et al. found that, amongst their random sample of 47 women, 62% of participants screened positive for abuse using two questions on the WAST, which asked them to describe any tensions in their relationship (none, some, or a lot) and any difficulty in working out arguments with their partner (none, some, or great)[81]. Of these participants, 37.9% reported experiencing emotional or physical violence within the past 5 years. More specifically, 34.5% experienced emotional abuse, 24.1% experienced physical abuse, and 17.2% reported being threatened by physical violence in the past five years. In a convenience sample of 30 Sri Lankan Tamil immigrant and refugee women, Guruge et al. found that 63% of participants reported having ever experienced IPV[85]. In the past 12 months, 30% reported experiencing psychological violence, 13% reported physical violence, and none reported sexual violence. Prior to the past 12 months, 10% reported psychological violence, 10% reported physical violence, and none reported sexual violence. The prevalence rates could not be reasonably compared due to different prevalence durations; Madden et al.[54] and Guruge et al.[85] investigated exposure to IPV in the past 12 months, whereas Ahmad et al.[89] investigated exposure in the past five years. However, there was consistency in the relative prevalence of types of IPV; emotional/psychological abuse was more prevalent than physical abuse, which was more prevalent than sexual abuse. In addition, although no studies were found comparing IPV prevalence amongst South Asians living outside of South Asia and within South Asia, in one qualitative study, participants expressed the belief that violence against women was more prevalent in their Canadian community (Surrey) than in their countries of origin, India or Pakistan[84].

The study by Ahmad et al., also investigated the relationship between women's patriarchal beliefs and their perceptions of spousal abuse by asking participants to categorize a vignette about a woman experiencing IPV as abusive or non-abusive[81]. The researchers found that women who held stronger patriarchal beliefs were 97% less likely to categorize the vignette as abusive (OR = 0.03, p = 0.03; CI not provided). In comparing the perceptions of abuse among women who have experienced IPV versus those who have not experienced IPV, participants were asked to agree or disagree with statements such as "male violence against women is an issue in our community" and "female victims often lie or overexaggerate about domestic violence". Madden et al. found that there were no significant differences between the two groups, suggesting that the perceptions of IPV may not differ across survivors and non-survivors[54].

While Madden et al sought to examine the differences in perceptions of IPV between survivors and non-survivors[54], Ahmad et al. investigated whether perceptions of IPV differ across males and females[87]. They conducted an interpretation exercise within an existing concept mapping study. In the larger study, 67 eligible participants (32 women and 28 men) engaged in the Brainstorming and Sorting & Rating activities; among these participants, there were 12 SA women and 11 SA men. In the Brainstorming activity, participants were asked to answer the question "What are the behaviours or attitudes that would make up the part of the relationship characterized by severe conflict, abuse, excessive control, neglect or even violence?". In the subsequent Sorting & Rating activity, the 71 statements produced from the first activity were sorted into themes, rated for importance in defining IPV, and labelled by 71 participants of varying ethnicities (42 women and 29 men). Among these participants, there were 8 SA women and 12 SA men. The resulting product was a concept map, the individual concepts ("clusters") of which were labelled and interpreted by

11 SA participants (5 women and 6 men). Amongst all of the clusters, men and women only agreed entirely on the definitions of the "victim retaliation/victim response" cluster, suggesting that men and women may differ in their conceptions of most domains of IPV. One example of a cluster that was conceptualized differently was named "psychological control" by women and included behaviours such as keeping victim and children separated. On the other hand, men called this cluster "excessive control" and included behaviours such as controlling the victim's social contact. Similarly, while women named a cluster "emotional abuse", which included behaviours such as criticizing the victim, men named this cluster "verbal abuse", and it consisted of cursing at and name calling the victim. This differential conception of IPV amongst men and women is also demonstrated by the finding that women delineated 9 clusters, whereas men delineated 8 clusters.

Mason and colleagues qualitatively investigated the perceptions and experiences of immigrant Tamil women living in Toronto, Ontario[78]. The researchers reported that participants defined IPV very broadly, including, physical abuse, sexual abuse, psychological abuse, and financial abuse. In fact, financial abuse was frequently reported in the context of husbands sending money back home to their families in Sri Lanka to the detriment of their immediate family in Canada. Mason et al. investigated psychological abuse in greater depth than other types of abuse and found that participants grouped their experiences into three categories. In the first category, women identified *abuse related to specific social locations.* This category included the experiences of women who had been married to Tamil men in Canada, only to find out later that their partner had a pre-existing family in Sri Lanka. Along the same lines, some women reported that their husbands overstated their social status or made false promises while negotiating marriage contracts in order to obtain greater dowries, which was especially the case in arranged marriages. Women also reported that

they observed behaviours wherein their husband would discredit or verbally abuse the woman's family to hurt her. Thus, women experienced abuse at the social locations of their husband's family, dowry, or her own family. Still, they expressed feeling unable to leave these abusive situations due to the stigma associated with divorce in their community. They reported that divorced or separated women were ostracized, which further impacted their social role in their community. This view was also expressed by other participants, who further stated that abusive partners may try to take advantage of the fact that women are marginalized by divorce as a way of asserting control[84]. The second category, *abuse related to culturally specific expressions*, contained experiences such as husbands' extreme jealousy or suspicion about their wives' fidelity. In addition, participants observed that their husbands used extremely abusive language, which many pointed out were more painful to hear in Tamil than in English. Participants felt that the verbal, and hence, emotional abuse was far worse than physical abuse because it was not forgotten easily. Finally, participants identified the third category of abuse as having *culturally specific meanings*, such as burning of a woman's sari, and threatening to send their wives back to Sri Lanka. The researchers posited the cultural importance of the latter threat should be understood in the context of the Tsunami of 2004 (which took place only a year prior to these interviews) and the war-like conflict between the Sinhalese and the Tamil groups in Sri Lanka, making for an extremely unsafe situation back home.

That abuse can be understood differently in a cultural and religious context was further corroborated by Couture-Carron et al., in their investigation of the behaviours/actions in a dating relationship that might be understood differently by South Asian Muslim women[88]. This study recruited both South Asian Muslim men and women. The researchers identified five behaviours or

actions that South Asian Muslim women might interpret differently, including 1) exposure to parents/community, 2) sexual behaviours, 3) controlling behaviours, 4) psychological/emotional behaviours/abuse, and 5) verbal behaviours/abuse. Firstly, participants mentioned that dating abuse in the South Asian Muslim community can occur when a boyfriend threatens to tell a woman's parents about the relationship in exchange for something he desires, such as sex. Although the threat of exposure of a secret relationship to a partner's parents can occur in any community, it is particularly harmful to women in the South Asian Muslim community due to the cultural and religious value ascribed to women's purity. Being in a relationship, and furthermore, engaging in sexual activity prior to marriage, is strictly forbidden in Islam, and therefore, dating relationships must be kept secret from the parents and the community at large. Exposure of the relationship can have dire consequences on the woman, her family and their social status, and her social prospects in the community, whether in terms of her marriage or that of her siblings and other family members. Thus, exposing not only a relationship, but a sexual relationship, to a woman's parents can be used as blackmail. The consequences of exposing a sexual relationship for a Muslim woman are so dire that some participants mentioned that they would feel hesitant to disclose a sexual assault to their parents due to the embarrassment that might ensue. Additionally, South Asian Muslim women and men reported that females in their community had greater tolerance for controlling behaviours, psychological abuse, and verbal abuse since the traits of loyalty and obedience are instilled within them at a young age. In comparison, they expressed the belief that "white" women would not respond as positively to controlling behaviours. In one example, a participant mentioned that if her boyfriend asked her not to wear certain clothing or to wear the hijab, she would consider this controlling behaviour not abusive (so as long as he was not verbally abusive), rather she would believe he was asking her to "cover up" to protect her social

image. Hence, the social value ascribed to a women's' behaviours permeates their decision to have a secret relationship and their tolerance of behaviours that individuals from other cultures might otherwise find abusive. Similar to the experiences of immigrant Tamil women, participants in this study agreed that, firstly, verbal and psychological abuse was more painful than physical abuse due to its permanence and potential to rapidly worsen. Secondly, they also agreed that verbal insults in their native language were more hurtful than in English, illustrating that perceptions of IPV are nuanced both culturally and linguistically. This was the only study that investigated dating violence amongst South Asian women in Canada.

Outcomes

Guruge et al. investigated the association between exposure to violence and mental and physical health through a cross-sectional survey administered to a convenience sample of 30 immigrant and refugee Tamil women[85]. Although they found no statistically significant associations, some important trends were identified. For instance, 60% of women reported their overall health as good to excellent, even though 37% of them reported experiencing physical problems that limited their daily activities and 40% reported experiencing moderate to severe pain, all in the past four weeks. Additionally, 60% of women reported having little to no energy, also in the past four weeks. In terms of mental health, 33% of participants reported mental health symptoms in the past month and high rates of recurrent nightmares, feeling jumpy and startled, feeling scared, trouble sleeping, feeling fearful about things, and spells of terror or panic. One of these 30 women had reported thoughts of committing suicide in the past week, and 10% had reported attempting suicide in their lifetime. The relationship between exposure to violence and physical and mental health was also seen in the qualitative study conducted by Ahmad et al. where all of the women in the study (n=11)

had frequent contacts with their family physician for mental or physical health issues or psychosomatic complaints[90]. Guruge et al. proposed several reasons for the lack of significant association between exposure to violence and physical and mental health[85]. For instance, the correlations were investigated for all participants in the study (the study also contained a sample of 30 immigrant and refugee Iranian women) rather than only Tamil women. In addition, this study recruited a convenience sample of women which may have excluded women with histories of abuse. The study was underpowered in the ability to detect significant associations between IPV exposure and health problems.

Coping Strategies

Kanagaratnam et al. investigated coping strategies employed by Tamil women in abusive relationships and found that strategies could broadly be divided into passive or emotion-based coping, and active-coping, which is aimed at making a change in a relationship[80]. The passive strategies were self-blaming, relying on faith, diverting the mind, normalizing abuse, endurance, and being strategic. Self-blaming strategies involved trying to better understand the abusive partner's behaviour and modify their actions to avoid incurring abuse. Women also relied on faith or religious beliefs to cope with distress and provide confidence, but they identified that this strategy could do little to fix the situation. Participants identified social and engaging activities to help divert the mind from abuse, such as, going to the temple and participating in hobbies. Some participants also expressed the belief about accepting abuse as a normal part of every relationship (normalizing abuse) and being patient enough to endure violence, since it is the duty of a woman to carry the marriage until her death (endurance). The final passive coping strategy mentioned was to avoid putting oneself in a situation where violence could ensue, such as not arguing with your

partner right after he comes home from work. The active coping strategies were gaining independence, obtaining a separation, seeking treatment for the abusive spouse, and obtaining professional help. Women expressed the belief that in order to lead independent and self-sufficient lives apart from their abusive partners, they must learn basic skills, such as banking, which could make the transition from marriage to separation easier. In addition, participants mentioned that it is the woman's responsibility to get professional help for her husband who might have other illnesses, such as alcoholism or drug addictions, that could lead to the violence. Finally, women suggested seeking professional help for IPV, but there were concerns about this approach related to the belief expressed that engaging professional help often led to separation/divorce or further deterioration of the relationship. Women were also hesitant to seek help due to the shame associated with disclosing exposure to abuse, and sexual abuse in particular. Hence, they expressed the opinion that women should seek help when they are at their breaking point and are sure that they would like to be separated.

In addition to coping strategies, Ahmad et al investigated resilience and help-seeking amongst a sample of 11 SA women through in-depth qualitative interviews and found that IPV survivors sought resources at the micro, meso, and macro levels, owing credence to the socioecological model of IPV[86]. The researchers identified 5 themes: 1) resources before the turning-point (the decision to take steps to change their status from victim to survivor), 2) resources after the turning-point, 3) transformations in self, 4) adapted social networks, and 5) being an immigrant. Before the turning-point, women reportedly relied on their willpower, friends and family, and children to reach the point at which they wanted to take steps to change or leave the relationship. After the turning point, women described relying on the continuation of support from their family and

friends, their belief in God, and professional support. Across these sources of support, women expressed the view that they were able to draw both material and moral support. Participants also discussed how they were transformed both in terms of their individual self, by experiencing positive psychological changes and by engaging in new activities, and also in their collective self, by enriching their relationships with other people who are significant in their lives. While still surviving abuse, women restricted their social network to avoid questioning or feeling embarrassed; however, after changing or leaving the abusive relationship, participants reported expanding their networks and rebuilding connections with people they felt they could trust. Finally, women referred to their status as an immigrant to Canada as central to their exposure to gender equality, through laws, increased social and police support, and school curriculum on healthy relationships. However, they also expressed the desire to have been better aware of their rights when they came to Canada, which could have facilitated better access to a range of health and social services, including IPV shelter or advocacy resources.

Help-Seeking

To better understand when and why women seek help for IPV, Ahmad et al. investigated reasons that survivors of IPV might delaying seeking help[83]. They generated a conceptual model that cuts across three key themes in their findings including 1) the reasons for the delay, 2) turning points, and 3) talking to professionals. The researchers found that socio-cultural and immigration factors, rather than individual characteristics, play a more important role in deciding to delay seeking help for IPV. Participants reported that a key reason for delaying help-seeking was due to the social stigma associated with disclosing experiencing IPV, which further affected the status and honour of their parents and of their families at large. In addition, women reported that they delayed seeking

help for abuse because they were conditioned to be subordinate and obedient, and they were taught, from a young age, that the responsibility to keep the family together rests on the shoulders of the woman. Additionally, they were concerned about the wellbeing of their children in a single-parent household and not having the financial means to support their children if separation ensued. They also reflected on the loss of social support that occurred as a result of immigration to Canada, and the further loss that could occur if they were to separate from their husbands. Other barriers to help-seeking included having limited knowledge about existing resources and lack of awareness and falling into the trap of believing common myths about male-perpetrated IPV. For instance, participants cautioned that women should not believe that alcohol misuse is the sole reason for violence or have unreserved optimism that their husband will improve his behaviour. When women overcame the reasons for the delay in seeking help, they first turned to coping methods similar to the participants in the study conducted by Kanagaratnam et al. These included trying to normalize and tolerate the abuse, praying to God, sacrificing themselves, and use of self-blame to meet the cultural and societal expectations of their husband[80]. However, when participants "hit rock bottom" and could no longer endure the psychosocial consequences of continuing to tolerate abuse for them and their children, they sought help. The inclination to wait to seek help until they were at their breaking point was also expressed by participants in the study conducted by Kanagaratnam et al.[80]

Role of Professionals

In the study conducted by Ahmad et al[83]., women reported that they most often disclosed their experiences of violence when they were explicitly asked by a family physician or an emergency physician at the hospital, and only did so after a major crisis. Very few women self-disclosed to

police or counselors. Participants felt that certain attributes held by family doctors and other professionals helped facilitate conversations about IPV. These included being trustworthy, having a non-judgmental attitude, being a friendly listener, and having a cross cultural understanding of relationships and IPV. Some participants stressed the need for physicians to provide timely referrals to mental health professionals; in this way, participants felt that physicians can help dispel the stigma that surrounds mental health in the South Asian community. In the studies by Janssen et al. and Ahmad et al., participants voiced their preference for a female and culturally concordant family physician, since they expressed feeling apprehensive about approaching mainstream (non-ethnic) physicians due to their status as ethnic minorities. However, participants in the study conducted by Janssen et al. did not believe that being a South Asian healthcare provider was sufficient to ensure cultural competence[84]. Further information about what factors are associated with cultural competence was not provided. Both groups of women also agreed that family physicians and obstetrical providers should routinely inquire about IPV when they are alone with the woman. Most women in the study conducted by Ahmed et al. were critical of the view that involving the physician might lead to divorce or deterioration of the relationship if the physician were to call the husband. However, this concern was noted amongst participants in the study conducted by Kanagaratnam et al. and Janssen at al.; in the latter, women expressed the worry that clinical administrative staff might share information that could make their family aware of their help-seeking.

In terms of social services, women expressed being deeply grateful for their existence and reported that access to IPV services in Canada is much greater in comparison to their country of origin. They also emphasized the importance of having culturally congruent services. They recommended

this could be accomplished through the increased availability of interpreters in both clinical and social service settings. Other participants suggested that certified interpreters should be used, because, although interpreters might understand the women's language very well, they may not be able to effectively translate it in English for the care provider[84].

Only one study inquired into the nature of prevention and educational materials preferred by this population[84]. Janssen et al. report that participants encouraged messaging that was subtle, such as a poster in a family physician's office, but that most conversations should take place on a one-on-one basis with the survivor. Thus, a private clinical setting was the ideal place to routinely enquire about abuse in the home, distribute information, and provide referrals for both survivors and perpetrators. Apart from the clinical setting, community-based interventions could take the form of linguistically appropriate advertisements on radio and TV.

Two studies examined the role of policy and advocacy in shaping help-seeking for IPV. In the study conducted by Janssen et al., participants reported that physicians can advocate for policies that support family violence interventions by electing officials who support its implementation and challenging those who may have incorrect conceptions of IPV[84]. They also suggested that physicians should advocate for culturally and linguistically appropriate services, such as a Punjabi-language crisis line and pamphlets in various South Asian languages. Lastly, they recommended that physicians should be aware of appropriate referrals that would be especially helpful for immigrant women (i.e. English language classes, job training), being mindful of their limitations with regards to technology (i.e. internet-based forms, automated telephone helplines). In terms of policy, Shirwadkar conducted an analysis that contrasts the aims of current domestic violence

policies and the barriers that immigrant Indian women face when reaping the benefits of these policies[82]. Examples of such policies are those put forward by Canada Mortgage and Housing Corporation (CMHC), which offer subsidized housing to women who are survivors of domestic violence. Eighty percent of the beneficiaries of these policies are Canadian-born, and the participants for this study (both service providers and survivors of IPV) agree that, subsidized housing, in general, does not align with the values of the Indian immigrant community. Instead, women would prefer to purchase a place of their own. In addition, Indian women feared that by opting to live in subsidized housing or shelters, they may be exposed to the "loose Western morals" of which they are fearful, such as drug use and racist discrimination. In addition, by removing women from their current situation, they may lose social support, which may be further compounded due to the stigma associated with separation or divorce. Shirwardkar explained that, for these reasons, many Indian immigrant women may have failed to experience the benefits of Canadian policies, and that future policies should create awareness of abuse within the Indian immigrant communities, establish networks of culturally appropriate services, and focus on providing social support without isolating the woman[82].

Limitations

The studies in this review have several limitations. Firstly, the prevalence estimates were based on relatively small sample sizes. In addition, the largest study with a sample of 188 women was based on a predominantly English and Punjabi-speaking population[54]. However, there are many more South Asian cultures that were likely not included in this convenience sample and hence this prevalence rate cannot be generalized to the Canadian South Asian population as a whole. Furthermore, none of the qualitative studies included in this review had a clear description of the

specific qualitative methodology being used. Although they reported using "thematic analysis" or "content analysis", these are methods of analysis, rather than theoretical approaches. Thus, there was a lack of congruence in the type of question being posed, the data collection method, and the analysis used, which compromises the trustworthiness of the data. In addition to the methodological limitations of these studies, it is important to note that there were only 12 studies eligible for inclusion in this review. This illustrates the paucity of research about IPV amongst South Asian women outside of South Asia, and more specifically in Canada. Even within this small number of articles, there is considerable heterogeneity in terms of qualitative and quantitative methodology, the specific South Asian population sampled, and method of analysis. This heterogeneity precludes meaningful interpretation.

Future research should focus on systematically characterizing and mapping the literature to better understand the heterogenous nature of the research that has been conducted on IPV amongst South Asian populations. Given that there were very few articles when the geographic scope was limited to Canada, as in the case of the present review, this summary should focus on literature on IPV amongst South Asian women living outside of South Asia. In this way, the goal of role of immigrant and/or ethnic minority status can be ascertained while expanding the number of articles eligible for review. Secondly, in order to contribute to the paucity of Canadian literature in this field, future research should use appropriate and robust methodologies to better understand the risk factors, perceptions, experiences, impacts, and help-seeking behaviours with regards to IPV amongst South Asians in Canada. In order to improve the quality of qualitative studies conducted in this field, future research should employ clear theoretical approaches that are congruent with the research question, data collection methods, and methods of analysis. Future research should

also investigate factors that might protect against IPV in this population, including the role of physicians and other clinicians in addressing IPV, which both represent topics that were seldom addressed in the current literature. In addition, since first-generation immigrant populations are overrepresented in the current body of literature, future investigations should also include second-generation South Asian immigrants and beyond.

Chapter 3: Scoping Review

The purpose of this chapter is to discuss the objectives, rationale, methodology, and results of the scoping review which was undertaken to better understand the body of research on IPV amongst South Asians living outside of South Asia.

Introduction

This scoping review was undertaken in order to systematically identify, characterize, and map the IPV literature to date in a population of South Asian women living outside of South Asia. The initial plan to conduct a scoping review was based on the lack of review literature about IPV in this population. While several reviews were found which summarized the data of South Asians living within South Asia (especially those conducted by the WHO)[47], this was not true of South Asians residing outside of South Asia. To this extent, only three reviews were identified that included studies with this population of interest. The first review, conducted by Finfgeld-Connett et al. only included qualitative or mixed method studies that recruited participants in Canada, England, and the United States, and was conducted in 2013[91]. The purpose of this systematic review was to describe the experiences in help seeking. However, there are several other dimensions of the IPV literature, such as prevalence studies, screening tool validation studies, knowledge and attitudes investigations, and intervention studies, for example, that have not yet been synthesized in this population. Secondly, the review conducted by Okeke-Ihejirika et al., as described extensively in Chapter 2, was limited to Canadian literature and included studies conducted with multiple immigrant groups[41]. Finally, the review conducted by Kim et al. on IPV amongst Asian communities in America was limited to the USA, and their search was focused on individuals who had immigrated from East Asian countries[92]. The only South Asian group

represented in their search strategy were Indians. There is a need for review literature that summarizes the IPV literature across a broader range of countries outside of South Asia, highlights aspects of IPV apart from help-seeking, captures the literature on South Asian groups separate from other cultural groups, and includes all South Asian ethnicities.

The need to better understand the IPV literature with regards to this population was further emphasized through the heterogenous nature of the studies that were included in the literature review in Chapter 2. As was mentioned earlier, the diversity in methodology, sampling, and interpretation preclude meaningful a meta-interpretation of the data. In addition to an overall paucity of research, the literature review also identified some specific research gaps. For example, these included research on factors that might protect against IPV victimization and the role of clinicians in addressing IPV. These gaps, and others, need to be identified, in order to guide future research. To this extent, a scoping review is well suited to characterize and map the current state of the diverse literature and identify important research gaps.

A scoping review, rather than a systematic review or meta-analysis, was conducted in order to understand the body of literature more generally, as opposed to answering a specific research question, although an overarching research question was established to focus the review process. According to the guidance put forth by Munn and colleagues, the indications for conducting a systematic review include uncovering international evidence, confirming current practice/addressing variations in practice/identifying new practices, identifying and informing areas for new research, identifying and investigating conflicting results, or producing statements to guide decision-making[93]. Conversely, the indications for conducting a scoping review are to

identify the types of available evidence in a field, to clarify key concepts/ definitions in the literature, to examine how research is conducted on a certain topic or field, to identify key characteristics or factors related to a concept, and to identify and analyse knowledge gaps. Thus, a scoping review was conducted due to the lack of updated scoping reviews regarding IPV in a population of South Asian women residing outside of South Asia and the methodological heterogeneity in the research conducted with this population. These two factors precluded conducting a systematic review or meta-analysis, both of which typically require an appreciable quantity of research and some consistency in data such that they are amenable to pooling. Thus, a scoping review was conducted to understand the IPV literature in this population more broadly, rather than to answer a granular research question. A narrative review or literature review was not conducted as the purpose of this exploratory work was intended to be analytical and comprehensive, with a clear, pre-established protocol[94].

Methods

The primary scoping review framework outlined by Arksey and O'Malley in 2005[95], then advanced by Levac et al. in 2010[96] was used for this project. The original 5-stage framework provided initial methodological guidance for conducting the scoping review. The stages include: (1) identifying the research question, (2) identifying relevant studies, (3) selecting the studies, (4) charting the data, and (5) collating, summarizing, and reporting the results. Levac et al. advanced this methodology by adding specific recommendations to each step of the original framework, based on their experiences in conducting scoping reviews in the field of rehabilitation science. This served to clarify the original framework and improve its application in the field of clinical

and health research. A description of this enhanced framework, the methodological decisions, and steps taken at each stage of the framework are detailed below.

Stage 1: Identifying the Research Question

Arksey and O'Malley state that the formulation of the research question requires a critical consideration of the parameters and definitions of the terms used in the question. These definitions should occupy a middle ground between being wide enough such that it sufficiently captures a wide range of articles, but not so broad that the number of articles is unmanageable. Levac et al. further recommend that purpose of the scoping study should be mutually considered with the research question.

The research question was: *What is known from the existing literature about intimate partner violence amongst South Asian women residing outside of South Asia?* IPV was defined using the definition from the WHO. This definition was used in lieu of the definition offered by the CDC since it explicitly mentions emotional abuse as a form of IPV rather than considering it a form of psychological aggression. South Asian women were defined as women who are ethnically from the Indian subcontinent, defined by the WHO as people from India, Pakistan, Bhutan, Bangladesh, Sri Lanka, Nepal, and the Maldives. Hence, *outside* was defined as regions other than the South Asian countries. The definition of the term *women* was based on self-identification, or study definition. The term *residing* was used to indicate that the study included women of South Asian origin who were not currently living in South Asia, but this term was not restricted otherwise. For instance, there was no specification about status (i.e. citizen, permanent resident, immigrant,

second-generation, etc.) since it was anticipated that the literature in this population was already limited.

Stage 2: Identifying Relevant Studies

In this stage, Arksey and O'Malley recommend the comprehensive searching of relevant sources such as electronic databases, reference lists, hand-searching of key journals, and through existing networks (i.e. conferences), with consideration of timespan and language constraints. Levac et al. additionally recommend that the research question and purpose should guide the aforementioned considerations, and that the limitations of each decision should be considered and stated. They also recommend that, at this stage, a team of individuals with content and methodological expertise should be formed for successful completion of the study.

The following databases were searched: CINAHL (Cumulative Index of Nursing and Allied Health Literature), EMBASE, MedLINE, and PsychINFO. Grey literature was searched through Open Grey, a repository of unpublished literature in Europe. These databases were decided upon consultation with a Research Librarian at McMaster University Health Sciences Library, who additionally assisted with developing relevant search terms specific to each database. Although the full search strategies for each database is available in Appendix 1, the general search terms included "intimate partner violence", "domestic violence", "violence against women", and "South Asian". It should be noted that because domestic violence is a wider term, which includes IPV, domestic violence is used to refer to IPV. In order to capture all relevant IPV literature, both terms were included in the search strategy, then articles were screened to ensure that the focus of the article was on IPV.

In addition to electronic databases, reviewers were instructed to hand-search the reference lists of review articles that were captured in the search for eligible studies. The reference lists of secondary articles that were identified in the literature review were also screened. Additional care was undertaken to ensure that relevant articles were identified; this included following key authors in this field on social media platforms (i.e. Twitter) and monitoring for new publications. For relevance, only studies published after 2000 until May 21, 2020, inclusively, were included. Other restrictions were not placed on publication date since the focus of this review is already on a very specific population, which would likely result in a smaller number of citations. However, only English articles were selected for review since the budget of this graduate thesis did not permit hiring a translator. The research team was comprised of experts in IPV, family violence, and health research methodology.

Stage 3: Selection of Studies

There is considerable disagreement between the methods proposed by Arksey and O'Malley as compared to Levac et al. at this third stage. Although both authors suggest that articles should be independently screened for inclusion by two reviewers, the two differ in terms of their recommendations regarding the establishment of inclusion and exclusion criteria. While Arksey and O'Malley suggest that the eligibility criteria can be established post-hoc after an initial perusal of the literature, Levac et al. recommend that the criteria are determined using an iterative process. Specifically, this requires that the team members establish preliminary criteria, then continually update the study strategy as reviewers undergo the abstract review process. They additionally recommend that a third reviewer settles any conflicts regarding study inclusion. For this review,

the approach proposed by Levac et al. was used, since most criteria surrounding population and setting could be established a priori, without requiring an initial perusal of the literature.

For the present review, two reviewers, who were familiar with systematic review methods, were recruited to independently screen the articles for inclusion. A third reviewer, the primary researcher, was tasked with resolving disputes. Prior to perusing the literature, the inclusion and exclusion criteria were decided based on the intended purpose of the study. The inclusion criteria consisted of primary research studies that (1) had IPV as their main research focus and (2) recruited South Asian women or service providers to South Asian women. The exclusion criteria consisted of studies that (1) only recruited participants who reside in South Asia or (2) were not peer-reviewed. These criteria were chosen to reflect the population of interest with maximal sensitivity. It was expected that some articles may include both women and their male partners, or report on ethnic minorities collectively; in an effort to maximize the number of studies (and hence, data) these aforementioned studies were included, although the indirectness of this evidence was acknowledged a priori. The three reviewers met to discuss the appropriateness of these criteria at three separate intervals during the title and abstract screening phase: at 33% completion, 66% completion, and 100% completion. It was decided that changes to the search strategy and/or eligibility criteria were not required. The screening and data abstraction were conducted using the web-based software systematic review platform, Covidence (Covidence Org., Veritas Health Innovation Ltd, Victoria, Australia). The citations, abstracts, and full texts of eligible studies were subsequently exported onto Microsoft Excel (Microsoft Corp., Seattle, WA, USA) software for data charting.

Stage 4: Charting the Data

The recommendations of Arksey and O'Malley suggest that the following data should be extracted: authors, year of publication, journal, study location, aims of the study, methodology, outcome measures, and important results. Levac et al. further suggest that the research team should meet collectively to design the data abstraction form, but that this should be an iterative process where researchers continue to refine the form as data are collected and extracted, and vice versa.

For this study, in addition to collecting basic study information, the data collection form was designed using a thematic approach, rather than identifying specific variables to extract due to the broad nature of the original research question. These themes were identified by the larger research team as key to understanding IPV amongst SA women residing outside of South Asia. These themes were (1) prevalence; (2) perceptions, experiences, and coping; (3) impacts; (4) prevention practices; (5) help seeking; (6) risk and protective factors; and (7) service providers. In accordance with the recommendations put forth by Levac et al, data were abstracted independently by two reviewers who were familiar with IPV research. The data abstractors continually reflected on the data collection fields as the data were abstracted, which resulted in the addition of a field regarding country of origin, to capture the distribution of South Asian countries from which participants originated in the body of research. Journals were categorized according to subject area and category obtained from Scimago Country and Journal Rank. The data extraction form is included in Appendix 2.

Stage 5: Collating, Summarizing, and Reporting the Results

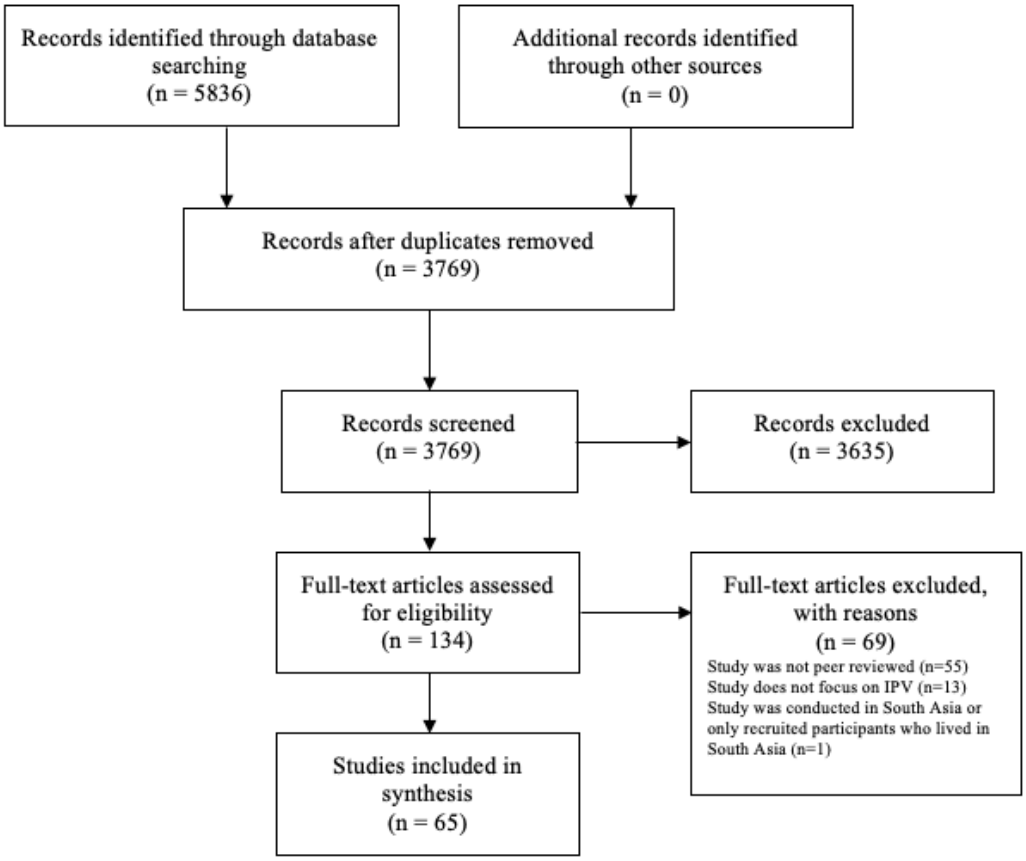
Arksey and O'Malley recommend that, at this stage, considerations about how to present all reviewed data should be made. For instance, a numerical summary of the descriptive data should be provided and supplemented with a qualitative thematic analysis. Levac et al. further recommend that the meanings of the findings should be used to discuss implications on policy, practice, and further research.

For this review, data on methodology and study location were planned to be presented as numerical descriptive summaries via counts and percentages. Additionally, with some anticipated overlap, studies were sorted into thematic categories, and subsequently reported as a narrative qualitative analysis. Where studies thematically overlapped, they were considered for inclusion in both categories. The relative number of studies in each of the thematic categories was used to determine the current research focus of the field and suggest areas for further research. Recommendations or implications of this research on policy and practice were not critically considered since the quality of the studies was not assessed. The results were reported in accordance with Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR) Checklist.

Results

The search identified 5836 studies. Following de-duplication, 3769 studies remained. Of these, 3635 studies were judged to be irrelevant based on subject matter (i.e. the study was not about IPV). 134 full texts were reviewed for eligibility and ultimately, 64 studies were included in this review. The flow diagram for including studies is available in **Figure 2.**

Figure 2. PRISMA flow diagram for study inclusion.

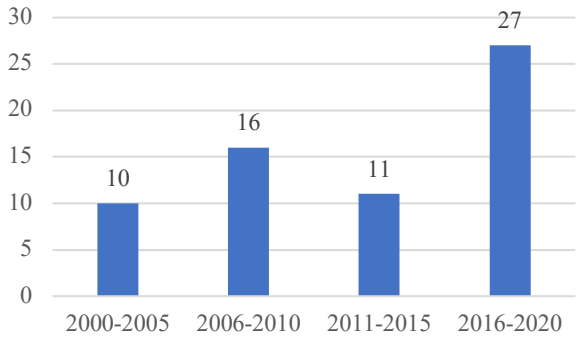


Study Characteristics

The majority of studies were conducted in the United States of America (USA; 53%, n=34). The remainder were conducted in Canada (19%, n=12), United Kingdom (UK; 13%, n=8), Hong Kong (11%, n=7), Germany (2%, n=1), and Italy (2%, n=1). One additional study (2%) recruited participants from both the UK and the USA; this was the only study that was conducted across more than one non-South Asian country. Only one study (2%) recruited participants from a South Asian country, in addition to participants from a non-South Asian country. This study compared a sample of women from USA and India. The majority of studies were published in either women's

health, IPV, or family violence journals (34.5%, n=22) or social science journals (34.5%, n=22). Others were published in medical journals (23%, n=15), nursing journals (3%, n=2), policy/legal journals (3%, n=2), and 1 study (2%) was published in SpringerPlus, a multi-disciplinary journal, which was not able to be characterized as any of the above. Year of publication was examined in five-year periods starting from the year 2000. The number of studies published in each five-year period from 2000 to 2020 are reported in **Figure 3**. 16% (n=10) of all studies were published between the year 2000 to 2005, 25% (n=16) were published between 2006 to 2010, 17% (n=11) were published between 2011 and 2015, and majority (42%, n=27) were published between 2016 and 2020.

Figure 3. Number of Studies Published in 5-year periods from 2000 to 2020.



Study Design and Methodological Characteristics

The majority of studies (66%) employed qualitative research methods (n=42), followed by 25% of studies which used quantitative methods (n=16), and 9% of studies used mixed methods (n=6). Only 39% of studies (n=25) included a description of the study methodology. Of these studies, one was a concept-mapping study, 21 were cross-sectional studies, four used grounded theory methodology, and two were qualitative ethnographies. This total does not amount to 25 since some were mixed-method studies that employed multiple methodologies. All quantitative studies

included a description of their methodology, while only 14% (n=6) of qualitative studies included in this review included a description of the specific qualitative tradition that was used in the study. With regards to data collection, 69% (n=44) of studies involved interviews or focus groups, 30% (n=19) involved surveys, and 1% (n=1) used concept maps. IPV screening or exposure tools were used in 22% of studies (n=14). Among these studies, the most commonly used tool was the Conflict Tactics Scale used in 50% of studies (n=7), followed by the Woman Abuse Screening Tool used in 15% of studies (n=2), and the Index of Spouse Abuse used in 7% of studies (n=1). Other studies used screening questions adapted from other surveys, as in the case of some studies which used questions from the Behavioural Risk Factor Surveillance System to determine exposure to IPV (21%, n=3). In addition, 1 study (7%) validated the South Asian Violence Screen, a tool newly developed by the researchers. Most studies were conducted in a community setting, typically within women's agencies (91%, n=58). Six percent of studies recruited participants from both the clinical and community setting (n=4), while 3% (n=2) studies exclusively recruited participants from a clinical environment. Of the six studies which recruited participants from clinical settings, 50% recruited from mental health clinics (n=3), 17% recruited from obstetrical wards (n=1), and 33% recruited from general medical clinics (n=2).

Population Characteristics

Population characteristics were examined in studies that did not exclusively recruit providers of IPV services (i.e. counsellors, police, clinicians), which altogether represented 11% of studies (n=7). In the remaining 57 studies, 53% of studies (n=30) exclusively recruited women who had experienced IPV, while the remainder included all women, regardless of their IPV history. Within these 57 studies, 97% (n=55) provided information on the immigration status of the participants.

To this effect, 55% of studies (n=30) exclusively recruited first-generation South Asian immigrant women. However, not all studies exclusively recruited women; 9% also included men (n=5). Only 1 of these studies explicitly compared men and women in their sample. Information on South Asian nationality or participants' country of origin was available in 81% of studies (n=52). The represented South Asian countries included India (n=45), Pakistan (n=37), Bangladesh (n=26), Nepal (n=14), Sri Lanka (n=9), and Bhutan (n=1). The studies included in this review did not include participants from the Maldives. Six percent of studies, which were typically comparative in nature, also included participants from other ethnic groups (n=4). These groups were equally distributed between participants who identified as Caribbean, Hispanic, Black, Iranian, Egyptian, and Moroccan.

Themes

The 64 included studies represented five of seven pre-determined outcome themes. These were: help-seeking (n=28); perceptions, experiences, and coping (n=23); risk or protective factors and correlates of IPV (n=21); prevalence (n=12); and service providers (n=11). None of the studies included in this review were categorized under the themes of "prevention of IPV" or "impacts of IPV exposure". The characteristics of studies included within each theme are discussed further here. The sum of some categories does not amount to the total number of studies in the corresponding theme since some studies were found to belong to more than one category.

Perceptions, Experiences, and Coping: Studies were categorized under this theme if the study objective or outcome focused on individuals' perspectives, attitudes, and behaviours with regards to IPV (perceptions) or lived experiences with IPV, including strategies or perceptions around

coping. Several studies that were characterized into the "coping" sub-theme were cross-categorized into the "help-seeking" subtheme, since many studies evaluated the transition from utilizing coping strategies (i.e. prayer, meditation) to seeking formal or informal help for IPV. Of the 23 studies categorized under this theme, the majority focused on experiences (n=14), followed by coping (n=7), and perceptions of IPV (n=5). All 14 studies that examined women's experiences with IPV used qualitative research methodologies; however, only one specified the use of grounded theory methodology. While the remainder did not specify the qualitative tradition that was used, they specified the use of content or narrative analysis to analyse participants' experiences. Two studies quantitatively assessed the perceptions of IPV amongst South Asian women by using vignettes (n=1) that participants characterized as abusive or non-abusive, or statements (n=1) that participants were required to categorize into IPV subtypes (i.e. sexual, emotional). Of the seven studies that investigated coping, few used a guiding framework to characterize women's perceptions or experiences with coping (n=3). These included frameworks that outline the transition between coping and help-seeking (n=2), and emotional versus problem focused coping frameworks (n=1).

Prevalence: Studies were categorized under the theme of "prevalence" if they determined a prevalence rate for IPV, or a subtype of IPV, within the study sample. Of 12 studies that were categorized under this theme, 75% (n=9) were conducted in the USA and 25% (n=3) were conducted in Canada. 83% (n=10) studies calculated a community prevalence rate, whereas the prevalence estimates in 17% (n=2) of studies was based on a combined clinical and community sample. Most commonly, prevalence was estimated for all types of IPV (n=12), followed by physical IPV (n=11), emotional IPV (n=7), and sexual IPV (n=6). Some studies also reported a

prevalence rate for a non-physical IPV composite measure, which included emotional, psychological, and/or financial IPV (n=2). The duration of IPV prevalence that was reported in the included studies was largely within the current relationship (n=6). Some studies also reported past year (n=4) or lifetime prevalence (n=3). The most commonly used instrument to measure IPV was the Conflict Tactics Scale (n=4), followed by the Woman Abuse Screening Tool (n=2), the Behavioural Risk Factor Surveillance System (n=2), the Index of Spouse Abuse (n=1), and the South Asian Violence Screen (n=1). Some studies did not use a validated tool to assess for IPV exposure, and instead used independently developed survey questions (n=2). Most studies utilized a random sample (n=7), followed by a convenience sample (n=6) and snowball sample (n=4) of participants.

Risk/Protective Factors and Correlates of IPV: Studies were categorized under the theme of "risk/protective factors and correlates of IPV" if the aim or outcome of the study assessed the relationship, whether qualitatively or quantitatively, between some factor and the occurrence of IPV. Most studies examined specific risk factors (n=24) while a minority of studies investigated risk factors, or perception of risk factors, in general (n=3). Of the studies that examined specific risk factors, most examined either the association of beliefs about patriarchy and gender roles (n=6) or culture (n=6), with IPV. Other factors that were studied included immigration (n=4), attitudes towards IPV (n=2), isolation (n=1), and shame (n=1). Although some studies claimed to assess health outcomes, their cross-sectional nature precluded conclusions about temporality. As such, some studies quantitatively examined the statistical association between IPV and health (n=3), more specifically with physical (n=1), sexual (n=1), and mental (n=1) health.

Help-seeking: Twenty-eight studies were categorized under the "help-seeking" theme since the study aims or outcomes identified help-seeking experiences, behaviours, or attitudes, in addition to factors that may facilitate or preclude a woman from seeking help for IPV. Several studies were categorized into this theme since they examined help-seeking behaviours as part of asking about IPV, and hence, were cross-classified in the "Perceptions, Experiences, and Coping" theme. However, half of these studies (n=14) explicitly sought to investigate help-seeking amongst this population. Of these, 43% of studies investigated experiences, attitudes, or behaviours associated with help-seeking (n=6) and 43% of studies investigated factors that influence help-seeking (n=6), followed by 14% which studied sources of resilience (n=2). Most studies qualitatively assessed help-seeking in this population (n=10), and five cross-sectional studies investigated factors that influence help-seeking (n=3) or help-seeking experiences/behaviours (n=2). The total of these studies is 15 since one was a mixed-methods study. Amongst the quantitative studies, the factors most commonly assessed for their association with help-seeking for IPV were social support (n=3) and acculturation (n=3), followed by patriarchal beliefs (n=2) and isolation (n=2), IPV attitudes (n=1), stigma associated with receiving help (n=1), and ties to one's spouse (n=1). Amongst all five quantitative studies, help-seeking was measured using Likert scales that indicated likelihood/frequency of, or satisfaction with, accessing a certain formal or informal source of support.

Service Provider: Studies were categorised under the theme of "service provider" if the study sample included professionals who serve South Asian women who have experienced IPV. Sub-themes that were represented across the 11 studies included in this category included the experiences or perspectives of professionals who assist women who have experienced IPV (n=7),

followed by issues surrounding access to services (n=3), and recommendations for changing practice (n=1). Amongst various IPV service providers, studies most often recruited social workers or IPV advocates (n=8), followed by physicians (n=2), police (n=2), therapists (n=1), political officials (n=1), and lawyers (n=1). The breadth of the physicians represented in this category include psychiatrists, gynaecologists, emergency physicians, and general practitioners. Most studies within this category exclusively recruited providers of IPV services (n=7) while some studies recruited both South Asian women and their providers (n=4). All studies were qualitative and used focus groups or interviews (n=10) and surveys (n=1) to assess the perspectives of IPV care providers.

Conclusion

This scoping review represents a comprehensive overview of the literature on IPV amongst South Asian populations living outside of South Asia. This review included 64 peer-reviewed studies that focused on IPV and that recruited South Asian women living outside of South Asia, or their service providers for IPV. This work builds on the reviews conducted by Kim et al.[92], who reviewed the IPV literature amongst Asian communities in the USA, and the scoping review by Okeke-Ijerika and colleagues, who reviewed the same amongst immigrant groups in Canada[41]. It also enhances the reviews conducted on IPV amongst South Asian groups, in particular. These studies include a systematic review by Finfgeld-Connett et al., who studied help-seeking behaviours amongst South Asian groups in England, Canada, and the USA[91]. Building on this evidence base, this scoping review identified, characterized, and mapped the literature amongst South Asian populations living outside of South Asia. Another goal of this study was to identify gaps and limitations in the reviewed body of literature. They are discussed in detail in Chapter 5.

Chapter 4: Qualitative Descriptive Study

This chapter provides the reader with a description of the methods and key findings from the qualitative descriptive study conducted. Then the results from the scoping review and this study will be discussed in Chapter 5.

Objectives

The objective of this qualitative descriptive study was to explore how South Asian women in Ontario understand and perceive women's experiences of IPV within the context of their South Asian community. The primary rationale for this study is driven by the need to better understand the finding that only 1.74% of participants in the START study reported experiencing IPV. This exploration is best accomplished by qualitative, as opposed to quantitative, research methodology, since a qualitative study enabled the investigation of perceptions and experiences, which underscore behaviours such as reporting, or its lack thereof. Other limitations identified in the current Canadian body of literature on IPV amongst South Asians include a paucity of research on the factors that may protect against IPV, the role of clinicians in addressing IPV, and the overrepresentation of first-generation immigrants in the sample, which consequentially has created a large research focus on IPV and immigration. Additionally, there were no studies that explicitly examined IPV amongst a population of South Asian women who were also mothers. It is important to study IPV amongst South Asian mothers since previous research from non-South Asian populations has shown that exposure to IPV can affect various aspects of motherhood[59]., and conversely, being a mother can affect IPV perceptions and experiences[97]. The current research study was designed to address these limitations by investigating protective factors, the perceived role of health care professionals in IPV, and the inclusion of non-immigrant South Asian mothers.

The aforementioned literature review on IPV amongst South Asian women in Canada and the scoping review on IPV amongst South Asian women living outside of South Asia both found an overrepresentation of qualitative, as opposed to quantitative or mixed-methods research. However, given the goals of the study to explore and understand IPV in a novel maternal population, a qualitative descriptive study was conducted.

The purpose of this study was to describe the perceptions of and/or experiences with IPV survivorship and help-seeking amongst South Asian mothers in Ontario, Canada. In particular, the Greater Toronto and Hamilton Area (GTHA) in Ontario was chosen; the rationale for this choice is discussed under the subheading entitled "Sampling". The overarching research question is, "*among partnered South Asian mothers, aged 18-50, living in the GTHA, what are the experiences and perceptions about individuals' experiences of IPV in their community?"* More specifically, amongst partnered South Asian mothers, aged 18-50 years, living in the GTHA, what are their experiences and perceptions of: (1) IPV, (2) the risk and protective factors for IPV, (3) impact of IPV, and (4) help-seeking for IPV, particularly from health care providers?

Methods

Qualitative Descriptive Design

The applied qualitative design used in this study was qualitative description. This design is useful when conducting research that seeks to discover and understand a phenomenon informed by the perspectives and worldviews of the people involved[98]. It is used when information is required directly from those experiencing the phenomenon under investigation[99]. In contrast to other applied qualitative designs such as ethnography, which seeks to understand culture, or grounded

theory, which seeks to generate theories[100], the qualitative descriptive design is used to describe a phenomenon in the perspectives and language of those who experience it[99]. As with all applied qualitative designs, qualitative description is governed by a set of philosophical, ontological, and epistemological assumptions, which are discussed in detail here.

Firstly, philosophical perspectives dictate what constitutes knowledge and how phenomena should be studied[101]. The philosophical underpinnings of qualitative description are in the naturalistic approach, which holds that phenomena should be studied in their natural context and understood by accessing the meanings that participants ascribe to them. Additionally, the naturalistic approach posits that researchers will inevitably affect the phenomenon under investigation due to the researcher's own values, experiences and assumptions, but that the reality which the research seeks to uncover cannot exist without the subjective interpretation of the researcher's own beliefs[102]. Bradshaw and colleagues also state that qualitative description takes an inductive approach, which describes the phenomenon being studied, and can develop or add to existing theoretical frameworks, but is not used to provide evidence for existing theoretical frameworks. They also expand on the role of the researcher by stating that, because the researcher talks directly to the participants who hold knowledge of the phenomenon under investigation, the researcher inherently becomes part of the phenomenon being studied. This lends to qualitative description as taking an emic stance, which posits that the perspectives of the participants serve as a starting point for generating knowledge, but that this initial knowledge is influenced by the subjectivity and interpretation of the researcher.

The ontological position of naturalistic research is relativism, which holds that reality is subjective and varies from person to person. As the study of being, ontology aims to describe what constitutes reality, and what can be known about it[103]. Relativism believes that there are many realities, each being as important as the other, and that no one reality can exist since individuals ascribe their own meanings to the phenomenon of interest[104]. One mechanism through which realities are created is through language, which can be used to create both a literal and symbolic/abstract description of the phenomena. The focus of qualitative descriptive research is primarily on the literal description of phenomena ("what?"), and then on the meaning that participants ascribe to them ("so what?")[105].

Epistemology is the study of how knowledge can be created, developed, and communicated[103]. Qualitative description is understood with the epistemological lens of subjectivism, which, similar to relativism, accepts the reality of all research objects. This means that both the participant and the researcher are involved in co-creating, co-developing, and co-communicating knowledge. Thus, because qualitative description agrees that multiple interpretations of realities exist, this design offers a subjective interpretation of phenomena (synthesized and interpreted by the participant and researcher), which are strengthened by quotations taken from participants. Because knowledge produced from qualitative descriptive studies are the joint product of both the researcher and the participant, subjectivism recognizes that an objective view cannot be discovered or replicated by others[102].

Sampling

A purposeful sample of South Asian mothers living in the GTHA were invited to participate in this study to share their beliefs and perceptions about women's experiences of IPV in their

community. In order to better understand IPV amongst START mothers as well as in the South Asian community at large, this study aimed to recruit half of the sample from the existing START[56] study (START arm) and the other half of the sample from the community (community arm).

The inclusion criteria for this study were derived from the criteria in the larger START study. Women were eligible to participate in the START study if they self-identified (1) being of South Asian origin, (2) were pregnant with a single fetus, and (3) were between the ages of 18 and 40. The study excluded women who had lived in Canada for less than nine months or if the father of the baby was not of South Asian origin. Additional exclusion criteria included having multiple births, more than four previous live births, artificial or assisted conception, surrogacy status, or certain illnesses (i.e. chronic medical conditions, active cancers, HIV, Hepatitis B or C, and others. The primary goal of this study was to determine the causes of excess adiposity and cardio-metabolic traits of the offspring over the first 3 years of their life. In addition, a detailed assessment of maternal health including information regarding stress, exposure to violence, mental health, decision making in the home and at work and family relationships was collected. Specifically, information relating to psychological wellbeing, mental health, and social support were collected at some or all of the follow-up timepoints: baseline, 3 months, 6 months, 1 year, 2 years, 3 years, and 5 years (Table 1). The Humiliation, Afraid, Rape, Kick (HARK) scale was chosen as the measure of IPV in the START study based on its ease of administration and its reported psychometric properties, with a sensitivity of 81% and a specificity of 95% when compared to the Composite Abuse Scale (CAS; criterion standard)[106]. A secondary analysis of data from the START study was conducted to determine the prevalence of IPV, which revealed that 1.75% (16/917) of participants who had at least one follow-up visit (data were collected at baseline and

at least one other time point 3 years after the baseline visit) reported experiencing at least one occurrence of abuse measured using the HARK scale. A woman was considered to have experienced abuse if she indicated exposure to at least one HARK item across any of the 1, 2, or 3-year follow-up time points.

To meet the objectives of the present study, the eligibility criteria in START were slightly modified. Women were eligible to participate if they self-identified as South Asian women who (1) identified the GTHA as their current place of residence, (2) were parenting at least one child under the age of 10 years (3) were partnered (through marriage or common-law) to a South Asian man, (4) could comfortably communicate in English and (5) were between the ages of 18 and 50. There was one exclusion criterion: women who had been in Canada for less than nine months. For the present study, participants in the START arm were a subsample from the original START population. These eligibility criteria were applied to the subsample of women recruited from the START study and the community, alike. However, one additional criterion was used to determine eligibility for the START subsample. Women were required to be generally adherent to the START study visits. Participants were considered adherent if they attended at least one follow-up for the START study, did not express any considerable disinterest in participating in the START study, and by the judgment of the START researchers, were not difficult to reach. This criterion was established to ensure participation and minimize participant disinterest or withdrawal.

The age range of the child was determined to be 10 years old or younger since the START study recruited women starting in 2011; the oldest START children will be 10 years of age in 2020. In order to balance this purposeful sample, which inherently has a greater potential for heterogeneity,

we balanced the ages of the children to recruit equal or approximately equal numbers of women with children under the age of five years (infancy & pre-school) and between six to 10 years (school age). These cut-offs were decided based on research which suggests that children's age is an important factor that affects their level of exposure to IPV and later impairments. Younger children are more likely to witness violent acts, but also display increased receptivity to their mother's wellbeing after she received services, including supportive care, anticipatory guidance, and guided referrals. [107]. This is in comparison to young and adolescent children (aged six to 18 years) who had the least improvement on internalizing behaviours following their mothers receiving help [108]. The mothers' age ranges of 18 to 50 years old were decided based on START study criteria; the larger study recruited women between the ages of 18 to 40 years in 2011, hence, 10 years later, in 2020, this age range was expanded to 18 to 50 years.

The larger START study recruited women from the Peel Region in Ontario, Canada. The Peel Region consists of the cities of Brampton, Mississauga, and Caledon. According to the 2016 Canadian Census, which represents the most recent national census to date, South Asians comprise 8.7% of the population of the province of Ontario. Ontario has the largest proportion of South Asians amongst any other Canadian province, and this proportion is 3.1% greater than the national proportion of 5.6% South Asians. Within Ontario, the cities of Brampton and Mississauga in the Peel Region are home to the largest proportion of South Asians, with South Asians representing 44.3% and 23.2% of the population, respectively. Hence, the Peel Region was chosen as a suitable location for the recruitment of South Asians for the START study. However, in addition to Brampton and Mississauga, there are other subdivisions which also have a considerable proportion of South Asians, such as Milton (21%), Ajax (20.9%), Markham (17.8%); these are a few examples

of cities that together comprise the GTHA. Hence, the sampling radius was expanded to the GTHA, which represents a large enough sampling area to meet the sample size targets while also including the Peel Region from which START participants were originally recruited. The GTHA was also accessible for travel by study staff.

In qualitative studies, samples sizes are estimated *a priori* and the decision to discontinue recruitment is based on the richness of the data. Although some researchers use the theoretical concept of saturation to describe the point at which no new information is elicited from study participants[109], the philosophical assumption of a qualitative descriptive study, posits that as each individual's perception of reality is unique, this precludes ever reaching saturation[110]. Thus, LoBiondo-Wood and Haber suggest that a number of factors should be considered when establishing an appropriate sample size for qualitative research. They recommend that researchers should consider the research design, the sampling procedure, and the relative frequency of the phenomenon being studied[111]. In addition, Fawcett and Garrity state that an adequate sample size is one that answers the research question with information-rich cases[112]. Given these recommendations, the estimated sample size for this study was determined to be 10 to 15 women. This was decided by taking into account the richness of the data that could be elicited from each interview due to the in-depth interviewing process, the triangulation of data sources (interviews, ecomaps, and field notes), and by considering the feasibility in terms of the scope of the project, which was part of a Master's thesis. Since the relative frequency of IPV in the South Asian population was largely unknown due to the variability of current estimates in the literature, this was not a reliable criterion with which sample size could be estimated.

Recruitment

Multiple recruitment strategies were used to locate and invite the aforementioned purposeful sample of first-time mothers to participate in this study. First, convenience sampling was used to recruit women through the START study. Convenience sampling is a technique by which individuals are invited to participate based on their convenient proximity to the researcher.

Women who have been generally adherent to follow-up visits in the START study were invited by a trained member of the research team to participate via telephone calls, or in person after obtaining consent for them to be contact them by a member in their circle of care. All generally adherent women in the START study who reported experiencing abuse (endorsed at least one HARK item; n=16) were invited to participate in this study. In order to achieve a theoretical balance of women who both reported and did not report experiencing abuse, an equal number of women in the START study who did not report exposure to at least one HARK item were also invited to participate. These latter participants were randomly selected and were similarly assessed for adherence prior to their invitation. Unless participants were due for an in-person START visit, they were invited via telephone by a member in their circle of care. Given the sensitive nature of the topic, women were told generally that this study is designed to explore women's relationships and family dynamics. A script for approaching potential participants in-person and via telephone is included in Appendix 3. Upon receiving their consent, their contact information along with their availability was given to the primary researcher who contacted them, explained the study in detail, and made an appointment to conduct the face-to-face interview. A script for explaining the study is included in Appendix 4.

From this initial convenience sample of women from the START study, snowball sampling was used to identify participants from the community. Snowball sampling is a technique where existing study subjects recruit future study subjects from their acquaintances. To achieve this goal, women were asked during their interview (as part of the semi-structured interview guide), if they knew anyone who would be interested in sharing their perceptions of IPV. If they were comfortable doing so, current participants were asked to share details that could assist the researcher in determining whether the potential future participant met eligibility criteria for this study. If they met the study criteria, women who were interviewed were asked to invite their acquaintance to participate in this study. They were encouraged to share the primary researcher's phone number and email address with their acquaintance, or alternate contact strategies customized to the needs of the acquaintance or the interviewee were created and subsequently documented. To meet sample size requirements, purposive sampling was also conducted from community organizations such as Supporting Our Community's Health (SOCH) and LotusSTEM, which are both well-established and well-known organizations within the South Asian community. These promotions took place through word-of-mouth, social media, and email correspondence. An example of a promotional item is provided in Appendix 5. Interested individuals were encouraged to email study staff at a secure email, and correspondence occurred through email or phone. During this interaction, the primary researcher explained the study in detail (using the script outlined in Appendix 4), eligibility was assessed, and where individuals were eligible to participate, a face-to-face interview was scheduled. While convenience sampling was used to recruit participants in the START arm, typical case sampling, in addition to snowball sampling, was used to recruit women from the community. Typical case sampling is a purposive sampling technique that is used to recruit typical

or normal instances of the phenomenon, which can lend to the overall description of the phenomenon[102].

Data Collection

The primary mode of data collection in this study involved one-on-one, semi-structured, in-depth interviews, designed to explore and deepen the understanding of women's perceptions of IPV in their community. Interviews were the data collection method of choice in this study, since they are particularly useful in getting the story behind a participant's experiences. They allow more in-depth questioning than a self-completed questionnaire[113]. Interviews were conducted one-on-one to ensure privacy and avoid influences between participants, and at a mutually convenient location in the GTHA. The interviews lasted approximately 60 to 90 minutes, and interview questions were open-ended to facilitate narrative responses and open discussion about topics that pertain to the interviewee's understanding of IPV. With the interviewee's consent, interviews were recorded and transcribed for later reference during the data analysis phase. All interviews followed a similar format; questions transitioned from general to specific[114], and probes such as "could you tell me more about that?" were used to assist the interviewee in obtaining information about topics that were not identified in the interview guide (Appendix 6). While the semi-structured interview guide was crafted to reflect key themes that would be elicited from interviews, it was anticipated that any pre-established guide may require modification with the emergence of new themes. All interviews ended with a formal closing in which participants were thanked for their time and were asked if there was anything further that they would like to discuss.

In addition to interviews of women who reported experiences of IPV, ecomaps were used to encourage these women to identify all the services, supports (formal and informal) that they had either accessed or thought about accessing related to IPV experiences. The ecomap exercise (Appendix 7) was embedded in the semi-structured interview. Ecomaps are a valuable tool that provides a visual representation of supportive care networks and capture data about relationships that may be better expressed in pictures than words[115]. They are diagrams that consist of an inner circle with the participant's name surrounded by circles that represent the elements in their social network[115]. Relationship lines are constructed between the inner and outer circles, where the strength of the relationship is depicted by either the number of lines or their thickness. Slashed or squiggled lines may also be used to indicate problematic or uncomfortable relationships, and arrows can be used to demonstrate the flow of resources between the two individuals or institutions connected by the line[116]. In this study, resources may refer to emotional, financial, or domestic support. Further clarifications about relationships can also be provided by writing comments above the lines[117]. Ecomaps can be constructed in three ways; the etic view holds that the interviewer constructs data as they perceive it, the emic approach engages only the participant in the construction process[118], or researchers and participants may work collaboratively to produce the ecomap. In the latter option, the participant is in control of the ecomap content, but the interviewer acts as a facilitator who can ask further questions as ecomap data emerges[119]. Due to its iterative nature wherein continuous validation checking can simultaneously be undertaken and to assist participants who will likely be unfamiliar with ecomaps, the collaborative approach was used in this study.

A debriefing protocol was prepared to support women who indicated that they were experiencing a high level of distress or those who gave any indication that suggested the interview was too stressful, such as uncontrollable crying or shaking. The protocol outlined by Haigh and Witham[120], modified from Draucker, Martsolf, and Poole[121] was identified for use, with slight modifications to the Stage 1 response. The modified portion of the protocol is outlined in Appendix 8; all other components of the protocol have been preserved. These changes were made to reflect the preparedness and qualifications of the primary interviewer in this study, who is not a health care professional. As such, specific clinical questions were removed and replaced with general questions.

Field notes are an essential component of rigorous qualitative research that encourage researchers to provide rich context about interviews and focus groups for further analysis. Field notes also provide non-textual or auditory information about participants, and when disclosed with other study information, they allow for a deeper understanding of the context of the study[122]. In this study, field notes were collected as per the recommendations put forth by Phillippi and Lauderdale[123], and considered the following domains: interview setting, participants, and the interview itself. The interview setting referred to the location of the interview, including the geographic location (i.e. Brampton) and the setting (i.e. private conference room in the public library). The description of location included how the location related to other points of interest within the context of the study (i.e. the participant was only able to meet in the public library because her husband does not allow her to meet others in isolated areas). Secondly, field notes about the participant contained information about their overall appearance and demeanour, and any baseline nonverbal behaviour such as nail biting, crossed arms, and slouching. Field notes

about the interview captured the participant's non-verbal responses to the interview questions as a whole, any changes in the interview questions, and the reason why the questions were changed. The interviewer was equipped with a physical field note journal, and each entry began with the date and time of the interview, as well as the participant identification number. During the interview, the interviewer took short, keyword-based, unobtrusive notes while maintaining eye-contact with the participant. After the interaction with the participant, the short field notes were used to create an electronic comprehensive field note, while the researcher's memory was still fresh. Following transcription of the interview, relevant field notes were used to "add back" nonverbal content into the transcript, where "added back" content was inserted in a pre-specified standard notation system (i.e. parentheses)[105].

Relevant demographic information was collected using a brief survey (Appendix 9) which was administered following the informed consent process and prior to the semi-structured interview.

Data Analysis

Demographic information was presented as frequencies in the case of categorical variables (i.e. number of children) and means with ranges in the case of continuous variables (i.e. age). In keeping with the tradition of qualitative description, the transcripts were analysed using reflective thematic analysis. Thematic analysis enables researchers to identify, analyse, and report patterns (themes) within data, and it is an appropriate method for providing a rich and detailed, yet complex, account of the data[124]. Thematic analysis enables the identification and subsequent interpretation of central and common themes across multiple data sources[124].

As proposed by Braun and Clarke, the steps of thematic analysis involve familiarizing oneself with the data, generating initial codes, searching for themes, reviewing themes, defining and naming themes, and producing the report. In the first phase, the researcher is expected to review the data (transcripts) several times in order to become familiar with what was said and how it was said. Next, the researcher can generate initial codes by looking for similarities in the data through a process called open coding. The open coding process enables researchers to collect potential codes under potential subcategories or themes, with the emphasis on the transient and iterative nature of the codes/themes. At this stage, codes are not required to be comprehensive or perfect, but should show the early stages of clustering. Additionally, researchers at this stage need to consider whether they are coding for manifest or latent codes, or both. Manifest codes are those that "mirror the participants' language and concepts", stay relatively close to the participant's meanings, and do not interpret beyond the surface of the data as would be the case with latent codes. Then, codes are collated into potential themes and all of the data (quotations) that are relevant to a particular code are collected. Braun and Clarke write that a theme "captures something important about the data in relation to the research question and represents some level of *patterned* response or meaning within the data set"[124]. Following this, the themes are reviewed for quality and assessed for similarity, in which case they are to be collapsed, and dissimilarity, in which case the boundary of the theme (what it does and does not include) are clearly defined. Then, each theme is defined and named, and finally the report is produced. Braun and Clarke suggest that the report contain direct, non-identifying quotations from participants to help enrich and explain the themes that have been created. In this study, interview data were additionally triangulated with ecomap and field note data to create a complete picture of support networks and perceived access to certain services,

which helped answer research question #4. This question sought to understand how participants perceive help-seeking or access IPV services, particularly from health care professionals.

Ethical Considerations

The study received approval from the Hamilton Integrated Ethics Board (HIREB; study #8036). The following ethical considerations were made and outlined in the informed consent form (Appendix 10). Some participants may have felt distressed during the semi-structured interview, but prior to its start, participants were reminded that their participation in the study was completely voluntary and they were free to withdraw at any time. All participants were also provided with a resource sheet to take home (Appendix 11), which contained community-specific resources that they may access to seek help for IPV, should they require it. Participants were reminded that they are not obligated to take this resource sheet home if it is not safe to do so, and they reserved the right to refuse this, or any other potentially dangerous study documentation, such as the informed consent form. All virtual study documents were stored in secure, encrypted folders and were only accessible to study staff. All physical documents, including field notes and reflexive journals, were de-identified and stored in a locked filing cabinet at McMaster University, located at 1280 Main St. West, Hamilton Ontario. As per the Child, Youth and Family Services act of 2017, it was planned that any instances of suspected or observed child abuse or neglect would be reported by study staff to the local child protection agency (Children's Aid Society). Participants were made aware of this legal obligation in consent documents and during the initial telephone contact.

Results

Six participants were interviewed. Although the estimated sample size for this study was 10 to15 women, interviews had to be stopped due to government- and university-enforced social distancing measures during the COVID-19 pandemic. All interviews took place in the participant's home. Demographic information is presented in **Table 3**. A summary of the research objectives and corresponding themes are presented in **Table 4**. Of the six women in this study, two had indicated experiencing IPV in their relationship, while the remaining four did not have personal experiences with IPV but knew of it in their community.

Table 3. Participant Demographic Information (n=6)

Mother	
Mean Age (Range)	38 years (37-41)
Country of Origin	
India	4
Pakistan	1
Sri Lanka	1
Mean Years Married (Range)	12 years (9-15)
Mean Number of Children (Range)	2 children (2-3)
Highest Level of Education	
High School	1
Bachelors	1
Professional/Graduate	4
Children	
Children's Mean Age (Range)	7 (4-13)

Table 4. Thematic Summary

Research Area	**Themes/Categories**
Experiences and Perceptions	Unequal Division of Responsibility In-law's Involvement
Risk and Protective Factors	The Generation Gap Women's Education
Impacts of Exposure	Children and Parenting
Help-Seeking	Children: Key Influencers Cultural Shame and Blame The Persistent and Prepared Physician

Experiences and Perceptions

In general, participants' views of IPV were congruent with the WHO's definition of IPV. All participants expressed the view that IPV occurs when there is physical, emotional, or mental abuse from one partner to another. However, only three participants explicitly mentioned sexual abuse as a manifestation of IPV, and one additional participant spoke about the importance of healthy, sexual intimacy in a happy relationship. Participants agreed that physical abuse was characterized by hitting or pushing. Although emotional and mental abuse were often used interchangeably, one participant clarified that emotional abuse consists of intentionally making a woman feel badly (typically by verbally abusing her), while mental abuse may involve controlling or dominating behaviours that undermine a woman's autonomy or self-esteem.

Unequal Division of Responsibility: An additional manifestation of male-dominating behaviours was the unequal distribution of responsibility with regards to household tasks. All participants felt that South Asian women were unduly burdened by the responsibility of household tasks (including cooking, cleaning, raising children), as part of traditional, culturally ascribed gender roles. Some women expressed in a powerful way that South Asian women were worked like "maids" and were treated in a way that reflected this perspective. However, in the post-migration context, women also had to work outside of the home in order to contribute to the family income. This further magnified the unequal sharing of responsibility. This imbalance itself, was perceived to be an additional form of exploitation and abuse by some. Others felt that this imbalance could lead to abuse by increasing relationship dissatisfaction and stress. One woman explained in a powerful way, "if I will not clean my washroom for months, nobody will clean it. It's my responsibility to do it. What is it? It's kind of exploitation of the person." (Participant 3)

In-laws' Involvement: Along the same lines, all but one participant spoke of the inviolable role of in-laws in contributing to relationship stress. Participants felt that, generally, in-laws are very involved in the relationship between the husband and the wife, which deprives the couple of their autonomy. Some participants gave the example that mothers-in-law will traditionally exert considerable control over their daughters-in-law by defining their household responsibilities, deciding whether or not they can work outside of the home, and deciding whether, or how often, they are permitted to visit their parents. In some cases, this control is exhibited before marriage; mothers-in-law, along with other members of the husband's family, may exploit a woman for dowry, and if their expectations are not met, use the lack of sufficient dowry as a vehicle for abuse later in the relationship. In both cases, participants expressed that in-laws, and mothers-in-law, had a very strong hold on their sons to the point where they listen to their opinions or tend to their needs over the needs of their wives or children. Participants believed that almost all instances of IPV co-existed with violence from in-laws. Of six participants in this study, the mother-in-law permanently lived with the family of only one participant, while she was an occasional visitor (ranging from a few weeks to a few months) in the homes of the other five participants. Although the mother-in-law did not reside with the participants in majority of cases, her influence was nonetheless strongly felt and expressed by all participants. One participant who reported experiencing verbal and emotional abuse stated that, "when they [in laws] are here, my husband is different, when they are not here, my husband is more caring." (Participant 4)

All participants acknowledged the presence of what they felt was normal fighting or arguing in every relationship and agreed that there was a difference between this normal fighting and IPV.

However, this difference was consistently difficult to articulate. In general, fighting was seen as a passionate expression of anger, while words used to describe IPV included "torture" or "hitting" and was considered an unjustifiable act used to intentionally hurt a person to the point where she cannot understand why she is being hurt or defend herself.

Risk and Protective Factors

Five participants perceived that experiences of IPV are more prevalent amongst South Asian women than non-South Asian women, and one participant believed that the rates of abuse were likely the same between the two groups of women. All participants strongly believed that IPV was a problem in the South Asian community. When risk and protective factors were discussed, often the same phenomena fell into both categories, with a few exceptions.

The Generation Gap: First, all but one participant spoke about extended family, and in-laws, in particular, as a risk factor for abuse. While the earlier discussion focused on the actions or behaviours of in-laws that tended to co-exist with experiences of IPV, the present discussion focused on the beliefs typically held by in-laws that enable IPV. Participants believed that there was a significant generation gap between their generation and that of their parents, especially with regards to their perspective on traditional gender roles. All participants, whether or not they expressed that in-laws played a role in enabling or perpetuating IPV, acknowledged the presence of this generational gap. Some women believed that the reason why their parents' generation espoused traditional gender roles was due to a lack of education. They expressed that the difference in education attainment between the two generations limited their ability to relate on critical topics. One participant mentions, "Because people with a different…people with generation gap as well

as people with different perspective, people with different visions cannot stay together" (Participant 1). Chief amongst these topics was the importance of employment in order to contribute to a woman and her family's financial wellbeing and her personal fulfilment. One participant expressed that, without education, their inability to relate could result in consequences ranging from throwing away important work papers to thinking she is incapable of handling her traditional responsibilities as a mother and a wife, when, in fact, she is juggling additional responsibilities. Participants believed that the effects of this generation gap could be mitigated by reducing proximity to in-laws (i.e. avoiding living in multigenerational homes), but simultaneously acknowledged that this may not always be realistic. Participants quoted that filial piety is a South Asian ideal which facilitates and sometimes, necessitates, living in multigenerational homes in order to serve their parents/elders. Although all women lived in double-income households, all participants expressed that they believed this duty would take a large financial toll on their family. The relationship between a woman and her in-laws is mediated by her husband. Participants believed that because South Asian culture emphasizes filial piety, husbands are often "caught" in between the wants and needs of their parents, and that of their wife. One woman mentioned that, "I live with my in-laws, so sometimes there are situations where my husband has a limited option to choose. There is no violence between us, but sometimes I've seen and feel him being helpless." (Participant 1)

Participants who reported experiencing IPV believed that their in-laws have considerable influence on their husbands. One such participant believed that her husband also espoused beliefs similar to his parents regarding gender roles, and his views continued to be strengthened by his parents after

marriage, which contributed to violence. Another participant believed that her husband internalized her in-laws' ways of thinking, which led to IPV.

Women's Education: Women's education was another factor that some participants expressed could be protective against IPV, or its lack thereof could increase a woman's risk of experiencing IPV. These participants believed that education empowers women to have confidence in themselves to communicate their concerns to their partners clearly, defy traditional gender norms by enabling them to work, and makes them aware of their rights. When women were not educated, did not work, and were financially dependent on the husband, they believed it was more likely that the husband could take advantage of her vulnerability and lack of economic independence and violence could ensue. One participant drew an interesting comparison between women's risk of experiencing IPV and tolerance of IPV in urban and rural areas in her home country of India. She explained that women in urban areas are educated, literate, employed, and therefore not financially dependent. She then goes on to say, "but in village areas, the ladies are always at home. They are not working, because they are not that much literate, right? … You are not earning that much, and you can't go back to your parents for financial support." (Participant 2)

In this way, the beliefs held by extended family such as parents and in-laws, and a woman's level of education were perceived to have important effects on influencing risk of IPV.

Impacts of IPV Exposure

Participants spoke about several impacts that IPV exposure could have on a woman and her children. First, the women expressed that experiences of IPV can take a toll on a woman's physical

wellbeing if the abuse is physical or sexual in nature. Participants also agreed that IPV can have serious effects on a woman's emotional or mental wellbeing in that she might lose her peace of mind, constantly have negative moods, develop depression or anxiety, feel unmotivated to do things (including household and professional work), experience suicidal thoughts, or generally, develop a negative or pessimistic outlook on life. With regards to a woman's relationships, many participants mentioned that if a woman is experiencing IPV, she would limit time spent with her friends to avoid attracting attention or suspicion. She might close herself off by creating excuses as to why she cannot spend time with her friends. Some women mentioned that exposure to IPV would also affect a woman's relationship with her own parents in several ways. First, if the husband disallows his wife from visiting her parents, or having them visit their home, her relationship with her parents may weaken overtime. On the other hand, if a woman is experiencing IPV and her parents are her source of support, some participants believed that this could create undue burden on the parents, while others believed that this could also strengthen the relationship with their parents. Being a burden on parents or other family members was often discussed in the context of a barrier to leaving an abusive relationship. All participants agreed that exposure to IPV would affect a woman's professional life, insofar as that she may not meet her professional goals (failure to advance in her career), be distracted or unproductive at work, or even lose her job. The participants in this study, all of whom were working women, spoke of the financial toll that this could eventually take on their family, which could further contribute to abuse.

Children and Parenting: All participants agreed that the worst consequence of exposure to IPV was the toll it could take on their children. Most often, women expressed that witnessing IPV in a parental relationship could cause negative psychosocial and academic consequences on their

children, such as getting involved with the "wrong crowd", using alcohol or drugs, having sex, or dropping out of school. These consequences seemed to be worse for older adolescent children, as opposed to younger children; however, many mothers also discussed how impressionable young children could be as a cause for concern. They believed that younger children might act in ways that mimic the behaviour of the abusive parent; one participant who had experienced IPV expressed that her son had begun to take a negative tone with her and perceived her as "irritating". All women also described the multigenerational impact of exposure to violence in childhood, such that their children may also become victims or perpetrators of IPV in their own intimate relationships in the future. Most often, participants described that sons would be most likely to perpetrate abuse while daughters would be most likely to endure it. Two participants who experienced abuse, both of whom had sons, were grateful that they did not have to raise daughters, highlighting the gendered, multigenerational impact of exposure to IPV. One of them said,

> "Thank goodness that I don't have a girl. Because, like, the expectations will be the same. Who going to do the suffering? My daughter will do the suffering. Oh, being a girl, you cannot do this, you cannot do this, you cannot do this. And, when there is too much pressure on the child, they will go on the other side, right? … They will go on the wrong path." (Participant 3)

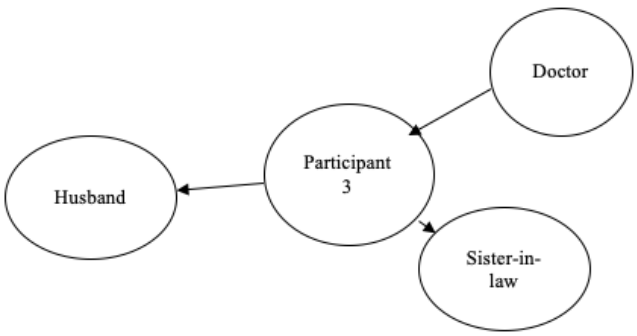
Conversely, some participants felt that a mother's exposure to IPV could also affect her ability, desire, and quality of parenting. Some women described that a mother might become easily frustrated with their children, she may not be able to express love or affection or provide for them through cooking or help with school. One participant believed that, "definitely [IPV] it will affect

it [parenting], because if she's more angry or more depressed, frustrated, or she's not happy with the relationship, that would definitely affect her parenting skills. Maybe she might take it out on kids, or she would neglect them, or it would affect her ability to take decisions for them. (Participant 6)

Help-Seeking for IPV

Participants identified several barriers and facilitators that could influence a woman's decision to seek help for IPV. Ecomaps were completed by two participants that experienced violence in their relationship. In her ecomap, the first participant of these two participants singularly identified calling 911 as a source of support, illustrating her belief that help-seeking is limited to emergency situations. In future interviews, the interviewer clarified that participants could identify help-seeking resources at any point in the experience of IPV. As illustrated by the ecomap in **Figure 4** created by Participant 3, participants accessed help from their family members, such as their sister-in-law; however, this was largely limited to emotional support and was more often one sided. The one-sided arrow demonstrates that the burden of providing support, despite experiencing violence in their relationship was largely on the same woman.

Figure 4. Ecomap illustrating sources of support for Participant 3.



Children: Key Influencers: Participants expressed that seeking help would almost always lead to separation. In this context, participants most commonly identified children as pivotal in a woman's decision to seek or not to seek help for IPV. Only one participant identified children as a facilitator to leaving; she believed that this could be the case if the woman experiencing abuse felt that she could provide a better life for her children outside of the current abusive relationship. However, all participants felt that children would more often be a barrier to leaving. This was because they believed that despite IPV in a couple's relationship, it is important for children to have a relationship with their father. Some women felt that their children may resent them for breaking up their home. They also believed that children growing up in a single-parent household would be subject to additional stress, which could lead them down a path of negative influences (i.e. drug and alcohol use). Interestingly, this impact of leaving on children was also identified as an impact of IPV exposure. All participants also identified financial reasons as a barrier to leaving; however, these reasons were always mentioned in the context of their children. They believed that a woman's financial dependence on her husband may preclude her from gaining custody of her children, and if she was granted custody, that she would be unable to provide for them on her income alone. These effects are magnified in the cases of immigrant families who may already be financially burdened. One participant's quotes are particularly illustrative; she mentions that, "if they separated, you know, anything happen, kids will…lose one parent, right? So, they don't want that. They want, like, you know, father and mother for them. And, most of the time, nowadays, too, the the people will judge. And, sometimes they [aren't] financially stable." (Participant 5).

Cultural Shame and Blame: After children, societal and family pressure was most commonly quoted as a barrier to help-seeking and leaving. Participants described that while separation or divorce are gradually becoming more culturally acceptable, there are still tremendous societal expectations for a woman to remain in a marriage. Chief among these reasons is the cultural belief that separation or divorce would bring dishonour to the family, since their family is now a "broken home". Participants believed that this was compounded by the tendency of the South Asian community to blame or judge women for abuse or separation, by saying that she was incapable of being a good wife or mother. Overshadowing these perceptions was the belief that IPV was itself a taboo topic in the community; it was understood that IPV occurred but was to stay within the confines of the home. Not being able to mention IPV to members in their community and being met with judgment or blame when it was mentioned, were also barriers to help-seeking. Although some participants felt comfortable relying on their family for emotional support, as illustrated in **Figure 4**, they felt that the relationship was one-sided. In addition, participants consistently expressed that a key mechanism through which a woman's family might prevent her from seeking help for IPV is by normalizing the abuse. When women expressed concerns about IPV to their family, they were told that arguments or disagreements are a "normal part" of marriage and that women are required to tolerate some abuse for the sake of their family and children. Given this co-occurrence of violence from in-laws with IPV, one participant relied on her husbands to assist in mitigating the former, although this help was accessed less commonly than from other family members, such as her sister-in-law. This is illustrated by the shorter relative distance between the participant and her sister-in-law, as opposed to her husband. Despite relying on their husband for support, this participant felt that her relationship with her husband, similar to that with their sister-

in-law, was one-sided and carried by her. She ascribed this feeling to the presence of IPV in her relationship.

The Prepared Physician: All participants agreed that accessing help from a physician could be useful in situations where IPV is present. **Figure 4** illustrates that the participant's relationship with their doctor is the only one in which they did not feel burdened. Despite Participant 3's perceived usefulness of their doctor, she was less likely to be accessed as compared to the sister-in-law. This can likely be attributed to the difference in type of support provided by each individual; while the sister-in-law provides informal emotional support, the doctor may provide tangible support. Several other participants believed that the emotional support is likely accessed more frequently, and before formal supports are sought.

Despite all participants' belief that a physician's help is useful, they believed that most South Asian women experiencing IPV would not feel comfortable speaking to their physician out of fear of being misunderstood or judged. They explained that speaking to a physician might lead to downstream interventions that could result in separation. They also spoke of a cultural gap between themselves and their physicians; they felt that while physicians typically had the capacity to understand different cultures, South Asian women may not be able to properly articulate the abuse and what it means to her. Most participants mentioned that they would feel more comfortable if their physician was a South Asian female. Participants recommended that physicians should not be reluctant to ask about IPV and should not take excuses such as, "I just fell down some stairs, or it's just a cooking thing*"* (Participant 2) as an answer. Participants believed that physicians should be aware of resources that exist and should be equipped to provide information about IPV

resources (i.e. social workers, websites) that can help with their situation. Two women who reported experiencing IPV had spoken to their physician and had received support in the form of referrals and strategies for safety planning, which they described as helpful.

Conclusion

This was a qualitative descriptive study designed to investigate the perceptions and experiences of IPV amongst South Asian mothers living in the GTHA, in Ontario, Canada. Thematic analysis of interviews from six participants revealed several themes across the research areas identified in this study, which were experiences and perceptions, risk and protective factors, impacts of exposure, and help-seeking. First, participants identified that a key characteristic of IPV in the South Asian community was the unequal division of responsibilities between males and females, and the co-existence of violence involving other family members (i.e. in-laws) alongside IPV. Women in this study also identified the presence of a generation gap, characterized by a difference in gender expectations, between themselves and their in-laws as a risk factor for IPV. An additional factor which was believed to increase a woman's risk of experiencing IPV was a lack of educational attainment; conversely, higher education attainment was expressed to be a protective factor against IPV. The participants in this study unanimously believed that the most significant consequence of their exposure to IPV was the toll it could take on their children, and their ability to parent their children. Finally, with regards to help seeking, participants identified that children carried great influence over a woman's decision to seek help for IPV, and that cultural taboos could be a significant barrier to help-seeking. The participants expressed that women who are experiencing IPV should speak to their physicians about their abuse and, in turn, physicians should not hesitate to ask and offer resources for these individuals. These results are discussed in detail in Chapter 5.

Chapter 5: Discussion & Conclusion

The goal of this final chapter is to discuss the results of the scoping review that was conducted to characterize and map the literature on IPV amongst South Asian women living outside of South Asia (Chapter 3), and the qualitative study designed to understand IPV amongst South Asian mothers living in the GTHA (Chapter 4). This section serves to contextualize the findings of the aforementioned studies within the current body of IPV literature, outline the strengths and limitations of each study, and provide suggestions for future research. The chapter ends with a set of concluding statements summarizing the methods and findings of each study.

Discussion

Scoping Review

The majority of studies included in this review were conducted in the USA, followed by Canada, and the UK; the prevalence studies were only conducted in the USA and Canada. However, there are also other countries that have experienced significant immigration from the South Asian diaspora. For instance, Chatterji and Washbrook write that South Asians have an increasing presence in South Africa and are gaining visibility in the Middle East[125]. Although most studies were conducted in the USA, where South Asians are estimated to comprise 1.9% of the population[126], no studies conducted in South Africa were identified, where they comprise 2.5% of the total population[127]. Future research should seek to capture IPV amongst the South Asian diaspora in countries beyond the USA, Canada, and the UK in keeping with immigration and population trends.

The majority of studies included in this review were conducted in community, rather than clinical, settings. The need to conduct studies investigating IPV in clinical environments can help better characterize the experiences of women who have accessed health care services for IPV. The discrepancy between prevalence estimates for clinical and community-based samples has been noted in a 2002 review of Canadian IPV prevalence studies[19]. The two studies which included a clinical sample only recruited participants from a general practice clinic[128,129]. However, previous work has shown that the prevalence of IPV may differ across clinical environments[16]. Similarly, in comparison to clinicians, community-based service providers were overrepresented in the current review. However, other studies have demonstrated that clinicians may play an important role in helping with IPV[130] and this role was better delineated in a study included in this review conducted by Janssen et al., in their investigation of the perceptions of South Asian women with regards to the role of obstetricians in addressing IPV[84]. Thus, future research on IPV amongst South Asian women should involve clinical samples, recruit populations across various clinical specialties, and investigate the perspectives of clinical care providers of South Asian women. Clinical samples are also important for conducting intervention studies involving patients who present with health concerns.

In addition to community-based populations, this review identified an overrepresentation of Indian participants, in comparison to non-Indian South Asian participants. In fact, no studies were identified that investigated IPV amongst Maldivian populations. While this overrepresentation may be justified with the argument that Indians are the largest South Asian ethnicity[131], the overall high prevalence of IPV in the South Asian region (WHO) demands that IPV is also investigated amongst South Asian minorities as well[47]. The various South Asian subtypes and the number of

studies that included each subtype, in addition to the global population projection in 20205 and the lifetime prevalence of physical or sexual IPV in each country is available in **Table 5**. In fact, some researchers have recommended that the pan-ethnic nature of the term Asian or South Asians renders the erasure of the experiences of minority groups[41]. Taken together with the notion that IPV has strong cultural underpinnings, these researchers suggest that nationalities should not be homogenized, and that IPV should, instead, be investigated separately within the individual ethnic groups[92]. Thus, future research should purposefully seek to increase representation of non-Indian South Asian participants, some of whom have higher prevalence of IPV than Indian populations.

Table 5. Number of studies, global population projection in 2025, and lifetime prevalence of physical and sexual IPV by each South Asian country.

South Asian Subtype	Number of Studies Represented	Global Population projection in thousands (2025)	Lifetime prevalence of physical or sexual IPV
Indian	45	1,445,012	28.8%[132]
Pakistani	37	242,234	24.5%[133]
Bangladesh	26	170,937	54.2%[134]
Nepal	14	31,757	25%[135]
Sri Lanka	9	21,780	N/A[136]
Bhutan	1	811	15.1%[137]
Maldives	0	522	24%*[138]

*includes emotional abuse

With regards to study methodology, most studies included in this review were qualitative in nature. The 16 quantitative studies that were identified employed cross-sectional methods to study topics ranging from perceptions and experiences, prevalence, correlates (risk and protective factors), and factors associated with help-seeking for IPV. There is a need for further quantitative studies, especially to investigate IPV from the lens of service providers, since there were no quantitative

studies identified under this theme. In addition to an overall need for additional quantitative studies, the current body of quantitative evidence contains specific methodological gaps with regards to the lack of longitudinal and comparative studies. The overrepresentation of case-control studies, and paucity of longitudinal cohort or case-control studies precludes the formation of temporal or causal assumptions. Thus, it is not currently clear whether correlates, such as depressive symptomatology, as investigated by Tonsing et al., are risk factors or impacts of exposure to IPV, or both[139]. Consequently, no studies were identified under the theme of "impacts of IPV" in the present review. In addition to a lack of longitudinal studies, this review also identified a lack of comparative studies that compared IPV amongst South Asians living within South Asia and those who were part of the South Asian diaspora. Only one study, conducted by Bhandari et al., was identified which investigated the experiences of IPV amongst Indians living in the USA and those living in India[140]. The need to conduct comparative studies is underscored by the need to identify the similarities and differences in IPV experiences between these two groups of women, in order to better understand the influence of regional context.

Although qualitative studies represented the majority of studies included in this review, the reporting quality was generally poor, with only 14% of qualitative studies clearly outlining the methodology used in the study. While some of these studies described using analytical techniques such as content or narrative analysis, qualitative studies should be driven by an adherence to a qualitative tradition which informs the formation of the research question and sampling, in addition to the analysis. This adherence throughout the research process is referred to as methodological congruence[141]. Methodological incongruence limits the interpretability of the qualitative findings. For instance, while the tradition of qualitative description lends to the recruitment of a purposive

sample to answer questions about how a certain phenomenon is experienced by the participants, studies utilizing grounded theory would utilize negative case sampling to create an overall theory about that phenomenon. This limitation of qualitative studies was also observed in the literature review in Chapter 2. Future studies should seek to employ and explicitly report the qualitative tradition used to investigate IPV within this population in order to promote interpretability. Moreover, future systematic reviews in this population should seek to assess the quality of the qualitative evidence using validated quality assessment tools, such as the Joanna Briggs QARI tool[142], as endorsed by Cochrane Qualitative and Implementation Methods Group[143].

This review found that only 16% (11/64) of studies used a validated IPV tool, while the remainder of the studies either used unvalidated questions, typically requiring dichotomous responses (yes/no). The finding that not all quantitative studies used validated tools may be underscored by the fact that commonly used IPV tools, such as the Conflict Tactics Scale (CTS), have not yet been validated in the South Asian population. Jones et al, in their critique of the second version of the CTS (CTS-2), write that there is difficulty in comparing measures across cultures[144]. Hence, it is crucial that scales, such as the CTS-2, are validated in the South Asian population, and this should serve as an important future research focus. One study included in this review validated the Index of Spouse Abuse (ISA) in a South Asian sample, and later developed the South Asian Violence Screen (SAVS), which they validated against the ISA in a combined clinical and community-based sample. When possible and appropriate, future research involving IPV amongst South Asian populations should use the ISA and SAVS to reliably detect for exposure to IPV.

Based on this discussion of the gaps identified in the current review, the recommendations for future research are as follows:

1. Expand research efforts to investigate IPV amongst the South Asian diaspora in countries with sizeable proportions of South Asians (i.e. South Africa, Middle Eastern countries).
2. Include clinical populations of South Asian women and service providers for South Asian women experiencing IPV.
3. Recruit participants from diverse South Asian ethnicities.
4. Conduct quantitative studies, especially to build on the literature of service providers of IPV and to better understand temporal associations with IPV.
5. Improve qualitative methodology and reporting to promote interpretability of and confidence in findings. Using standardized quality assessment tools, characterize the state of the qualitative evidence with regards to IPV amongst women in the South Asian diaspora.
6. Use validated screening tools, such as the SAVS, to detect IPV, and validate broadly used tools, such as the CTS-2, in a South Asian population in a research setting.
7. Investigate prevention of IPV.

The quality of this study is strengthened by the systematic and thorough search, developed through the expertise of a research librarian. The systematic nature of the search, screening, and data extraction phases is an additional strength of the study. However, this study also has several limitations. For instance, the included articles were limited to peer-reviewed literature in health-related databases, which may have resulted in the exclusion of important dissertations, legal or political articles that may not be published in peer-reviewed journals, but which may nevertheless be important in characterizing the IPV body of literature. Another limitation which may result in

the omission of otherwise important studies is that only English-language articles were included. This limitation may be especially pronounced in the present review since the population of interest is non-English speaking. However, the decision to include only articles published in English was due to budgetary constraints owing to this project's position as one component of a Master's thesis. Additionally, the inadvertent omission of some search terms, such as "wife abuse" that were later uncovered after studying the literature may have resulted in the exclusion of some articles. Moreover, only studies from the year 2000 were examined, due to ease of accessibility on electronic platforms, which may result in the omission of important articles. Finally, although study quality appraisal is not typically performed in a scoping review, its absence in this study limits the application of the work with regards to policy or practice guidelines.

Qualitative Descriptive Study

The influence of in-laws was a persistent theme across several different research areas, including women's perceptions of the characterization of IPV, risk factors, and help-seeking. In general, in-laws were perceived to play a role in IPV through family violence, by espousing traditional gender roles, and by minimizing or normalizing abuse in order to prevent help-seeking for IPV. The co-existence of family violence with IPV has been corroborated by Raj et al., who found that women who experienced IPV were 5.7 times more likely to experience violence from their in-laws (95% CI = 1.5-21.5)[145]. This cross-sectional, mixed methods study also found, through qualitative interviews, that abuse from in-laws is typically characterized by extreme expectations of women's domestic servitude. Similarly, Bhandari et al. found that a woman's underperformance in her household tasks, in the perspective of her in-laws, served as pre-text for experiencing domestic violence, from which IPV could subsequently ensue[146]. The present study identified that mothers-

in-law, in particular, were perceived as key actors in perpetrating domestic violence, and this finding has been reported previously. This study, conducted by Panchadeswaran et al. found that, amongst their sample of 90 Indian women who experienced IPV, 47% of IPV cases were instigated by in-laws (and mothers- in-law, in particular), second only to reasons such as their partner's jealousy or their partners' alcohol/drug abuse[147]. As a result, programs such as the Dil Mil intervention have been undertaken to mitigate violence between daughters-in-law and mothers-in-law, and the adverse outcomes, such as IPV, that are liable to ensue[148]. Although few studies have investigated in-laws as a risk factor for IPV, fewer still have investigated the specific reasons or mechanisms through which domestic violence from in-laws originates, or the ways in which it may co-exist with, or lead to, IPV. One theory, proposed by Fernandez et al, suggests that the perpetration of domestic violence from mothers-in-law may be underpinned by a shift in her own identity, as a once "victim" to a "now-batterer", due to the change in her power status from a daughter-in-law to a mother-in-law[149]. However, other researchers have suggested that becoming a mother-in-law is not accompanied by a shift in power since she continues to retain the subordinate identity of being a woman in a patriarchal household[150]. Other researchers have suggested that the larger patriarchal context of families, and societies in general, necessitates that violence between female members of a family unit is examined using a feminist lens[146]. Moreover, that in-laws contributed to preventing help-seeking for IPV through minimization or normalization of the abuse was also noted by Ahmad-Stout et al. In this qualitative study, participants reported that one reason why in-laws may be so heavily involved in the staying/leaving process is because of their heavy involvement in all aspects of the couple's life[151]. Unlike the present study, participants in the study conducted by Ahmad-Stout et al. believed that their in-laws arranged their marriage to their son, despite being aware of his behavioural issues, which later manifested as IPV.

This consequence is particularly pronounced since arranged marriage continues to be a popular South Asian tradition. They believed that the in-laws' involvement in the couple's lives, even before marriage, enabled their involvement in their daughter-in-law's help-seeking journey. Excessive involvement of in-laws was also noted in the current study as a risk factor for violence that could later lead to IPV. Taken together, these results suggest that the influence of a woman's in-laws, as very involved third parties in her relationship, may affect multiple points in her experience with IPV.

The results of this study suggest that there was considerable influence of traditional gender roles on a woman's experience with IPV. First, women believed that the unequal distribution of responsibility in the home was underpinned by traditional South Asian gender roles wherein females are the homemakers and their husbands earn money outside of the home[152]. Participants in the study conducted by Gill et al., also expressed the belief that, in the South Asian culture, a woman's traditional responsibility after marriage is to manage household chores and take care of her in-laws[153]. In the post-migration context, as reported by Hyman et al. in their study with Tamil women in Toronto, women often have to both work within and outside of the home, in order to contribute to the family income which is constrained due to immigration[79]. Participants in this study expressed that "exploitation" of their labour in the home was a form of abuse. This finding is corroborated by Rianon et al., who, in their qualitative study involving 23 immigrant Bangladeshi women, found that mental abuse may take the form of failure of a husband to acknowledge or recognize a woman's contributions to the household[154]. All of these findings together suggest the interplay of traditional gender norms, immigration, and acknowledgment of household service, or lack thereof, as contributing to IPV. Women in this study believed that the

gender roles that defined a South Asian woman's primary responsibility as a homemaker were rooted in the South Asian culture itself. The finding that the South Asian culture puts undue burden on women to maintain family harmony is corroborated by Tonsing et al., who found that even when women knew abuse was wrong, they continued to endure IPV for the sake of their familial obligations and responsibilities[155]. Altogether, South Asian culture appears to underscore experiences of IPV through rigid gender norms, which, first, over-exert women within and outside of the home, and secondly, perpetuate abuse by shaming women for leaving abusive situations. Although this study uncovered several characteristics of the South Asian culture that may function to enable IPV, no one definition of South Asian culture was determined. To this extent, Ahmed et al. write that South Asian women have tacit knowledge about what South Asian culture is, and what the role of women is within the culture; hence, the understanding of one's culture, though it may escape verbalization, can have significant influences on the meanings that are ascribed to IPV[90].

Participants in the present study expressed that children played a critical role, both in terms of experiencing negative impacts due to direct or indirect exposure to IPV and as key influencers in a woman's decision to seek help for IPV. Although this was the first study to investigate the perceptions of IPV exclusively amongst South Asian mothers, several other studies have reported the finding that mothers who are exposed to IPV are chiefly concerned about the wellbeing of their children. For instance, Bhandari et al. report that women were concerned that even their husbands' paternal responsibilities towards their children did not change their partners' abusive behaviours[156]. Similarly, the finding that children can hold significant influence over a woman's decision to seek help for IPV was reported by Tonsing et al. In their qualitative study involving

South Asian women in Hong Kong, they identified a theme, namely 'concern for children', which captured women's apprehensions of leaving an abusive relationship out of fear of damaging their children's future prospects[157]. Similar to the present study, women placed an emphasis on maintaining a relationship between children and their father in order to prevent behavioural issues in the future. Some researchers have identified enduring abuse in order to provide a better future for children as a coping strategy[158]. On the other hand, others have identified children as a woman's source of strength to leave the abusive relationship in pursuit of a better life for themselves and their children[86], although this idea was sparingly represented in the present study. Although several studies have identified this apparent duality of children as both a source of strength to endure the abusive relationship and leave it, it is unclear what factors may be responsible for this difference in outcome. Future studies should investigate the role of children in situations of IPV and the circumstances under which decisions of tolerance, as compared to help-seeking, are undertaken.

Women in this study identified women's educational attainment as a means to protect against IPV, since it may serve to empower women to break traditional gender norms, decrease their financial dependency on their partners, and make them aware of their rights. These results are corroborated by Sabri et al., who reported that women expressed the importance of both formal education and community-based empowerment strategies to seek help for IPV[152]. They further identified that women who are educated can identify instances of IPV better than those who are not educated and can help the latter to address and overcome their abuse. These results should be interpreted in light of previous studies, which have demonstrated that educational attainment is not necessarily correlated with IPV[159]. That is, highly educated women may still experience IPV at similar, or higher rates, as compared to women who have less formal education[160]. However, the results from

this study demonstrate the significance that South Asian women place on education as a perceived protective factor.

This study served to fill a gap in the current body of literature by investigating South Asian women's perceptions of health care providers as agents in helping women who have experienced IPV. In general, women believed that physicians should be prepared to ask about IPV, not take "excuses" at face value, and be prepared to offer resources that could help women who are experiencing IPV. The role of clinical care providers in addressing IPV has also been investigated by Janssen et al, who similarly found that South Asian women believed that physicians should not hesitate to ask about IPV so as long as it is done in private conversations[84]. Although other studies have identified that the lack of culturally competent care providers makes disclosure difficult for South Asian women, the results of the present study seem to suggest that women are concerned about their own ability to communicate the granularities of the abuse, and its cultural importance, rather than their physician's ability to understand them[82]. Taken together, given the importance that South Asian women place on patient-physician interactions as key opportunities for disclosure of IPV, future research should investigate the specific barriers and facilitators to disclosure in this specific clinical context.

To my knowledge, this was the first study to investigate IPV amongst mothers of the South Asian diaspora. Rigour was established in several ways. Credibility was established with triangulation of study methods. The joint use of semi-structured interviews, field notes, and ecomaps enables cross-validation of information such that one source can be checked against another, which further contributes to data intensity (the volume of relevant data collected). In addition, credibility was

ensured by performing peer debriefing when discussing the interpretive results with a nurse (Susan Jack) and physicians (Harriet MacMillan, Sonia Anand) who have extensive prior research experience in IPV or clinical expertise working with the South Asian population. Member-checking prompts were built into the semi-structured interview guide and during the eco-mapping exercise, wherein the interviewer asked the participant whether their interpretation of the participants answers was agreed upon by the participant themselves. As part of this process, the interviewer summarized and paraphrased their interpretation of the participant's response in order to check their understanding of the participant's experience. A rich description of the participants and results contextualized within this community was provided to promote transferability to other contexts. In addition, purposive sampling was used to engage differing informants (i.e. women from the START study and SOCH) to intentionally create heterogeneity in responses. Strict records of all research-related activities were maintained and reported to ensure dependability. For example, the following documents will be reported: the researcher's reflexive notes, and a record of analysis and interpretation of the data. Confirmability was established by the maintenance of an audit trail. An audit trail consists of a thorough collection of documentation, including the decision-making processes of the researcher, the researcher's experience in the conduct of the study (reflexive journals), memos generated during analysis, the establishment of coding schemes, and its subsequent evolution into larger themes[161]. Versions of various documents at all steps of the research process were named using the date and version number and were saved onto a secure server. The reflexive process is a method of systematically attending to and addressing the effect of the researcher's own beliefs and practices on the investigation at every step of the research process, and at the end of each interview. Study staff used a reflexive journal to identify, document,

and declare their personal biases. Reflexive journals will be made publicly available at the time of publication.

This study had some limitations, primarily due to the COVID-19 pandemic. Recruitment for this study began in January 2020 and was halted in March 2020 as a result of public health directives that restricted face-to-face meetings. It was decided that for the safety of the participants, remote interviews should not be pursued. However, as a result, this decreased the number of participants that were able to be recruited for the study. Since recruitment could not be completed as planned, not all South Asian ethnicities are represented in the current sample; the present study only includes participants from India, Pakistan, and Sri Lanka. Because there were less opportunities for purposive sampling, heterogeneity in experiences or children's ages, as was planned, could not be reasonably created. With regards to data richness, since the current data is limited to the experiences and perceptions of 6 participants only, the themes outlined in the present study require further investigation from future participants. Apart from COVID-19-related limitations, the results of this study are likely limited to English-speaking populations. As such, this may not represent the experiences of non-English speaking populations (such as more recent immigrants, or those with less education in English), which may differentially affect various facets of IPV such as risk of experiencing abuse, reporting, and help-seeking.

Future qualitative research involving IPV with South Asian women should be larger, aiming to recruit sample sizes of 10 to 15 women, in order to create heterogeneity in responses, which will enable the formation of rich themes. It should be noted that sample size requirements may differ based on the qualitative tradition chosen. With the recent relaxation of the public health social

distancing guidelines, it is planned that the current study will be expanded to its estimated sample size of 10 to 15 women. Considering that the role of in-laws in IPV was a consistent theme across several research areas in the present study, future research should look to characterizing their role throughout various stages of a couple's relationship and should engage in-laws in research regarding IPV against South Asian women. Emphasis should also be placed on delineating the factors that influence the perception of children as sources of support to tolerate or seek help for abusive situations. Finally, the role of health care providers continues to represent a significant gap in the research. Future research should work towards understanding opportunities for meaningful exchange between South Asian women and their physicians, and the factors that would enable disclosure and help-seeking from other health care professionals, in addition to physicians.

Conclusion

The present thesis was designed to investigate IPV amongst women in the South Asian diaspora through two separate, but related components. The first component was a scoping review, which was undertaken to systematically identify, characterize, and map the literature on IPV amongst South Asian women living outside of South Asia. This review identified research gaps in terms of the countries and South Asian ethnicities represented in the body of research, the underutilization of clinical samples, and the lack of studies investigating the prevention of IPV in this population. Some methodological gaps that were identified included the need for more quantitative studies, especially longitudinal studies, improvement of qualitative methodology and reporting, quality assessment of the literature, and the broader use of validated scales to assess IPV in the South Asian population. The second component of this thesis was a qualitative descriptive study which was undertaken to understand South Asian mothers' perspective of IPV. The themes identified in

this study revealed that women characterize IPV as violence from in-laws and the unequal distribution of labour between partners and that a generation gap between in-laws and themselves may contribute to IPV, whereas greater education attainment may protect them from IPV. This study also found that children were key considerations in terms of the impacts of IPV exposure and help-seeking, where the latter was also influenced by cultural factors. Results suggest that the availability of a persistent and resourceful physician can be helpful for women who are experiencing IPV. Taken together, this thesis contributes to the body of literature on IPV amongst South Asian women by characterizing the current state of the literature and contributing the perspective of mothers in the South Asian diaspora.

Appendix A: Search Strategy

CINAHL: Cumulative Index of Nursing and Allied Health Literature

S1 (MM "Intimate Partner Violence") OR "intimate partner violence"
S2 "intimate partner homicide" OR (MH "Homicide+") OR (MH "Battered Women") OR (MH "Domestic Violence")
S3 (MH "Domestic Violence") OR "domestic abuse" OR (MH "Sexual Abuse")
S4 "violence against women" OR (MH "Married Women") OR (MH "Gender-Based Violence")
S5 "South Asian"
S6 S1 OR S2 OR S3 OR S4
S7 S5 AND S6

Embase

1. Intimate Partner Violence.mp. or exp partner violence/
2. Intimate partner homicide.mp or exp domestic violence/
3. Intimate partner aggression.mp.
4. Domestic abuse.mp or battered woman/
5. Gender based violence.mp or gender based violence/
6. Violence against women.mp.
7. Sexual abuse.mp. or sexual abuse/
8. Spouse abuse.mp or partner violence/
9. South Asia/ or South Asia*.mp.
10. India/ or India*.mp.
11. Pakistan/ or Pakistan*.mp.
12. Bhutan/ or Bhutan*.mp.
13. Bangladesh/ or Bangladesh*.mp.
14. Sri?Lanka*.mp.
15. Sri Lanka/
16. Nepal/ or Nepal*.mp.
17. Maldives/ or Maldiv*.mp
18. 9 or 10 or 11 or 12 or 13 or 14 or 15 or 16 or 17
19. 1 or 2 or 3 or 4 or 5 or 6 or 7 or 8
20. 18 and 19

Medline

1. Exp Intimate Partner Violence/
2. Intimate partner homicide.mp.
3. Intimate partner homicide.mo.
4. Domestic violence.mp. or exp Domestic Violence/
5. Intimate Partner violence.mp
6. Intimate partner aggression.mp.
7. Exp Spouse Abuse/
8. Battered Women/ or domestic abuse.mp.
9. Gender based violence.mp. or Gender-Based Violence/
10. Violence against women.mp.
11. Sexual abuse.mp.

12. Asia, Southeastern/
13. South Asia*.mp.
14. India.mp. or India/
15. Pakistan.mp. or Pakistan/
16. Bhutan.mp. or Bhutan/
17. Bangladesh.mp. or Bangladesh/
18. Sri Lanka/ or Sri*Lanka.mp.
19. Nepal.mp. or Nepal/
20. Maldives.mp.
21. 12 or 13 or 14 or 15 or 16 or 17 or 18 or 19 or 20
22. 1 or 2 or 3 or 4 or 5 or 6 or 7 or 8 or 9 or 10 or 11
23. 21 and 22

PsychINFO

1. Intimate Partner Violence.mp. or Intimate Partner Violence/
2. Exp Domestic Violence/ or Intimate Partner Homicide.mp.
3. Intimate partner aggression.mp.
4. Exp Battered Females/ or domestic abuse.mp
5. Sexual Abuse/ or gender based violence.mp.
6. Violence against women.mp.
7. Spouse abuse.mp.
8. Battered women.mp.
9. 1 or 2 or 3 or 4 or 5 or 6 or 7 or 8
10. South Asian cultural groups/
11. South Asia*.mp.
12. India*.mp.
13. Pakistan*.mp.
14. Bhutan*.mp.
15. Bangladesh*.mp.
16. Sri?Lanka.mp.
17. Nepal*.mp.
18. Maldives.mp
19. 10 or 11 or 12 or 13 or 14 or 15 or 16 or 17 or 18
20. 9 and 19

Appendix B: Data Extraction Form

Study Design and Methodological Characteristics

1. What is the year of study publication? Select one:
    a. 2000-2004
    b. 2006-2010
    c. 2011-2015
    d. 2016-2020
2. In what type of Journal was the article published? Select one:
    a. Women's Health/IPV or Other violence
    b. Social Science
    c. Policy/legal
    d. Nursing
    e. Medical
    f. Other
3. If 2=f, what was the name of the Journal? [free text]
4. In what country was the study conducted? [free text]
5. Was the study conducted in more than one non-South Asian country? Y/N
6. Did the study include participants who were living in South Asia? Y/N
7. What was the study methodology? Select one:
    a. Qualitative
    b. Quantitative
    c. Mixed-Methods
8. Was the specific method described in the study? Y/N
9. If 8=Y, what study method was used? [free text]
10. What method of data collection was used? Select one:
    a. Interviews/Focus Groups
    b. Surveys
    c. Other
11. If 10=c, what method of data collection was used? [free text]
12. If applicable, what screening tool was used? Select one:
    a. CTS or CTS-2
    b. WAST
    c. PVS
    d. CAT
    e. HITS
    f. WAVS
    g. Other
    h. None

Population Characteristics

1. Did the study recruit first-generation immigrants only? Y/N
2. Did the study only recruit women who had exposure to abuse? Y/N
3. Did the study recruit males? Y/N
4. Did the study recruit non-South Asian populations? Y/N
5. If 18=Y, what ethnicity were they? [free text]

6. Was information on South Asian ethnicity available? Y/N
7. If 20=Y, what ethnicity? [free text]
8. What was the setting of the study? Select one:
    a. Clinic only
    b. Community only
    c. Clinic and community
9. What type(s) of abuse was/were researched? Select whichever apply:
    a. All IPV
    b. Sexual
    c. Physical
    d. Emotional/Psychological

Thematic Categories

1. What theme(s) were represented in the research? Select whichever apply:
    a. Prevalence
    b. Perceptions, Experiences, Coping
    c. Risk/protective factors and correlates
    d. Impacts (prospective studies only)
    e. Prevention
    f. Help-seeking
    g. Service provider perspective

Prevalence

1. What type(s) of sample(s) were used in the studies? Select whichever apply:
    a. Random
    b. Snowball
    c. Convenience
    d. Other
2. If 1=d, what type of sample was used in the study? [free text]
3. What measures of prevalence were determined? Select whichever apply:
    a. Lifetime
    b. Current relationship
    c. Past year

Perceptions, Experiences, Coping

1. What sub-themes were represented in the article? Select whichever apply:
    a. Perception
    b. Experiences
    c. Coping

Risk/Protective Factors & Correlates

1. Did the study examine specific factors? Y/N
2. If 1=Y, what factor(s)? [free text]

Help-Seeking

1. Which of the following apply to this study? Select whichever apply:

   a. Help-seeking experiences, attitudes, or behaviours
   b. Factors that influence help-seeking
   c. Other
2. If 1=b which *a priori* factors were investigated?
3. If 1=c, describe. [free text]

Service Provider Perspective

1. Which of the following apply to this study? Select whichever apply:
   a. Experiences or perspectives of service providers
   b. Issues surrounding access to services
   c. Other
2. If 1=c, describe. [free text]
3. In addition to service providers, did the study also include South Asian women as participants? Y/N
4. Which service providers were recruited? Select whichever apply:
   a. Community-based IPV service providers (women's agencies staff)/advocates/activists
   b. Therapists/clinician
   c. Police
   d. Lawyers
   e. Politicians/Government officials
5. If 3=b, which type of clinician included?

Appendix C: Script for Approaching Potential Participants

Hi, thank you for meeting with me. I'd like to speak to you about a new study that we are doing, in which you may be interested in participating. Would you like to hear more about it?

If yes, proceed.
If no, say: No problem, thank you for your time. Have a great day!

We are looking to understand family relationships and family dynamics in South Asian homes, especially amongst mothers. We will conduct interviews to better understand your beliefs and perceptions around South Asian family life. If you choose to participate, you will be required to attend an interview that will last approximately 1 hour to 90 minutes. Are you interested?

If yes, proceed.
If no, say: No problem, thank you for your time. Have a great day!

That's great! I would like to ask you a few questions to assess whether you are eligible to participate in this study.

1. Are you parenting a child who is under the age of 10?
2. Would you consider yourself a resident of the Greater Toronto and Hamilton Area (GTHA)?
3. Do you self-identify as a South Asian woman?
4. How long have you lived in Canada?
5. Are you comfortable communicating in one of the following languages: English, Hindi, Urdu, or Punjabi?

If eligible, invite them to participate. Let them know another member of the research team will be in contact with them and ask them the best way and time to contact them.

If not eligible, say: Thank you for agreeing to participate in this study, however, we are looking to recruit women who <insert eligibility criteria that was not met>. Thank you so much for your time!

Appendix D: Detailed Script for Explaining the Study

Hello, my name is Priya Thomas calling- may I please speak to Ms. _____?

Great! I am inviting you to participate in a study that looks at South Asian women's understanding of intimate partner violence or domestic violence. As you might already know, Intimate Partner Violence is a big issue in our community. We see that women are hurt in their relationships, but do not speak about it for many reasons. But we do not really know why. There is not much research that is done in our community- usually, research about intimate partner violence is done in White communities. But it is important that we study this in our community too. I think that if we can understand how South Asian women, like yourself, think about this problem, we can help doctors and nurses take better care of women.

Would you like to learn more about the study?

If you participate in this study, we will meet with you in person and we will do an interview, which take about an hour. We will ask you about your beliefs and understanding of Intimate Partner Violence in the South Asian community, how a woman might look for help, and your personal experiences in your relationship.

If you do not wish to share personal details, that is fine. We would still like you to answer some general questions about the community.

I assure you that you are participating in this study confidentially. I will not use your name or any information that would allow you to be identified. Although I will protect your privacy, the law requires that I will have to reveal certain personal information to the Department of Social Services if the information provided indicates that a child has experienced harm or is at risk of harm. This law is the same for any health care professional.

Would you like to participate in this study?

Great! I would like to meet with you in person to conduct the interview. What time and day works for you? And where would you like to meet?

Thank you so much for your time. I look forward to seeing you at <<date & time>>. Would you like me to send you a reminder phone call or text prior to our meeting? When would you like to be reminded?

Appendix E: Promotional Flyer

Appendix F: Interview Guide

Thank you so much for having me and for agreeing to participate in this interview. Today's interview is part of a study, which is designed to understand how South Asian women living in Ontario, like yourself, think about Intimate Partner Violence.

I am interested in understanding your perceptions and hearing about your experiences. I am here to listen and learn from you. There are no right or wrong answers. If you feel uncomfortable, you can stop the interview at any time. As we discussed in the consent form, all of the information we discuss today will be kept confidential.

Is this okay with you? Do you have any questions before we get started?

Great, I would like to get to know you a little bit better. Can you tell me about where you have lived over the past 5 or 10 years? What has your life looked like?

- Who do you currently live with?

Definitions:

1. People have many different experiences in their relationships. Given this, when you hear the term "intimate partner violence"- how would you describe this term?
    a. Between who does IPV happen?
    b. When you think of "Intimate Partner Violence", what kinds of violence do you think of?
    c. How would you differentiate between a couple who is fighting and Intimate Partner Violence?

South Asian Community:

2. Do you think that Intimate Partner Violence is an issue in the South Asian community? Why or why not?
    a. Is it more or less common than other ethnic groups?
    b. What makes South Asian women more or less vulnerable than other groups to IPV?
    c. You have indicated that your home country is _____. How would you compare Intimate Partner Violence in _____ compared to South Asians who are living in Canada?
        i. Is it more or less common amongst South Asians in Canada or in <<home country>>? Why or why not?
3. What factors contribute to IPV? What might cause IPV in someone's relationship?
4. The family plays an important role in many people's lives.
    a. What is the role of older family members in IPV?
        i. Mother/father/MIL/FIL?
        ii. What is the role of more distant family members (brothers/sisters, cousins, aunts/uncles)?
    b. What is the role of a woman's child(ren) in IPV?
5. IPV is defined as physical, emotional, verbal, financial, or sexual abuse by a current or previous partner. I want to know more about your experiences in your personal

relationships to better understand your perspective about Intimate Partner Violence. It is up to you whether you want to answer this question, and we can still continue the interview even if you do not want to answer. Have you ever experienced Intimate Partner Violence in your personal relationship?

If the woman has not experienced abuse or does not wish to disclose: Proceed to Track B- Perceived Outcomes of IPV.

I**f the woman has experienced abuse:** *I'm very sorry to hear that you have experienced abuse. No one deserves to feel unsafe in their relationship. If it's okay with you, I'd like to ask some questions about the kind of abuse that you have experienced. This information, like the rest of the interview, will be kept strictly confidential. If at any time you feel uncomfortable, or if a question distresses you, and you wish to terminate the interview, please let me know. Is this okay with you?*

If participant consents, proceed to Track A.

If she does not consent, proceed to Track B.

Track A

Thank you for agreeing to speak to me about your difficult experience. It takes a lot of courage and I truly appreciate it.

Experience:

1. Can you tell me about the kind of abuse you experienced?
    a. Did it involve sexual abuse? Verbal abuse? Emotional abuse? Physical abuse?
2. How often does the abuse occur?
3. When did the violence begin?
4. Do you live with other family members?
    a. Are they aware of the abuse?
    b. What role do they play?
5. What role does your child play?
    a. Has your child ever been implicated in an episode of domestic abuse?
    b. Are you concerned about your child(ren)'s wellbeing?

Perceived Outcomes:

1. In reflecting on your experiences in your personal relationships, how did/does experiencing IPV affect your life?
    a. How does it impact your health (Mental/Physical)?
    b. How does it impact your relationships?
    c. How does it impact your role as a parent?
    d. How does it impact your work life?
    e. Are some consequences worse than others? If so, what are they and why?

Help Seeking Ecomap Exercise (see Appendix 2): *At this point, I'm interested in understanding how you, or women who are in similar situations as you, might seek help for IPV.*

I would like to complete an exercise with you, called Ecomapping, which visually maps out the different resources you believe you can access to receive help for IPV. It will take no longer than 20 minutes to complete and poses no additional risks. Are you willing to participate in this exercise?

Ecomapping:

6. Family
    - **a.** Parents
    - **b.** In-Laws
    - **c.** Children
    - **d.** Siblings
    - **e.** Extended Family- cousins/aunts and uncles
7. Friends?
8. Health care professionals- doctors, nurses
9. Women's shelter/social services?
10. Justice system/police?
11. Religious circle?

Recommendation:

12. Would you talk to a healthcare provider (doctor, nurse, pharmacist) about this abuse?
    a. Why or why not?
13. What recommendations do you have for health care providers about how they ask about and respond to IPV?

Recruitment

14. Do you know of any women in your network (whether or not they have experienced IPV) and who may be willing to talk to me?

Debriefing About Abuse: *Before we conclude our interview, I'd like to ask whether you would like assistance, considering you are currently experiencing/have experienced domestic abuse.*

1. If you go home, are you safe?
    a. Would you like to review resources that may help you?
2. Are you concerned about your child(ren)'s wellbeing?

Track B

If participant has experienced abuse but declines to participate in Track A: *That's okay. I respect your privacy and your decision to not provide specific information about your experience. I would still like to learn more about how you understand IPV in the South Asian community by asking you general questions, that do not require you to share information about your experiences. Is this ok with you?*

If participant consents, continue with Track B.

If participant does not consent, ask her, *do you wish to conclude the interview?* **If yes, conclude.**

Perceived Outcomes of IPV:

2. In reflecting on your experiences with your religious or social circles, or even in your personal relationships, how would experiencing IPV affect a woman's life?
    a. How does it impact a woman's health (Mental/Physical)?
    b. How does it impact her relationships?
    c. How does it impact her role as a parent?
    d. How does it impact her work life?
    e. Are some consequences worse than others? If so, what are they and why?

Help Seeking:

3. For a South Asian woman in your community, who was experiencing IPV, what are the different sources of support that she could access for help?
4. What would push a South Asian woman experiencing abuse to seek help or report IPV?
5. When a woman is experiencing IPV, it can be hard to look for help. But some factors can make it easier for her to get help. What kinds of factors do you think would make it easier for a woman to get help?
    a. What is the role of her Family?
    b. What is the role of her children?
    c. What is the role of her friends and other social networks?
6. Do you believe that there are any challenges that South Asian women, in particular, face when trying to get help or reporting IPV? If so, what are they?
    a. What sort of challenges might she experience with her:
        i. Family?
        ii. Friends?
        iii. Health care professionals- doctors, nurses
        iv. Women's shelter/social services?
        v. Justice system/police?
        vi. Religious circle?
7. What can be done to address those challenges?

Recommendations:

8. Would you talk to a healthcare provider (for example, a doctor, nurse, or pharmacist) if you were experiencing IPV?
    a. Why or why not?
9. What recommendations do you have for health care providers about how they ask about and respond to IPV?

Recruitment:

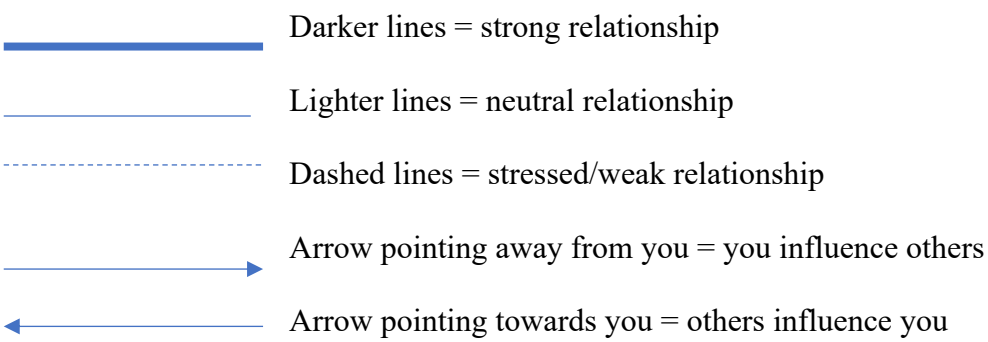
10. Do you know of any women in your network (whether or not they have experienced IPV) and who may be willing to talk to me?

Conclusion: Thank you for your time and participation in this study. Is there anything else that you would like to contribute?

Appendix G: Ecomap Exercise Guide

Prompt: For this exercise, I'd like you to think about who you might turn to for help about violence in your relationship, or if you have sought help in the past, who you turned to then. An ecomap is a diagram that maps out these various resources in relation to you. You are represented by a circle in the center of the page entitled "Me", and the resources are mapped all around you. You can put certain resources closer or farther from you, depending on how close or accessible you feel they are. You may also use lines to connect the resource circles to you. I have prepared a legend, which we can review together now before you begin drawing. You can also add your own symbols and add them to the legend. If it's alright with you, I'd like to ask you questions as you complete this ecomap to both help stimulate your thoughts and ensure that I am correctly interpreting what you are drawing.

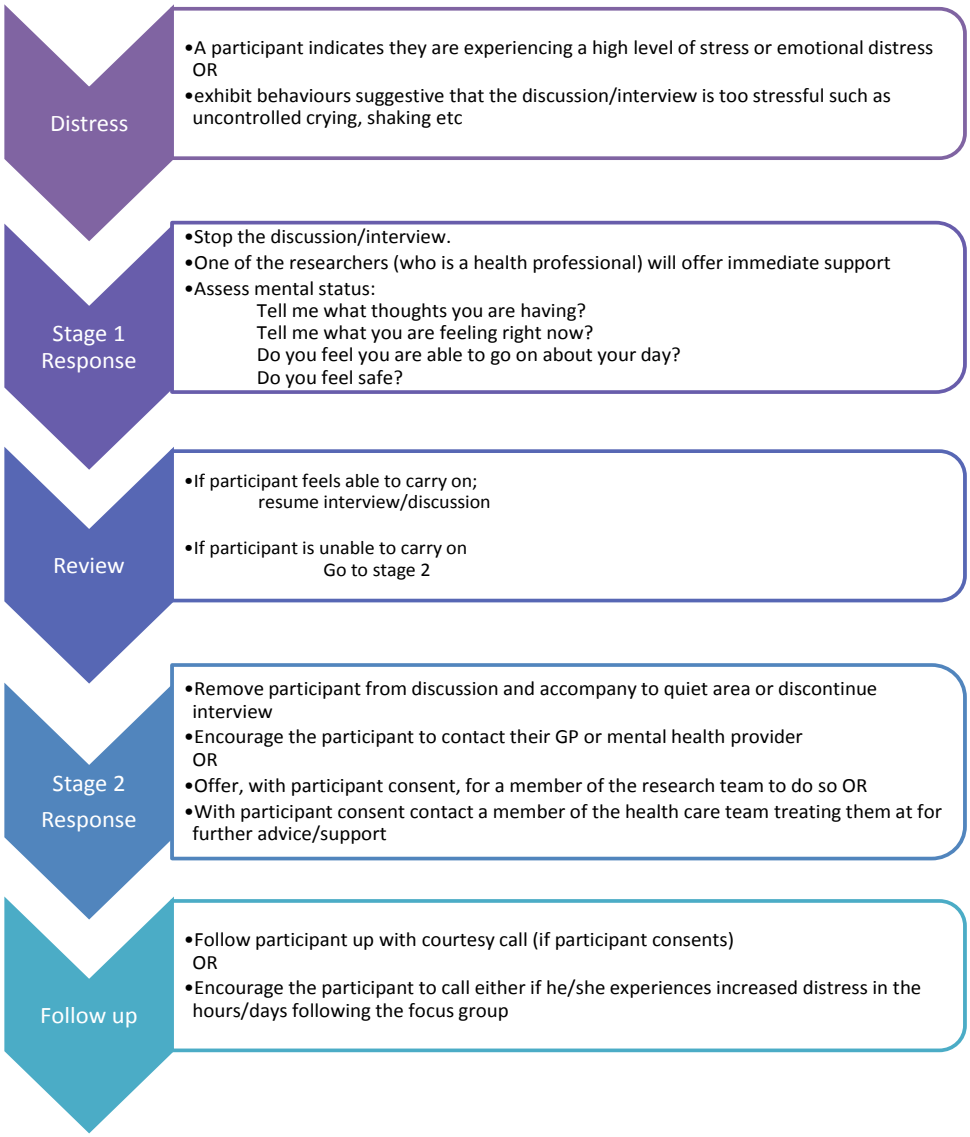
Legend



Add your own codes below:

Appendix H: Debriefing Protocol

Distress Protocol 1: The protocol for managing distress in the context of a research focus group /interview
(Modified from : Draucker C B, Martsolf D S and Poole C (2009) Developing Distress Protocols for research on Sensitive Topics. *Archives of Psychiatric Nursing* 23 (5) pp 343-350)



Modification: Stage 1 Response

- Stop the discussion/Interview
- Offer support: drink of water, take a walk,
- Ask general questions related to mental status:
    - Tell me what you are feeling right now? Do you feel you are able to go on about your day? In the past, when you have experienced similar emotions or reactions, what strategies have you found helpful?

Appendix I: Demographic Information Sheet

To be filled in by study staff:

Participant ID: _____

Interviewed by: _____

Please provide your full name: _____

Please provide your initials: _____

What is your gender? _____

What is your address (please also provide your postal code)?

_____

_____

_____

_____

What is your email address? _____

What is your date of birth (dd/mm/yy) _____ / _____ / _____

What is your age? _____ years

What is your country of origin? _____

How long have you been married or common-law? _____ years

How old is your child/children?

- Child 1: _____ years/months (please select)
- Child 2: _____ years/months (please select)
- Child 3: _____ years/months (please select)
- Others:_____
  _____

What is the highest level of education that you have completed? Please select:
[ ] No schooling
[ ] Elementary (kindergarten to grade 8)
[ ] High school (grade 9 to grade 12)
[ ] Bachelor's Degree
[ ] Graduate degree (Master's or PhD)

Thank you for providing this information. The interviewer will meet with you shortly.

Appendix J: Informed Consent Form

LETTER OF INFORMATION / CONSENT

START-INSPIRE: explorIng womeN'S Perceptions of Intimate paRtner violEnce

Investigators:

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Purpose of the Study: You are being invited to participate in a study designed to explore South Asian women's perceptions of intimate partner violence (IPV) within the context of their ethnic community. This study is conducted under the supervision of Dr. Sonia Anand (Principal Investigator), along with researchers from the Population Health Research Institute and Offord Centre for Child Studies. Information from this study will help contribute to our currently limited understanding of IPV within the South Asian community.

Procedures involved in the Research: You will participate in one semi-structured interview ranging from 60-90 minutes, administered by a trained member of the research staff. During the interview, you will be asked about your perceptions of IPV in the South Asian community (i.e. contributing or deterring factors), help-seeking behaviours, and your exposure to violence.

Potential Harms, Risks or Discomforts: The risks involved in participating in this study are minimal. You may find it stressful or uncomfortable to answer some questions during the interview. You may also experience feelings of emotional distress. If this occurs, a researcher will ask you if you would like to stop the interview immediately. You do not need to answer questions that you do not want to answer or that make you feel uncomfortable. You can stop to take a break. You can withdraw (stop taking part) at any time. I describe below the steps I am taking to protect your privacy.

Potential Benefits: The research will not benefit you directly. We hope to learn more about how South Asian women perceive or understand domestic violence. This could help health care professionals be better equipped to identify and address this issue in the South Asian community.

Confidentiality: You are participating in this study confidentially. I will not use your name or any information that would allow you to be identified. No one but me (or other members of the research team such as the research assistant) will know whether you participated unless you choose to tell them. The information/data you provide will be kept in a locked desk/cabinet

where only I will have access to it. Information kept on a computer will be protected by a password. Once the study has been completed, all identifying data will be destroyed. Once the study is complete, an archive of the data, without identifying information, will be kept on a secure server. For the purposes of ensuring the proper monitoring of the research study, it is possible that a member of the Hamilton Integrated Research Ethics Board and this institution and affiliated sites may consult your research data for quality assurance purposes. However, no records that identify you by name or initials will be allowed to leave the research office. By signing this consent form, you authorize such access.

Legally Required Disclosure: Although I will protect your privacy as outlined above, if the law requires it, I will have to reveal certain personal information to the Department of Social Services if the information provided indicates that a child has experienced harm or is at risk of harm. This law is the same for any health care professional.

Participation and Withdrawal: Your participation in this study is voluntary. If you decide to be part of the study, you can decide to stop (withdraw), at any time, even after signing the consent form or part-way through the study. If you decide to withdraw, there will be no consequences to you. You have the option of removing your data from the study OR information provided up to the point where you withdraw will be kept unless you request that it be removed. If you do not want to answer some of the questions you do not have to, but you can still be in the study. Withdrawing from this study will have no effect on any services that you may wish to access right now or in the future.

Information about the Study Results: I expect to have this study completed by approximately June 2020. If you would like a brief summary of the results, please let me know how you would like it sent to you.

Questions about the Study: If you have questions or need more information about the study itself, please contact me at thomap7@mcmaster.ca or at 416-505-5108.

This study has been reviewed by the Hamilton Integrated Research Ethics Board (HiREB). The HiREB is responsible for ensuring that participants are informed of the risks associated with the research, and that participants are free to decide if participation is right for them. If you have any questions about your rights as a research participant, please call the Office of the Chair, HiREB, at 905.521.2100 x 42013.

CONSENT

I have read the information presented in the information letter about a study being conducted by Dr. Sonia Anand and Priya Thomas of McMaster University. I have had the opportunity to ask questions about my involvement in this study and to receive additional details I requested.
I understand that if I agree to participate in this study, I may withdraw from the study at any time. I will be given a signed copy of this form. I agree to participate in the study.

_____	_____	_____
Name of Participant (Printed)	Signature	Date

Consent form explained in person by:

_____	_____	_____
Name and Role (Printed)	Signature	Date

Appendix K: Resource Sheet

The following resources are available in your community, for women seeking help from intimate partner violence. You may refuse this sheet if it is unsafe for you to take home.

Assaulted Women's Helpline:

GTA: 416-863-0511
TTY: 416-364-8762
24/7 Crisis Support Line Peel Region: 905-278-9036

Peel:

Peel Region Police (Non-Emergency Number): 905-453-3311
Victim Services of Peel: 905-568-1068 / https://www.vspeel.org
Family Services of Peel: 905-453-5775 / fspeel.org
Women's Center of Peel: 416 346 0295 / womencentreofpeel.org
Shelters:

- **Armagh House:** 1801 Lakeshore Rd. W. Mississauga, ON L5J 4S6 P.O. Box 52581
- **Interim Place:** (905) 403-9691

York:

York Regional Police (Non-Emergency Number): 1-866-876-5423
Victim Services: 905-953-5363 / https://www.victimservices-york.org/
Family Services: http://www.fsyr.ca/
Women's Center of York: 905-853-9270 / http://www.wcyr.ca/
Shelters:

- **Blue Door Shelters (Emergency Shelter):** 905-898-1015 / info@bluedoor.ca
- **Sandgate Women's Shelter:** 1-800-661-8294 / info@sandgate.ca

Durham:

Durham Regional Police (Non-Emergency Number): 1-888-579-1520
Victim Services: 905-721-4226 / https://victimservicesdurham.ca/
Family Services: 905-666-6240 / https://www.durham.ca/en/living-here/counselling.aspx?_mid_=24458
Women's Center of Durham: 905-427-7849 / https://wmrcc.org/
Shelters:

- **Cornerstone Durham:** 905-433-0254 / GeneralInquiry@CornerstoneDurham.com
- **Denise House:** 1-800-263-3725 / info@thedenisehouse.com

Halton:

Halton Regional Police (Non-Emergency Number): 905-825-4747
Victim Services: 905-825-4777 ext 5239 / www.haltonpolice.ca/about/victimservices/index.php
Family Services: 905-845-3811 / www.haltonfamilyservices.org
Women's Center of Halton: 905-847-5520 / https://thewomenscentreofhalton.com/
Shelters:

- **Halton Women's Place North Shelter:** 905-332-1593

- **Halton Women's Place South Shelter:** 905-878-8970

Hamilton:

Hamilton Regional Police (Non-Emergency Number): 905-546-4925
Victim Services: (905) 546 -4904 / https://hamiltonpolice.on.ca/victim-services
Family Services: 905-527-3823 / intake@cfshw.com
Women's Center of Hamilton: (905) 387-9959 / info@intervalhousehamilton.org
Shelters:

- **Mission Services:** 905-528-4212 / admin@mission-services.com
- **Martha House:** 905.523.8895

Toronto:

Toronto Regional Police (Non-Emergency Number): *416-808-2222*
Victim Services: 416-808-7066 / http://victimservicestoronto.com/contact/
Family Services: 416-595-9230 ext. 0 / https://familyservicetoronto.org/
Women's Center of Toronto: (416) 532-2824 / https://www.workingwomencc.org/
Shelters:

- **YWCA Toronto:** 416-693-7342 / https://www.ywcatoronto.org/
- **Nellies:** 416-461-8903 / community@nellies.org

References

1. About Gender-Based Violence - Status of Women Canada. https://cfc-swc.gc.ca/violence/knowledge-connaissance/about-apropos-en.html. Accessed September 23, 2020.
2. Gender based violence. https://www.unece.org/stats/video/violence.html. Accessed September 23, 2020.
3. Gender-Based Violence (Violence Against Women and Girls). https://www.worldbank.org/en/topic/socialsustainability/brief/violence-against-women-and-girls. Accessed September 23, 2020.
4. Perreault S. *Criminal Victimization in Canada, 2014*.; 2015. https://www150.statcan.gc.ca/n1/en/pub/85-002-x/2015001/article/14241-eng.pdf?st=MkYfc6yz. Accessed September 23, 2020.
5. Conroy S, Cotter A. Self-reported sexual assault in Canada, 2014. July 2017. www.statcan.gc.ca. Accessed September 23, 2020.
6. Hoddenbagh J, Zhang T, McDonald S. *An Estimation of the Economic Impact of Violent Victimization in Canada*. Ottawa; 2014. http://publications.gc.ca/collections/collection_2014/jus/J4-34-2014-eng.pdf. Accessed March 21, 2019.
7. Greaves L, Hankivsky O, Kingson-Riechers J. *Selected Estimates of the Costs of Violence Against Women*. London; 1995. http://www.learningtoendabuse.ca/our-work/pdfs/pub_greaves19951.pdf. Accessed September 23, 2020.
8. Conroy S, Burczycka M, Savage L. Family violence in Canada: A statistical profile, 2018. www.statcan.gc.ca. Accessed June 22, 2020.
9. CDC. *Intimate Partner Violence Surveillance: Uniform Defintions and Recommended Data Elements*. https://www.cdc.gov/violenceprevention/pdf/intimatepartnerviolence.pdf. Accessed March 21, 2019.
10. Garcia-Moreno C, Guedes A, Knerr W. *Understanding and Addressing Violence against Women*.; 2012.
11. *Global and Regional Estimates of Violence against Women: Prevalence and Health Effects of Intimate Partner Violence and Non-Partner Sexual Violence*.; 2013. www.who.int. Accessed June 22, 2020.
12. Podaná Z. Reporting to the Police as a Response to Intimate Partner Violence. *Czech Sociol Rev*. 2010;46(3):453-474. https://www.jstor.org/stable/pdf/41132867.pdf?casa_token=jBn67qVmb3gAAAAA:dZYo2VfGRFt3n6ZAGTmqVlU_H47VuYqNH2TogiM8UaADDBr9O29AGlRNmTKB5sxv_ZkYzHQ-2FVDOBsx0hNnxQrb2_XwffNokQoFIhZqEv7MqOp6rk. Accessed September 23, 2020.
13. *Family Violence in Canada: A Statistical Profile, 2011*. www.statcan.gc.ca,. Accessed June 22, 2020.
14. Zhang T, Hoddenbagh J, Susan McDonald M, Scrim K. *An Estimation of the Economic Impact of Spousal Violence in Canada, 2009*.
15. *General Social Survey: An Overview, 2013 Social and Aboriginal Statistics Division General Social Survey How to Obtain More Information Standards of Service to the Public*.; 2013. www.statcan.gc.ca,. Accessed June 22, 2020.
16. MacMillan HL, Wathen CN, Jamieson E, et al. Approaches to Screening for Intimate Partner Violence in Health Care Settings. *JAMA*. 2006;296(5):530.

doi:10.1001/jama.296.5.530
17. Bhandari M, Sprague S, Dosanjh S, et al. The prevalence of intimate partner violence across orthopaedic fracture clinics in Ontario. *J Bone Jt Surg - Ser A*. 2011;93(2):132-141. doi:10.2106/JBJS.I.01713
18. Ahmad F, Hogg-Johnson S, Stewart DE, Levinson W. Violence involving intimate partners: Prevalence in Canadian family practice. *Can Fam Physician*. 2007;53. www.cfpc.ca/cfp. Accessed September 27, 2020.
19. Clark JP, Du Mont J. Intimate partner violence and health: A Critique of Canadian Prevalence Studies. *Can J Public Heal*. 2003;94(1):52-58. doi:10.1007/bf03405053
20. Ibrahim D. Police-reported violence among same-sex intimate partners in Canada. www.statcan.gc.ca. Accessed June 22, 2020.
21. Kelly UA. Theories of intimate partner violence: From blaming the victim to acting against injustice: Intersectionality as an analytic framework. *Adv Nurs Sci*. 2011;34(3). doi:10.1097/ANS.0b013e3182272388
22. Rosenbaum A, Hoge SK, Adelman SA, Warnken WJ, et al. Head injury in partner-abusive men. *J Consult Clin Psychol*. 1994;62(6):1187-1193. doi:10.1037//0022-006x.62.6.1187
23. Buss DM, Duntley JD. Intimate Partner Violence in Evolutionary Perspective. In: *The Evolution of Violence*. Springer New York; 2014:1-21. doi:10.1007/978-1-4614-9314-3_1
24. Fals-Stewart W, Golden J, Schumacher JA. Intimate partner violence and substance use: A longitudinal day-to-day examination. *Addict Behav*. 2003;28(9):1555-1574. doi:10.1016/j.addbeh.2003.08.035
25. Powers RA, Cochran JK, Maskaly J, Sellers CS. Social Learning Theory, Gender, and Intimate Partner Violent Victimization: A Structural Equations Approach. *J Interpers Violence*. 2020;35(17-18):3554-3580. doi:10.1177/0886260517710486
26. Murray CE. Controversy, Constraints, and Context: Understanding Family Violence Through Family Systems Theory.
27. Lawson J. Sociological Theories of Intimate Partner Violence. *J Hum Behav Soc Environ*. 2012;22(5):572-590. doi:10.1080/10911359.2011.598748
28. *World Report on Violence and Health*. https://www.who.int/violence_injury_prevention/violence/world_report/en/introduction.pdf. Accessed March 21, 2019.
29. Bronfenbrenner U. Toward an experimental ecology of human development. *Am Psychol*. 1977;32(7):513-531. doi:10.1037/0003-066x.32.7.513
30. Weeks LE, LeBlanc K. An Ecological Synthesis of Research on Older Women's Experiences of Intimate Partner Violence. *J Women Aging*. 2011;23(4):283-304. doi:10.1080/08952841.2011.611043
31. Renner LM, Slack KS. Intimate partner violence and child maltreatment: Understanding intra- and intergenerational connections. *Child Abus Negl*. 2006;30(6):599-617. doi:10.1016/j.chiabu.2005.12.005
32. Whitaker DJ, Hall DM, Coker AL. Primary prevention of intimate partner violence: Toward a developmental, social-ecological model. In: C. Mitchell, D. Anglin, eds. *Intimate Partner Violence: A Health-Based Perspective*. Oxford University Press; 2009:289-305. https://psycnet.apa.org/record/2009-09095-021. Accessed September 27, 2020.
33. Smith Slep AM, Foran HM, Heyman RE, et al. An ecological model of intimate partner violence perpetration at different levels of severity. *J Fam Psychol*. 2014;28(4):470-482.

doi:10.1037/a0037316
34. Capaldi DM, Knoble NB, Shortt JW, Kim HK. A Systematic Review of Risk Factors for Intimate Partner Violence. *Partner Abuse*. 2012;3(2):231-280. doi:10.1891/1946-6560.3.2.231
35. Yakubovich AR, Heron J, Feder G, Fraser A, Humphreys DK. Intimate partner violence victimisation in early adulthood: Psychometric properties of a new measure and gender differences in the Avon Longitudinal Study of Parents and Children. *BMJ Open*. 2019;9(3):25621. doi:10.1136/bmjopen-2018-025621
36. Devries KM, Child JC, Bacchus LJ, et al. Intimate partner violence victimization and alcohol consumption in women: A systematic review and meta-analysis. *Addiction*. 2014;109(3):379-391. doi:10.1111/add.12393
37. Li S, Zhao F, Yu G. Childhood maltreatment and intimate partner violence victimization: A meta-analysis. *Child Abus Negl*. 2019;88:212-224. doi:10.1016/j.chiabu.2018.11.012
38. Stellar C, Garcia-Moreno C, Temmerman M, Van Der Poel S. A systematic review and narrative report of the relationship between infertility, subfertility, and intimate partner violence. *Int J Gynecol Obstet*. 2016;133(1):3-8. doi:10.1016/j.ijgo.2015.08.012
39. Vives-Cases C, Gil-González D, Carrasco-Portiño M. Verbal marital conflict and male domination in the family as risk factors of intimate partner violence. *Trauma, Violence, Abus*. 2009;10(2):171-180. doi:10.1177/1524838008331193
40. VanderEnde KE, Yount KM, Dynes MM, Sibley LM. Community-level correlates of intimate partner violence against women globally: A systematic review. *Soc Sci Med*. 2012;75(7):1143-1155. doi:10.1016/j.socscimed.2012.05.027
41. Okeke-Ihejirika P, Yohani S, Muster J, Ndem A, Chambers T, Pow V. A Scoping Review on Intimate Partner Violence in Canada's Immigrant Communities. *Trauma, Violence, Abus*. 2020;21(4):788-810. doi:10.1177/1524838018789156
42. *Employment Equity Act*.; 1995.
43. Tjaden P, Thoennes N. *Prevalence, Incidence, and Consequences of Violence Against Women: Findings From the National Violence Against Women Survey*.; 1998. http://www.cdc.gov/ncipc/dvp/fivpt. Accessed June 22, 2020.
44. Bonomi AE, Anderson ML, Cannon EA, Slesnick N, Rodriguez MA. Intimate Partner Violence in Latina and Non-Latina Women. *Am J Prev Med*. 2009;36(1):43. doi:10.1016/j.amepre.2008.09.027
45. Frye V, Galea S, Tracy M, Bucciarelli A, Putnam S, Wilt S. The role of neighborhood environment and risk of intimate partner femicide in a large urban area. *Am J Public Health*. 2008;98(8):1473-1479. doi:10.2105/AJPH.2007.112813
46. Klein E, Campbell J, Soler E, Ghez M. *Ending the Violence*. Thousand Oaks: Sage; 1997.
47. *WHO Multi-Country Study on Women's Health and Domestic Violence against Women*. https://www.who.int/gender/violence/who_multicountry_study/summary_report/summary_report_English2.pdf. Accessed May 7, 2019.
48. Johnson H, Ollus N, Nevala S. The Prevalence and Severity of Violence Against Women. In: *Violence Against Women*. New York, NY: Springer New York; :33-65. doi:10.1007/978-0-387-73204-6_3
49. Wilsnack SC. The GENACIS project: a review of findings and some implications for global needs in women-focused substance abuse prevention and intervention. *Subst Abuse Rehabil*. 2012;3(Suppl 1):5-15. doi:10.2147/SAR.S21343
50. PRAISE Investigators, Sprague S, Bhandari M, et al. Prevalence of abuse and intimate

partner violence surgical evaluation (PRAISE) in orthopaedic fracture clinics: a multinational prevalence study. *Lancet*. 2013;382(9895):866-876. doi:10.1016/S0140-6736(13)61205-2
51. Tjaden P, Thoennes N. *Extent, Nature, and Consequences of Intimate Partner Violence Findings From the National Violence Against Women Survey*. http://www.ojp.usdoj.gov. Accessed March 21, 2019.
52. Raj A, Silverman JG. Intimate partner violence against South Asian women in greater Boston. *J Am Med Womens Assoc*. 2002;57(2):111-114. http://www.ncbi.nlm.nih.gov/pubmed/11991419. Accessed March 21, 2019.
53. Thapa-Oli S, Dulal HB, Baba Y. A Preliminary Study of Intimate Partner Violence Among Nepali Women in the United States. *Violence Against Women*. 2009;15(2):206-223. doi:10.1177/1077801208329389
54. Madden K, Scott T, Sholapur N, Bhandari M. Prevalence of Intimate Partner Violence Among South Asian Women Living in Southern Ontario. *J Immigr Minor Heal*. 2016;18(4):913-920. doi:10.1007/s10903-015-0333-7
55. Census Profile, 2016 Census. https://www12.statcan.gc.ca/census-recensement/2016/dp-pd/prof/index.cfm?Lang=E. Accessed September 27, 2020.
56. Anand SS, Vasudevan A, Gupta M, et al. Rationale and design of South Asian Birth Cohort (START): A Canada-India collaborative study. *BMC Public Health*. 2013;13(1):79. doi:10.1186/1471-2458-13-79
57. Campbell JC, Lewandowski LA. Mental and physical health effects of intimate partner violence on women and children. *Psychiatr Clin North Am*. 1997;20(2):353-374. doi:10.1016/S0193-953X(05)70317-8
58. Bacchus LJ, Ranganathan M, Watts C, Devries K. Recent intimate partner violence against women and health: A systematic review and meta-analysis of cohort studies. *BMJ Open*. 2018;8(7). doi:10.1136/bmjopen-2017-019995
59. Alhusen JL, Ray E, Sharps P, Bullock L. Intimate partner violence during pregnancy: Maternal and neonatal outcomes. *J Women's Heal*. 2015;24(1):100-106. doi:10.1089/jwh.2014.4872
60. Vos T, Astbury J, Piers LS, et al. Measuring the impact of intimate partner violence on the health of women in Victoria, Australia. *Bull World Health Organ*. 2006;84(9):739-744. doi:10.2471/BLT.06.030411
61. Kimerling R, Alvarez J, Pavao J, Kaminski A, Baumrind N. Epidemiology and Consequences of Women's Revictimization. *Women's Heal Issues*. 17(2):101-106. https://www.academia.edu/6910291/Epidemiology_and_Consequences_of_Women_s_Re victimization. Accessed September 28, 2020.
62. Crane CA, Hawes SW, Weinberger AH. Intimate Partner Violence Victimization and Cigarette Smoking. *Trauma, Violence, Abus*. 2013;14(4):305-315. doi:10.1177/1524838013495962
63. Wathen N. *Preventing Violence Across the Lifespan Research Network The Impacts of Intimate Partner Violence on Workers and Workplaces*.; 2014. www.prevailresearch.cacontact@prevailresearch.ca. Accessed June 22, 2020.
64. Riger S, Raja S, Camacho J. The Radiating Impact of Intimate Partner Violence. *J Interpers Violence*. 2002;17(2):184-205. doi:10.1177/0886260502017002005
65. Osofsky JD. Prevalence of children's exposure to domestic violence and child maltreatment: Implications for prevention and intervention. *Clin Child Fam Psychol Rev*.

2003;6(3):161-170. doi:10.1023/A:1024958332093
66. Graham-Bermann SA, Lynch S, Banyard V, DeVoe ER, Halabu H. Community-Based Intervention for Children Exposed to Intimate Partner Violence: An Efficacy Trial. *J Consult Clin Psychol*. 2007;75(2):199-209. doi:10.1037/0022-006X.75.2.199
67. Holt S, Buckley H, Whelan S. The impact of exposure to domestic violence on children and young people: A review of the literature. *Child Abus Negl*. 2008;32(8):797-810. doi:10.1016/j.chiabu.2008.02.004
68. Anderson K, van Ee E. Mothers and children exposed to intimate partner violence: a review of treatment interventions. *Int J Environ Res Public Health*. 2018;15(9). doi:10.3390/ijerph15091955
69. Levendosky AA, Graham-Bermann SA. Trauma and parenting in battered women: An addition to an ecological model of parenting. *J Aggress Maltreatment Trauma*. 2000;3(1):25-35. doi:10.1300/J146v03n01_03
70. Wuest J, Ford-Gilboe M, Merritt-Gray M, et al. Abuse-related injury and symptoms of posttraumatic stress disorder as mechanisms of chronic pain in survivors of intimate partner violence. *Pain Med*. 2009;10(4):739-747. doi:10.1111/j.1526-4637.2009.00624.x
71. Ford-Gilboe M, Wuest J, Varcoe C, et al. Modelling the effects of intimate partner violence and access to resources on women's health in the early years after leaving an abusive partner. *Soc Sci Med*. 2009;68(6):1021-1029. doi:10.1016/j.socscimed.2009.01.003
72. Finlay L. *Reflexivity: An Essential Component for All Research?* 61st ed. British Journal of Occupational Therapy; 1998.
73. Willig C. *Introducing Qualitative Research in Psychology: Adventures in Theory and Method.* New York: Open University Press; 2008.
74. Probst B, Berenson L. The double arrow: How qualitative social work researchers use reflexivity. *Qual Soc Work Res Pract*. 2014;13(6):813-827. doi:10.1177/1473325013506248
75. Coghlan D, Brydon-Miller M. *The SAGE Encyclopedia of Action Research*. Vol 1-2. London: SAGE Publications Ltd; 2014. doi:10.4135/9781446294406
76. Creswell JW, Cresswell DJ. *Research Design: Qualitative, Quantitative, and Mixed Methods Approaches*. Sage Publications Inc.; 2014. https://us.sagepub.com/en-us/nam/research-design/book255675. Accessed June 22, 2020.
77. Nirbhaya case: 7 years after bus rape and murder, attackers hanged in New Delhi - CNN. https://www.cnn.com/2020/03/19/asia/india-rape-execution-intl-hnk/index.html. Accessed September 28, 2020.
78. Mason R, Hyman I, Berman H, Guruge S, Kanagaratnam P, Manuel L. violence is an international language: Tamil women's perceptions of intimate partner violence. *Violence Against Women*. 2008;14(12):1397-1412. doi:10.1177/1077801208325096
79. Hyman I, Mason R, Guruge S, Berman H, Kanagaratnam P, Manuel L. Perceptions of factors contributing to intimate partner violence among Sri Lankan Tamil immigrant women in Canada. *Health Care Women Int*. 2011;32(9):779-794. doi:10.1080/07399332.2011.569220
80. Kanagaratnam P, Mason R, Hyman I, Manuel L, Berman H, Toner B. Burden of Womanhood: Tamil Women's Perceptions of Coping with Intimate Partner Violence. *J Fam Violence*. 2012;27(7):647-658. doi:10.1007/s10896-012-9461-1
81. Ahmad F, Riaz S, Barata P, Stewart DE. Patriarchal Beliefs and Perceptions of Abuse

among South Asian Immigrant Women. *Violence Against Women*. 2004;10(3):262-282. doi:10.1177/1077801203256000
82. Shirwadkar S. Canadian domestic violence policy and Indian immigrant women. *Violence Against Women*. 2004;10(8):860-879. doi:10.1177/1077801204266310
83. Ahmad F, Driver N, McNally MJ, Stewart DE. "Why doesn't she seek help for partner abuse?" An exploratory study with South Asian immigrant women. *Soc Sci Med*. 2009;69(4):613-622. doi:10.1016/J.SOCSCIMED.2009.06.011
84. Janssen PA, Henderson AD, MacKay KL. Family Violence and Maternal Mortality in the South Asian Community: The Role of Obstetrical Care Providers. *J Obstet Gynaecol Canada*. 2009;31(11):1045-1049. doi:10.1016/S1701-2163(16)34349-3
85. Guruge S, Roche B, Catallo C. Violence against Women: An Exploration of the Physical and Mental Health Trends among Immigrant and Refugee Women in Canada. *Nurs Res Pract*. 2012;2012:1-15. doi:10.1155/2012/434592
86. Ahmad F, Rai N, Petrovic B, Erickson PE, Stewart DE. Resilience and resources among south asian immigrant women as survivors of partner violence. *J Immigr Minor Heal*. 2013;15(6):1057-1064. doi:10.1007/s10903-013-9836-2
87. Ahmad F, Smylie J, Omand M, Cyriac A, O'Campo P. South Asian Immigrant Men and Women and Conceptions of Partner Violence. *J Immigr Minor Heal*. 2017;19(1):57-66. doi:10.1007/s10903-015-0301-2
88. Couture-Carron A. One Size Doesn't Fit All: Dating Abuse Against Women From the Perspective of South Asian Muslim Youth in Canada. *J Interpers Violence*. 2017;32(23):3626-3647. doi:10.1177/0886260515600875
89. Ahmad F, Riaz S, Barata P, Stewart DE. Patriarchal Beliefs and Perceptions of Abuse among South Asian Immigrant Women. *Violence Against Women*. 2004;10(3):262-282. doi:10.1177/1077801203256000
90. Ahmed B, Reavey P, Majumdar A. Constructions of "culture" in accounts of South Asian women survivors of sexual violence. *Fem Psychol*. 2009;19(1):7-28. doi:10.1177/0959353508098617
91. Finfgeld-Connett D, Johnson ED. Abused South Asian women in westernized countries and their experiences seeking help. *Issues Ment Health Nurs*. 2013;34(12):863-873. doi:10.3109/01612840.2013.833318
92. Kim C, Schmuhl M. Understanding Intimate Partner Violence in the Asian Communities in America: A Systematic Review. *Trauma, Violence, Abus*. 2020;21(4):779-787. doi:10.1177/1524838018791537
93. Munn Z, Peters MDJ, Stern C, Tufanaru C, McArthur A, Aromataris E. Systematic review or scoping review? Guidance for authors when choosing between a systematic or scoping review approach. *BMC Med Res Methodol*. 2018;18(1):143. doi:10.1186/s12874-018-0611-x
94. Grant MJ, Booth A. A typology of reviews: an analysis of 14 review types and associated methodologies. *Health Info Libr J*. 2009;26:91-108. doi:10.1111/j.1471-1842.2009.00848.x
95. Arksey H, O'Malley L. Scoping studies: towards a methodological framework. *Int J Soc Res Methodol*. 2005;8(1):19-32. doi:10.1080/1364557032000119616
96. Levac D, Colquhoun H, O'Brien KK. Scoping studies: Advancing the methodology. *Implement Sci*. 2010;5(1):69. doi:10.1186/1748-5908-5-69
97. Gutowski E, Goodman LA. "Like I'm Invisible": IPV Survivor-Mothers' Perceptions of

Seeking Child Custody through the Family Court System. *J Fam Violence*. 2020;35(5):441-457. doi:10.1007/s10896-019-00063-1
98. Caelli K, Ray L, Mill J. 'Clear as Mud': Toward Greater Clarity in Generic Qualitative Research. *Int J Qual Methods*. 2003;2(2):1-13. doi:10.1177/160940690300200201
99. Neergaard MA, Olesen F, Andersen RS, Sondergaard J. Qualitative description-the poor cousin of health research? *BMC Med Res Methodol*. 2009;9(1):52. doi:10.1186/1471-2288-9-52
100. Doody O, Bailey ME. Setting a research question, aim and objective. *Nurse Res*. 2016;23(4):19-23. doi:10.7748/nr.23.4.19.s5
101. Weaver K, Olson JK. Understanding paradigms used for nursing research. *J Adv Nurs*. 2006;53(4):459-469. doi:10.1111/j.1365-2648.2006.03740.x
102. Bradshaw C, Atkinson S, Doody O. Employing a Qualitative Description Approach in Health Care Research. *Glob Qual Nurs Res*. 2017;4. doi:10.1177/2333393617742282
103. Denzin NK, Lincoln YS. *The Sage Handbook of Qualitative Research*.
104. Frowe I. Language and Educational Research. *J Philos Educ*. 2001;35(2):175-186. doi:10.1111/1467-9752.00219
105. Sandelowski M. Focus on qualitative methods. The use of quotes in qualitative research. *Res Nurs Health*. 1994;17(6):479-482. doi:10.1002/nur.4770170611
106. Sohal H, Eldridge S, Feder G. The sensitivity and specificity of four questions (HARK) to identify intimate partner violence: a diagnostic accuracy study in general practice. *BMC Fam Pract*. 2007;8:49. doi:10.1186/1471-2296-8-49
107. Ybarra GJ, Wilkens SL, Lieberman AF. The influence of domestic violence on preschooler behavior and functioning. *J Fam Violence*. 2007;22(1):33-42. doi:10.1007/s10896-006-9054-y
108. McFarlane JM, Groff JY, O'Brien JA, Watson K. Behaviors of children following a randomized controlled treatment program for their abused mothers. *Compr Child Adolesc Nurs*. 2005;28(4):195-211. doi:10.1080/01460860500396708
109. Coyne IT. Sampling in qualitative research. Purposeful and theoretical sampling; merging or clear boundaries? *J Adv Nurs*. 1997;26(3):623-630. doi:10.1046/j.1365-2648.1997.t01-25-00999.x
110. Ironside PM. Using narrative pedagogy: learning and practising interpretive thinking. *J Adv Nurs*. 2006;55(4):478-486. doi:10.1111/j.1365-2648.2006.03938.x
111. LoBiondo-Wood G, Haber J. *Nursing Research: Methods and Critical Appraisal for Evidence-Based Practice - PDF Free Download*. St. Louis: Elsevier; 2014. https://docplayer.net/10190481-Nursing-research-methods-and-critical-appraisal-for-evidence-based-practice.html. Accessed September 28, 2020.
112. Lefaiver CA. Evaluating Research for Evidence–Based Nursing Practice by J. Fawcett and J. Garity (Philadelphia: F. A. Davis, 2009). *Nurs Sci Q*. 2012;25(3):289-290. doi:10.1177/0894318412447555
113. Kvale S. Introduction to Interview Research. *SAGE Res Methods* . 2007:2-10. doi:10.4135/9781849208963
114. Spradley JP. *The Ethnographic Interview*.; 1979. https://trove.nla.gov.au/work/8617832?selectedversion=NBD1314278. Accessed April 4, 2019.
115. Ray RA, Street AF. Ecomapping: an innovative research tool for nurses. *J Adv Nurs*. 2005;50(5):545-552. doi:10.1111/j.1365-2648.2005.03434.x

116. Bennett J, Grant NS. Using an Ecomap as a Tool for Qualitative Data Collection in Organizations. *New Horizons Adult Educ Hum Resour Dev*. 2016;28(2):1-13. doi:10.1002/nha3.20134
117. Hartman A. Diagrammatic Assessment of Family Relationships. *Soc Casework*. 1978;59(8):465-476. doi:10.1177/104438947805900803
118. Tracy EM, Whittaker JK, Pugh A, Kapp SN, Overstreet EJ. *Support Networks of Primary Caregivers Receiving Family Preservation Services: An Exploratory Study*.; 1994. https://kuscholarworks.ku.edu/bitstream/handle/1808/10378/Support Networks of Primary Caregivers.pdf?sequence=1. Accessed June 7, 2019.
119. Grbich C. Qualitative Research Design. In: *In Handbook for Research Methods in Health Sciences*. Frenches Forest: Addison-Wesley; :124-145.
120. Haigh C, Witham G. *Distress Protocol for Qualitative Data Collection*.; 2015. https://www2.mmu.ac.uk/media/mmuacuk/content/documents/rke/Advisory-Distress-Protocol.pdf. Accessed August 6, 2019.
121. Draucker CB, Martsolf DS, Poole C. Developing distress protocols for research on sensitive topics. *Arch Psychiatr Nurs*. 2009;23(5):343-350. doi:10.1016/j.apnu.2008.10.008
122. Elo S, Kyngäs H. The qualitative content analysis process. *J Adv Nurs*. 2008;62(1):107-115. doi:10.1111/j.1365-2648.2007.04569.x
123. Phillippi J, Lauderdale J. A Guide to Field Notes for Qualitative Research: Context and Conversation. *SAGE*. 2018;28(3):381-388. doi:10.1177/1049732317697102
124. Braun V, Clarke V. Using thematic analysis in psychology. *Qual Res Psychol*. 2006;3(2):77-101. doi:10.1191/1478088706qp063oa
125. Chatterji J, Washbrook D. *Routledge Handbook of the South Asian Diaspora*. (Chatterji J, Washbrook D, eds.). Routledge; 2014. doi:10.4324/9780203796528
126. American FactFinder - Results. https://archive.vn/20200214011110/https:/factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_15_1YR_B02018&prodType=table. Accessed September 28, 2020.
127. *Statistical Release Mid-Year Population Estimates 2011*.
128. Soglin LF, Ragavan M, Immaneni S, Soglin DF. Assessing Intimate Partner Violence in South Asian Women Using the Index of Spouse Abuse. *Violence Against Women*. 2019;26(6-7):697-711. doi:10.1177/1077801219842945
129. Soglin LF, Ragavan M, Immaneni S, Soglin DF. Assessing Intimate Partner Violence in South Asian Women Using the Index of Spouse Abuse. *Violence Against Women*. 2020;26(6-7):697-711. doi:10.1177/1077801219842945
130. Miller E, McCaw B, Humphreys BL, Mitchell C. Integrating intimate partner violence assessment and intervention into healthcare in the United States: A systems approach. *J Women's Heal*. 2015;24(1):92-99. doi:10.1089/jwh.2014.4870
131. Population, total - South Asia | Data. https://data.worldbank.org/indicator/SP.POP.TOTL?locations=8S. Accessed September 28, 2020.
132. India. https://evaw-global-database.unwomen.org/en/countries/asia/india. Accessed September 28, 2020.
133. Pakistan. https://evaw-global-database.unwomen.org/en/countries/asia/pakistan?formofviolence=fac5fe48636e4d3882b

bd2ebbf29bd60. Accessed September 28, 2020.
134. Bangladesh. https://evaw-global-database.unwomen.org/en/countries/asia/bangladesh?formofviolence=b51b5bac425b470883736a3245b7cbe6. Accessed September 28, 2020.
135. Nepal. https://evaw-global-database.unwomen.org/fr/countries/asia/nepal. Accessed September 28, 2020.
136. Sri Lanka. https://evaw-global-database.unwomen.org/en/countries/asia/sri-lanka. Accessed September 28, 2020.
137. Bhutan. https://evaw-global-database.unwomen.org/fr/countries/asia/bhutan. Accessed September 28, 2020.
138. *Republic of Maldives Maldives Demographic and Health Survey*.; 2016.
139. Tonsing KN, Tonsing JC, Orbuch T. Domestic Violence, Social Support, Coping and Depressive Symptomatology among South Asian Women in Hong Kong. *J Loss Trauma*. 2020;0(0):1-19. doi:10.1080/15325024.2020.1738056
140. Bhandari S. Identification of abuse experiences of South Asian women in the US and women in Mumbai, India. *Health Care Women Int*. 2020;41(6):649-672. doi:10.1080/07399332.2020.1725765
141. Thurston WE, Cove L, Meadows LM. Methodological congruence in complex and collaborative mixed method studies. *Int J Mult Res Approaches*. 2008;2(1):2-14. doi:10.5172/mra.455.2.1.2
142. *CHECKLIST FOR QUALITATIVE RESEARCH Critical Appraisal Tools for Use in JBI Systematic Reviews*.
143. Noyes J, Booth A, Cargo M, Flemming K. Chapter 21: Qualitative evidence | Cochrane Training. In: *Supplementary Guidance for Inclusion of Qualitative Research in Cochrane Systematic Reviews of Interventions*. ; 2011. https://training.cochrane.org/handbook/current/chapter-21. Accessed September 28, 2020.
144. Toby Jones R, Browne K, Shihning Chou nottinghamacuk. A Critique of the Revised Conflict Tactics Scales-2 (CTS-2) . *Aggress Violent Behav*.
145. Raj A, Livramento KN, Santana MC, Gupta J, Silverman JG. Victims of intimate partner violence more likely to report abuse from in-laws. *Violence Against Women*. 2006;12(10):936-949. doi:10.1177/1077801206292935
146. Bhandari S, Sabri B. Patterns of abuse among South Asian women experiencing domestic violence in the United States. *Int Soc Work*. 2020;63(1):55-68. doi:10.1177/0020872818767250
147. Panchanadeswaran S, Koverola C. The voices of battered women in India. *Violence Against Women*. 2005;11(6):736-758. doi:10.1177/1077801205276088
148. Krishnan S, Subbiah K, Khanum S, Chandra PS, Padian NS. An Intergenerational Women's Empowerment Intervention to Mitigate Domestic Violence: Results of a Pilot Study in Bengaluru, India. *Violence Against Women*. 2012;18(3):346-370. doi:10.1177/1077801212442628
149. FERNANDEZ M. Domestic Violence by Extended Family Members in India. *J Interpers Violence*. 1997;12(3):433-455. doi:10.1177/088626097012003008
150. Chan KL, Tiwari A, Fong DYT, Leung WC, Brownridge DA, Ho PC. Correlates of in-law conflict and intimate partner violence against chinese pregnant women in hong kong. *J Interpers Violence*. 2009;24(1):97-110. doi:10.1177/0886260508315780
151. Ahmad-Stout F, Nath SR, Khoury NM, Huang H. Experiences of Intimate Partner

Violence: Findings From Interviews With South Asian Women in the United States. *J Interpers Violence*. 2018. doi:10.1177/0886260517753850
152. Sabri B, Simonet M, Campbell JC. Risk and protective factors of intimate partner violence among South Asian immigrant women and perceived need for services. *Cultur Divers Ethnic Minor Psychol*. 2018;24(3):442-452. doi:10.1037/cdp0000189
153. Gill A. Voicing the Silent Fear: South Asian Women's Experiences of Domestic Violence. *Howard J Crim Justice*. 2004;43(5):465-483. doi:10.1111/j.1468-2311.2004.00343.x
154. Rianon NJ, Shelton AJ. Perception of spousal abuse expressed by married Bangladeshi immigrant women in Houston, Texas, U.S.A. *J Immigr Health*. 2003;5(1):37-44. doi:10.1023/A:1021052212981
155. Tonsing JC. Domestic Violence: Intersection of Culture, Gender and Context. *J Immigr Minor Heal*. 2016;18(2):442-446. doi:10.1007/s10903-015-0193-1
156. Bhandari S. South Asian women's coping strategies in the face of domestic violence in the United States. *Health Care Women Int*. 2018;39(2):220-242. doi:10.1080/07399332.2017.1385615
157. Tonsing JC. Conceptualizing Partner Abuse Among South Asian Women in Hong Kong. *J Transcult Nurs*. 2014;25(3):281-289. doi:10.1177/1043659614522650
158. Tonsing KN, Tonsing JC. Exploring South Asian Women's Experiences of Domestic Violence and Help-Seeking Within the Sociocultural Context in Hong Kong. *Violence Against Women*. 2019;25(12):1417-1432. doi:10.1177/1077801218821443
159. Dobash R, Dobash R. Wives: The "appropriate" victims of marital violence. *Victimology*. 1977. https://www.ncjrs.gov/App/Publications/abstract.aspx?ID=46160. Accessed September 28, 2020.
160. Mahapatra N, Rai A. Every cloud has a silver lining but… "pathways to seeking formal-help and South-Asian immigrant women survivors of intimate partner violence." *Health Care Women Int*. 2019;40(11):1170-1196. doi:10.1080/07399332.2019.1641502
161. Rodgers BL. *The SAGE Encyclopedia of Qualitative Research Methods*. (Given LM, ed.). Thousand Oaks: SAGE Publications, Inc.; 2008. doi:10.4135/9781412963909