Social Science & Medicine 69 (2009) 613–622

Contents lists available at ScienceDirect

Social Science & Medicine

journal homepage: www.elsevier.com/locate/socscimed

"Why doesn't she seek help for partner abuse?" An exploratory study with South Asian immigrant women

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ARTICLE INFO

Article history:
Available online 2 July 2009

Keywords:
Partner abuse
Women
South Asian
Immigrant
Help-seeking
Canada

ABSTRACT

This study explores why South Asian immigrant women with experiences of partner abuse delay seeking help from professionals. Three focus groups were conducted in Hindi language with South Asian immigrant women in Toronto. Twenty-two women participated with a mean age of 46 years (range 29–68 years). Thematic analysis was conducted on the transcribed data using constant comparison techniques within and across the groups. We found that three major themes emerged from the discussions: reasons for delayed help-seeking, turning points and talking to professionals. Women expressed delaying help-seeking to the point when "Pani sar se guzar jata he" (water crosses over your head). Their dominant reasons for delayed help-seeking were social stigma, rigid gender roles, marriage obligations, expected silence, loss of social support after migration and limited knowledge about available resources and myths about partner abuse. Women usually turned for help only after experiencing pronounced mental and physical health problems.

The findings are interpreted in light of participants' immigration context and the socio-cultural norms of patriarchy, collectivism and familism. Prevention approaches to address partner abuse and delayed help-seeking among South Asian immigrant women should include tailored community education, social services to reduce vulnerability, and cultural competency of professionals. Further research and program evaluation is needed to advance the field.

Introduction

Partner abuse is a serious and globally prevalent public health issue. The World Health Organization defines partner or spousal abuse as the intentional use of physical force or power, threatened or actual, by an intimate partner that either results in or has a high likelihood of resulting in physical injury, psychological harm, neglect or deprivation (WHO, 2002). The nature and consequences of partner abuse are more severe for women compared to men. Studies demonstrate that women abused by partners are three times more likely to be killed (Statistics Canada, 2000), two times more likely to be injured, and six times more likely to require medical attention (Statistics Canada, 2005). Further, repeated victimization of women culminates in chronic ill health and social issues including depression, suicide attempts, addictions, chronic physical symptoms, poor pregnancy outcomes and a negative impact on children's health and behaviour (Aldarondo & Sugarman, 1996; Bauer, Rodriguez, & Perez-Stable, 2000; Health Canada, 1999; Hegarty, Gunn, Chondros, & Small, 2004; McFarlane & Soeken, 1994; Plichta & Falik, 2001; Stewart & Cecutti, 1993).

Although all women are at risk of partner abuse, the risk is alarmingly high in certain socio-politically marginalized subgroups. For instance, the lifetime prevalence of physical or sexual partner abuse is estimated as 29% and 25% for Canadian and American women (Statistics Canada, 1993; U.S. Department of Justice, 1998, 2003) while the rates are as high as 53% in urban Bangladesh (Garcia-Moreno, Jansen, Heise, Watts, & WHO Multi-country Domestic Violence Against Women Team, 2006) and 40% in India (Kumar, Jeyaseelan, Suresh, & Ahuja, 2005). Partner abuse is acute in South Asia (i.e., India, Pakistan, Bangladesh and Sri Lanka) with severe manifestation of abuse, such as honor killings and dowry death (Johnson & Johnson, 2001; Prasad, 1999). The history of South Asia, where civilization has existed since 2500 B.C. has had many eras of glory. Some scholars link the current high rates of domestic violence in South Asia to the postcolonial aftermath with a breakdown of local culture and the political system, suspension of

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doi:10.1016/j.socscimed.2009.06.011

economic progression, rise of structural hierarchies and the subjugation of women to house chores (Niaz, 2003). Prior to colonization, during 500 years of the Moghal Era women were prominent as rulers, scholars and poets (Hasan, 1982). Others document the fall of women's literacy rate from 90% in 1847 to 12% in 1947 under the British rule (Niaz, 2003). Compounded by increasing global capitalism, economic hardship and political instability continues in the region and many South Asians (SAs) are migrating to other countries with growth opportunities including Canada and the United States. SA immigrants form one of the fastest growing immigrant groups in North America. For example, the number of SA immigrants in Canada rose by 37% between 1996 and 2002 (Statistics Canada, 2003). This trend is likely to persist in Canada due to its ongoing immigration policy driven by its aging population and declining birth rate which present a risk to economic growth. In today's era of global migration, a socio-historical understanding of the issues faced by a vulnerable subgroup of immigrant SA women is salient to address their needs in a timely manner.

Migration is not without challenges for SA women arriving in Canada where most of the population is of European descent. Immigrant SA women may experience multiple oppressions not only from their own community (e.g. gender and class based norms) but from the dominant society as well based on their immigrant and ethnic minority status. Several studies report that immigrants encounter settlement challenges due to systemic, informational, cultural and linguistic barriers (Bayne-Smith, 1996; Reitz, 1995). The intensity of these settlement barriers is often higher for SA immigrants due to their visible minority status leading to experiences of being different, also called 'minoritisation' (Burman & Chantler, 2005). Further, SA women may have lesser opportunities to adjust in the adopted country compared to SA men. First, the majority of SA immigrant women in North America arrive as accompanying family members and are legally dependent on men who are the primary applicants (Merchant, 2000). Women often become financially dependent on their male partners and stay at home limiting their opportunities to socialize, learn English and develop skills to access available services. Second, the loss of an extended family system after migration increases their social isolation along with a greater burden of house chores which used to be shared in the extended family. Finally, SA immigrant women commonly endure culturally prescribed rigid gender roles and patriarchal norms (Fikree & Pasha, 2005; George & Ramkissoon, 1998; Gerwal, Bottorff, & Hilton, 2005). Thus, those SA immigrant women who work outside the home report triple workloads of paid work, unshared household chores and care giving, unlike their male counterparts. Due to a small circle of family and friends, the magnitude of their multiple work responsibilities is also higher than mainstream women. This new reality is likely to limit SA immigrant women's opportunities to integrate in the adopted country.

The interplay of settlement challenges, minoritization, and traditional gendered norms could have a cumulative effect on SA immigrant women's vulnerability to stress in relationships. Although large-scale data is lacking, some community-based studies have examined the rates of partner abuse among SA women in the US and Canada. In 2000, Ayyub reported that one out of four SA immigrant women reported domestic abuse but emphasized that many might not have disclosed due to pronounced social stigma (Ayyub, 2000). In 2000, Dasgupta conducted a survey with highly educated SA women and reported a prevalence of 35% for physical abuse and 19% for sexual abuse by their partners (Dasgupta, 2000). In 2002, a survey by Raj and Sliverman in Boston found even higher rates of 41% for physical abuse experienced by SA immigrant women (Raj & Silverman, 2002). In 2004, Ahmad et al. conducted a survey with SA immigrant women in Toronto (Ahmad, Riaz, Barata, & Stewart, 2004). Using the Wife Abuse Screening Tool, the authors found that 67% of the participant women screened positive for stress in intimate relationships. Within positively screened women, 34.5% reported emotional abuse, 24% reported physical abuse and 17% threats-to-hit within the last 5 years. Further, Raj and Silverman report that the likelihood of injury from partner abuse is significantly higher for SA immigrant women if they report lower levels of acculturation (odds ratio, OR 2.06), no family in the US (OR 2.8), lower general social support (OR 1.5) and no social support if abused (OR 5.4) (Raj & Silverman, 2003).

This is of significant concern in light of studies that report a long delay in seeking help from professionals among abused women of all backgrounds (Reidy & VonKorff, 1991). Help-seeking is a coping strategy, which is also found to have a positive association with lower levels of distress among abused women (Kemp, Green, Hovanitz, & Rawlings, 1995; Mitchell & Hodson, 1983). Studies with SA immigrant women indicate low rates of help-seeking from medical, social and legal professionals. Raj and Silverman found that 6.3% of the abused SA immigrant women reported a need to see a doctor due to injury related to abuse but only 3.1% sought care (Raj & Silverman, 2002). This rate was much lower than the rate of 11.1% reported for the general population in the 1997 Behavioral Risk Factor Surveillance Survey in Massachusetts (Hathaway et al., 2000). Ahmad et al. also found that abused SA immigrant women sought help infrequently from professional resources though they often talked to friends and family (Ahmad et al., 2004). Similar findings are reported by Yoshioka et al. in a comparative study with South Asian, African American and Hispanic abused women (Yoshioka, Gilbert, El-Bassel, & Baig-Amin, 2003). These authors found that counselors, police/lawyers, doctors or clergy were approached much less for disclosures of partner abuse by SA women (25%; 25%; 0%; 10%) than the African American (50%; 33%; 0%; 5.6%) or Hispanic (43.5%; 47.8%; 4.3%, 0%) women. At the same time, there is limited knowledge that addresses why SA abused women delay help-seeking. We aimed to examine this by a qualitative study.

The study design and procedures followed an integrative theoretical view informed by the critical-emancipatory (Eakin, Robertson, Poland, Coburn, & Edwards, 1998) and feminist perspectives with an ethno-gender lens (Abraham, 2000a; Fine & Weis, 2005). According to this view, the reality of partner abuse is socio-historically built and context dependent whereby oppression arises out of the social structures, such as women's gendered and inferior roles through societal norms of men's superiority. It also follows that the minoritization of immigrants' experience is a consequence of their underrepresentation in the social, economic, and political fabric of mainstream society. Nevertheless, a dialectical relationship exists between humans and environment. Thus, individuals have the ability to cope, resist, mitigate, envision new possibilities and change their life circumstances through interpreting the meaning of their experiences, historical problems of domination, alienation, and social struggle (Fay, 1987; Morrow & Brown, 1994). It seems that humans form reasons out of their complex life context and the reasons underlay their decision to act in certain ways. In our review of human behaviour theories, we identified the Behavioral Reasoning Theory (Westaby, 2005) as a promising new theory. This theory builds on the well established Theory of Reasoned Action and Theory of Planned Behaviour (Ajzen, 1991; Fishbein & Ajzen, 1975). Westaby theorizes that reasons have direct and indirect influence on human intention of a behaviour whereby the chain of underlying psychological processes entails: beliefs reasons global motives (attitudes, subjective norms, and perceived control) intention behaviour. Despite this theoretical advancement, the role of context remains least examined in human behaviour.

Taking this integrative theoretical perspective, the primary objective of this study was to explore the views of SA immigrant women with experiences of partner abuse about the meaning of help-seeking and reasons for and against help-seeking. The secondary objective was to explore the factors perceived as salient in effective communication with healthcare professionals, particularly family physicians. Through this research we also aimed to correct the invisibility of help-seeking experiences among abused SA immigrant women. We anticipate that unpacking the complex interplay between the context and the participant women will inform the development of helpful outreach strategies for this population – an area perceived challenging by the professional community (MacLeod & Shin, 1990; Paradkar, 2000).

Methods

Study design

We selected the focus group as our primary data collection method. The focus group method, unlike individual interviews, allows critical interaction among participants who ask questions of each other and consider and reconsider their understandings of specific situations and experiences (Schatzman & Strauss, 1973). This is a crucial feature of this research method because it leads to greater insights as to why certain beliefs and opinions are held (Morgan, 1988), and highlights the shared world-view, values and beliefs of participants (Kitzinger, 1995). Further, this method has been found beneficial for research participants, particularly for people from marginalized groups (Race, Hotch, & Parker, 1994). This was consistent with our critical-emancipatory feminist perspective. We anticipated that focus groups organized in supportive environments, also called 'safe spaces' (Madriz, 2000), would be a forum for empowerment of minority SA immigrant women experiencing partner abuse. To create such a supportive environment, a research team with SA descent conducted the fieldwork and the participants were recruited via counselors for domestic abuse at community-based agencies; the implications are discussed below.

Study setting and participants

Toronto is a metropolitan city with population of more than 5 million (Statistics Canada, 2008a). The City is culturally diverse where 50% of the residents are immigrants, compared to 20% nationally. Nearly 700,000 Toronto residents identify themselves as SA regardless of immigration status, accounting for 54% of all SA in Canada. SA residents represent 31.5% of all visible minorities in Toronto, and 13.5% of Toronto's total population. The majority of SA immigrants in Canada came from India (48.8%), Pakistan (14.6%), Sri Lanka (11.7%) and Bangladesh (3.6%). The other source countries for SA diaspora are Guyana (4.2%), Trinidad and Tobago (2.5%), Fiji (2.4%), Tanzania (1.9%), Kenya (1.8%) and the United Kingdom (1.6%) (Statistics Canada, 2008b).

This study was conducted in 2002 in collaboration with three community-based agencies serving immigrants in the Greater Toronto Area (GTA). The agencies were located in the downtown, eastern and western part of the GTA and had a high density of SA population. This was a purposeful selection because each agency had counselors for SA abused women. The counselors reviewed the preliminary study protocol, provided feedback for the recruitment strategies, and approved the study flyers.

Immigrant SA women were eligible to participate if they were at least 18 years old, spoke Hindi and had experienced partner abuse in a current or previous intimate relationship. Twenty-two SA immigrant women aged 29–68 years participated (Table 1). Most of the participants were born in India (68%) followed by Pakistan (27%) and Bangladesh (5%). Almost all participants had children and two-thirds were separated or divorced. The majority reported at least high school education and one-third had employment in the last year. On average, they perceived their English language ability, social support, and health status as 'fair'. Two-thirds of the women reported a major health problem. Thirteen women reported either musculoskeletal, or cardiovascular problems (diabetes or hypertension) while two had cancer. All of the women (100%) had a regular family physician; the majority of the physicians (77%) were male.

Table 1
Socio-demographic characteristics, South Asian immigrant women.

Variable	Participants ($n = 22$)
Age, mean	45.9
Country of birth, %	
India	68.2
Pakistan	27.3
Bangladesh	4.5
Years lived in Canada, mean	14.3
Marital status, %	
Married	22.7
Separated	45.5
Divorced	22.7
Widowed	9.1
Had children, %	95.5
Number of children, mean	2.5
Women living with children, %	72.7
Education, %	
Less than elementary	31.8
High school completed	36.4
College/university some	9.1
University completed/post graduate	22.7
Employment status in last year, %	
Not employed	59.1
Part-time or full-time	36.4
Volunteer	4.5
Perceived English language ability,[a] mean	2.4
Perceived social support,[a] mean	2.2
Perceived health,[a] mean	2.1
Had major health problems, %	68.2
Had a regular family physician, %	100
Sex of family physician, %	
Female	22.7
Male	77.3
Visited a health facility in last year, %	81.8
Health professionals visited in last year,[b] %	
Family doctor in general practice	94.4
Doctor in emergency	33.3
Nurse (general practice/emergency)	27.8
Psychiatrist/psychologist	11.1
Social worker	22.2
Other specialists	27.8

[a] Scale of 1–5: 1 = poor, 2 = fair, 3 = good, 4 = very good, 5 = excellent.
[b] Categories are not mutually exclusive.

Ethical review

The study protocol was approved by the Research Ethics Board of the University Health Network. Our collaborative research approach had high ethical sensitivity (Edwards & Mauthner, 2002). First, the strategy to approach potential research participants via counselors, rather than research staff, gave participants more time to think about their voluntary disclosure of victimization. Second, the conduction of group discussions at the community centers created a comfortable environment for participants because the counselors were available to provide support, in case of need,

diffusing or limiting any researcher–participant hierarchy. Possibly, these strategies augmented the trust of participants.

Data collection

Three focus groups were conducted with SA immigrant women; one group per community centre. The counselors informed their eligible clients and identified willing, volunteer research participants. Prior to the focus groups, participants gave written informed consent and completed a one-page background questionnaire. To create a comfortable environment, refreshments were served during each session. One of the authors (FA) facilitated the discussions in Hindi using an open-ended discussion guide. A bilingual assistant-moderator took notes and de-briefed the participants about the main discussion points at the end of each session. The focus group guide first prompted discussion on the sources and timing of help-seeking for partner abuse followed by women's reasons for delay in help-seeking. Then, participants were encouraged to talk about their communication with healthcare professionals with respect to partner abuse. Each group discussion lasted for 1.5–2 h. Two focus group discussions were audio taped. Participants in the third focus group did not feel comfortable with audio recording and, hence, only detailed written notes were taken. Each focus group participant received token payment as recognition for her time and travel costs.

Data management and analysis

After each focus group, the moderator team met for 20–30 min and discussed the high points of discussions and contrasted them with previous groups. The moderator team identified considerable saturation in the discussions by the end of the third group and this determined the total number of groups for this study. All audio taped discussions were transcribed verbatim by the bilingual research assistant and Word files were prepared. Accuracy was checked by the first author. The technique of *constant comparison*, derived from the grounded theory approach (Glaser & Strauss, 1967), was used to identify emergent themes and concepts within and across the groups (Boeije, 2002). Initially, all collected information organized by focus group questions, was read and hand-coded by two of the authors (FA and ND) who subsequently discussed the emergent themes, concepts and linkages (Creswell, 1998). Further review of the data entailed collapse and/or expansion of the earlier categories using word files to reach the final stage of coding and interpretation. Attention was directed to the range and diversity of experiences, meanings and perceptions with inclusion of unique perspectives. To enhance the trustworthiness of interpretation, we used participant de-briefing and team discussions (Kreuger, 1993) along with insights gained from a critical review of theories on help-seeking behaviour (Hunter, Lusardi, Zucker, Jacelon, & Chandler, 2002).

Findings

Thematic analyses of the focus group for cross-cutting discussions revealed three major themes: (1) reasons for delayed help-seeking; (2) turning points; and (3) talking to professionals. The three themes are not only chronologically linked but broadly depict the psychological processes proposed by the Behavioral Reasoning Theory where beliefs form reasons which in turn contribute directly or indirectly to intention and behaviour. Moreover, our findings reveal a dominant influence of the socio-cultural and immigration context, in addition to some individual-level characteristics, on the discussed reasons. These theoretically informed and new insights laid the foundation of our conceptual model presented in Fig. 1. The three central boxes represent the three themes and sub-themes or specific points raised by the participants. The thick arrows indicate the strong linkages between themes. To the left of the boxes are the participant characteristics and the socio-cultural/immigration context that emerged as affecting their reasons for delayed help-seeking. Notably, the individual-level characteristics (i.e. education, income, housing, and English language skills) were infrequently discussed compared to the higher-level socio-cultural context of patriarchy, familism, and collectivism along with immigration. This model makes theoretical contributions in advancing the existing theories on help-seeking in this population; discussed subsequently.

Reasons

All women agreed that they sought professional help after a very long time even though they suffered from multiple mental, physical and social health consequences of partner abuse. Many women expressed this delay as "Pani sar se guzar jata he" or water crosses over your head. This idiom symbolizes having thoughts of help-seeking only after drowning. Some women expressed regrets as chronic partner abuse also had a negative impact on their children.

> "Listen I never went because of this situation…I had kept it within me…my children used to say mom why aren't you talking? …But I couldn't even talk to my daughter" (Focus Group or FG 3, p. 12)
>
> "Women go very late for help and by that time half their body is gone" (FG2, p. 1)
>
> "I delayed. Now, my daughters think that they should not marry because all men abuse women" (FG1, p. 3)

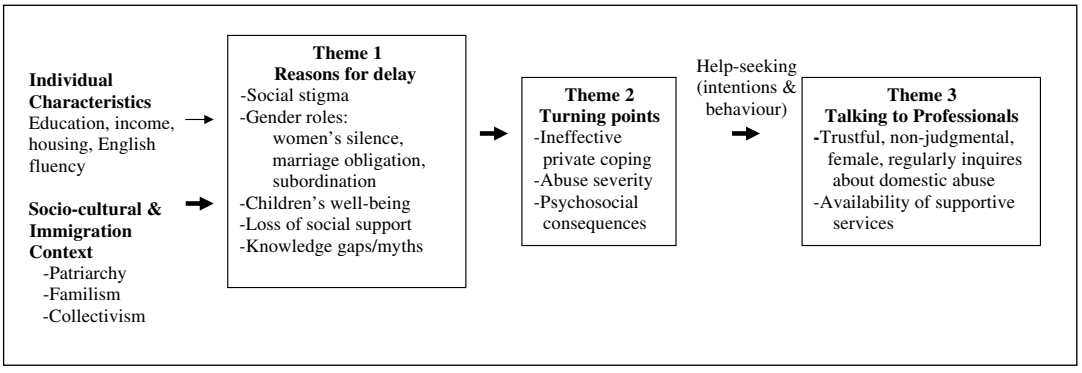

Fig. 1. Conceptual model on help-seeking for partner abuse: SA immigrant women.

Several reasons were discussed by the participants for such a prolonged delay. Reasons included: social stigma; women's gender roles (silence, marriage obligations, subordination); children's well-being; lack of social support; and knowledge gaps and myths. Most of the reasons at the root of delayed help-seeking were linked to the socio-culturally prescribed values and norms and/or the immigration context. The latter was more dominant when participants discussed their children's well-being, social support and knowledge of available services.

Social stigma

Women talked about social stigma or shame on disclosure of domestic violence. Such disclosures were perceived to bring suffering and loss of respect especially for their family and parents. Some women discussed their worries about "parents' suffering" more than themselves due to the social stigma associated with an unsuccessful marriage of one's daughter.

> "…But you can't even run because you are bonded, bonded because you have respect. The respect of my family. The thing is that we have to make a society where it's not necessary to give someone a divorce" (FG3, p.4)
> "One of the biggest reasons is shame, we consider this situation (partner abuse) very shameful. In one way, it's even worse than cancer. We always think like that, this is no good, what will people think, what will people say about us, that it's her fault." (FG3, p. 8)

Gender roles: women's silence, marriage obligation, subordination

Across all focus groups, elements of discussions reflected socio-culturally defined gender roles within the family and community, which hindered participants' help-seeking. Many participants discussed the meaning of their silence. On one side, they used silence as a strategy to divert attention away from themselves, and viewed this practice as an indicator of their own strength, as opposed to their weakness. On the other, women felt that the social prescription of 'silence' enhanced their vulnerability to abuse because their husbands took advantage and the situation worsened.

> "…if anybody calls, even if you are crying, you fake it, you pretend: Hi how are you? But inside you are crying even though you are talking as if everything is okay (all women nodding and saying yes)" (FG3, p. 3)
> "I didn't even tell my own family, why would I tell the doctor? I was very strong at that time…" (FG3, p. 12)
> "My mind is like India, hide things for the sake of brothers and parents. But this makes you sick and "pani sar se guzer jata he" (water crosses over your head)." (FG2, p. 2)

Marital obligations seemed to be a major factor in delaying help-seeking efforts. In the context of an arranged marriage and a desire for harmony, women felt obliged to maintain the bond and, hence, identify themselves as a 'real woman'.

> "We have the obligation, the duty to join the family, not to break the family…" (FG3, p.4)
> "In the beginning no one thinks to go for help…Because when parents get you married they tell you that now that's your house, (all the women are agreeing). And so even we start to think that we'll leave that house only when we die." (FG3, p.7)
> "Oh, I was told that you are a woman, you can change your husband, you can change your kids, it's in your hands. If you cannot do it that means you don't have the quality of a woman, you're not real woman (other women are agreeing)…. You aren't capable of doing… (participant is crying)…as if everything is my fault you know?" (FG3, p. 8)

Women's silence and marital obligations, as discussed above, were fuelled by the socio-culturally embedded subordinate role of women and the superiority of men. Some participants described their mothers' suffering from partner abuse as well. One woman linked this persistence to the community's blind eye to the issue and symbolized it "as eating food and drinking water".

> "They bring a wife here like a servant…they don't like their wives, we are just servants to them" (FG1, p. 8)
> "They [parents and community] don't understand, they say – Oh you are a woman you should take everything. You know, we are forced to accept abuse and accept everything that comes with it." (FG3, p. 2)

Children's well-being: emotional and economic

Women's concern about the well-being of children in a single- versus two-parent family had a major role in their delayed help-seeking. They felt responsible to provide a united family for the children. Participants agreed that children's emotional well-being is compromised in single-parent families. They expressed worries whether the income of a single mother could provide decent food and shelter for children. Some women expressed difficulties in finding work because they did not have close family members to take care of their children and babysitting was expensive. There were a few participants who critically analyzed their past concerns about their children's well-being as a reason for delaying help-seeking and felt that it had not been a good strategy as it had an adverse effect on their kids.

> "I don't want my younger son's health or emotions to be affected… No matter how hard the situation, you need to keep it inside, it shouldn't come outside." (FG3, p. 11)
> "There is fear of income insecurity, how to pay for rent and food for kids." Another participant added "Where to leave kids when you go to work" (FG1, p. 2)
> "Later we felt that it was a waste to stay together because children were witnessing and felt the pressure" (FG2, p. 2)

Loss of social support

Loss of social networks and extended family system after immigration accentuated the delay in women's help-seeking through depleted quality and quantity of both emotional and instrumental support. One participant discussed how she was physically isolated by her husband and in-laws but no one knew because she was new in the country. In the countries of origin of participants, social support through extended networks seemed to buffer conflict in relationships.

> "(after being abused by partner) Here we just stay inside of the house scared not even calling anyone. What we are thinking at that time is what can I do? Where can I go? I don't have anyone of my own over here." (FG3, p. 4)
> "When I first came here my in-laws were in the house…they used to lock the door on me so I could not get out…and they did something to the phone. We could get incoming calls but couldn't make outgoing calls… [after a year of being beaten by her husband] I looked into my neighbours house from my window and told her…can you call 911…the police came and broke the lock of my door" (FG1, p. 6)
> "Back home if something like this happens, all village people go with sticks to tell the man that it should not happen, but here, we do not have anyone…" (FG1, p. 1)

Some participants also expressed worries about gossip rather than support on approaching others in the community. This reflected participants' careful approach in selecting sources of support.

"Just like the other lady said, that family problems can spread like gossip. This is the main reason in our Indian people that we don't let our home or family situations leave the house." (FG3. p. 9)

Knowledge gaps and myths

Participants' limited knowledge about the existing resources was a barrier to accessing health or social services. Some learned about available services from friends. Women identified the need to enhance community awareness about partner abuse though they were wary of the response from SA men.

"There should be more programs on TV and radio to increase awareness. People do not know what is the right way. Some people need boosting". (FG 2, p. 3)
"If someone telecasts any program on woman abuse, other South Asian men curse him/her, call bad names and may even kill (many women laughed sarcastically)" (FG2, p. 3)

Some myths about partner abuse also surfaced. This included partner's use of alcohol as the sole cause of violence, partner's "bad blood" or genetic reasons for violence, and women's hope for improvement in partner's behaviour. Notably, women's hope was not driven by their love for the spouse but their obligation to keep the family together.

"Yes, you have the hope that things will get better tomorrow or the day after, you keep delaying things (all women are agreeing)." Another participant added, "A woman doesn't want to take drastic steps, and she hopes that everything will be okay, and she wants the children and all to live united" (FG3, p. 9).

Turning points: private to assisted coping

Across all focus groups, participants first tried private strategies to cope with abuse and did not even tell close friends and family members. In the beginning, women went through disbelief and minimization. Then, they tried to tolerate, sacrifice themselves, pray to God and change themselves in order to meet the culturally prescribed expectations for a 'real woman' (i.e., silence, marital obligation, subordination), and for the sake of children while avoiding social stigma to preserve family respect.

"I never thought I'd have to (starts crying) see this because I thought that I knew Indian culture and the western culture. Because I was born there but I was brought up here (crying)." (FG3, p. 2)
"[situation with partner] It should not come out. I have to change myself. If I change myself, listen to my husband, tolerate him, this will bring happiness to my family." (FG3, p. 11)
"It takes years even before our own mothers find out… sometimes when we go to get medication, the doctor asks us what happened, and we just answer 'nothing'." (FG1, p. 11)

The private coping lasted for several years but seemed ineffective. When participants' personal coping abilities were depleted or they "hit rock bottom", disclosures to professionals were triggered as turning points by the severity of abuse and its unbearable consequences for themselves and/or their children.

"So, one day when things get out of hand and it's not getting better, that's when you take another step." (FG3, p.7)
"In the beginning, you can't think of leaving all by yourself [and seek help]…when it becomes too painful, they can't tolerate it any more, they want to talk to someone." (FG1, p. 4)

Most of the women described that their first disclosures to a professional occurred through specific inquiry by a family physician or in the hospital emergency department. Only few women self-disclosed first to police or counselors at the community centers. At the same time, all women had frequent contacts with their family physicians for mental or physical health issues and/or psychosomatic complaints.

"I felt as if I had cancer (symbolic) and then told the doctor" (starts to cry) (FG2, p. 3)
"I was extremely emotionally down, there was no other way left to save my life. I went to the psychiatrist." (FG2, p. 2)
"I went to the hospital because I was burned and my son called 911 and the ambulance came and took me." (FG3, p. 5)

Unlike most of the participants who disclosed to a professional only after a crisis, one participant talked to her physician at an early phase. This participant worked as a social worker before coming to Canada.

"One time when my husband told me to off [to get out of the room]…I asked my husband to take me to an Indian doctor. I never told him what I wanted to talk about…I asked the doctor can I speak privately [and disclosed her husband's verbal abuse]…The doctor then told my husband that if you tell her off again she will come straight to me…He said sorry to me there and up till today he has never said anything to me (other women saying it's smart)" (FG3, p. 6)

Talking to professionals

When probed the participants identified factors that facilitated their discussions with family physicians and other professionals in relation to partner abuse. High trust, non-judgmental attitude (friendly listener), and cross-cultural understanding were important qualities of professionals identified by the participants.

"You need to pick a doctor that listens to you, checks you properly, and has time for you. And when you feel comfortable then you can talk about anything" (FG3, p. 13).
"He [family doctor] spoke to me a lot about my children, about my husband, about the culture, and told me about differences in cultures and not to worry. He gave me attention and a lot of time." (FG1, p. 8)

Many participants preferred a female family physician from a similar cultural background. Some women expressed worries about approaching mainstream physicians due to their ethnic minority status. Others made suggestions about ways to improve communication with physicians, such as increasing the number of interpreters and being able to access culturally concordant physicians.

"English doctors just speak of one thing, shelter, divorce and welfare, these things are very popular here" (FG 3, p. 13)
"They should have doctors according to communities. If there are more Indians in a place, they should have more Indian doctors." (FG 3, p. 15)

While one participant appreciated the involvement of family members by her family physician in addressing partner abuse, a few others were critical of this approach.

"Sometimes things can get worse if you talk to your doctor about this. I've also seen this, a lot in Canada. People tell the doctor, he calls her husband, and he calls his son. Then, the son goes home and gets angry, so the situation is worsened and then you can get a divorce (FG 3, p. 12).

When asked to comment whether physicians should routinely inquire about partner abuse, all women unanimously agreed.

> "Everyone here is telling you more or less that they spoke to the doctors, I think that doctors should be part of the circle that if they get a clue that a lady is going to be abused he should double-check, or confirm. The doctors should be part of the system to check for woman abuse (FG1, p. 11)

In terms of social services, some women discussed their improved availability and deeply appreciated the existence of such services. They also acknowledged that supportive professional services for victims of violence are much more available in Canada than in their countries of origin, and have increased over time.

> "Now, you can go to community centers but before, 10–15 years ago there weren't many community centers and women were also isolated. They didn't know how they can get help or where …"(FG3, p.5)
> "What I liked is that, I didn't have anyone who was earning around me, they (social worker, shelter staff, and police) put me on welfare, they loved me, gave me all sorts of help…" (FG1, p. 7)

Discussion

In this study the SA immigrant women with experiences of partner abuse sought professional help after a long delay. Despite recognizing a link between their experiences of partner abuse and health problems, an array of reasons kept them from disclosing to helpful professionals, including family physicians that they frequently visited. Women privately coped with abuse for several years and turned for professional help only when the consequences became unbearable for themselves and/or their children. The majority of the discussed reasons against disclosure and help-seeking seemed to be linked to the intertwined contextual factors of immigration and the socio-cultural norms, in particular patriarchy and elements of collectivism and familism (Fig. 1). The findings contribute towards setting the direction of future interventions and research to address the issue of partner abuse in a timely manner for SA immigrant women, as discussed below.

Gender-based roles discussed by the participant women emerged as a major reason for their inhibition to disclose partner abuse and seek help from professionals and even from close friends and family members. Participants felt that their family and community expect a 'real' woman to remain silent about abuse and to maintain the marital bond as an obligation of good wives, daughters and sisters who they perceived to have a subordinate role to men. Some researchers have called it "three obediences" of a woman to her father, to her brother, and to her husband (Kim, Lau, & Chang, 2006). These perceptions seem to primarily stem from the social norm of patriarchy – an ideology about a set of ideas and beliefs that justify male domination over women in society (MacKinnon, 1983). While overt patriarchy is decreasing in many societies (Mintz, 1998), it continues to thrive in South Asian countries (Ahmed-Ghosh, 2004; Johnson & Johnson, 2001). Several studies demonstrate the link between patriarchal beliefs and men's perpetration of partner abuse (Dobash & Dobash, 1979; Smith, 1990; Yllö & Strauss, 1984) and even women's own justification of wife abuse (Haj-Yahia, 1998a, 1998b, 2002). Recent study reports the presence of such beliefs among South Asian immigrant women in Canada and its link to their inability to recognize abuse (Ahmad et al., 2004). Nonetheless, patriarchy is not static and it varies within men and/or women, such as, by age, education, employment status and acculturation (Ahmad et al., 2004; Bhanot & Senn, 2007; Bhopal, 1997; Haj-Yahia, 1998a, 1998b, 2002; Smith, 1990). The interpretation of our participants' discussions about their socially prescribed gender roles through their cultural context indicates a strong need to improve women's social status in the SA community. It is imperative to educate the community about gender inequality and its harmful linkages to domestic stress and partner abuse with serious consequences not limited to the victims. To trigger critical self-reflections for a positive change, an emphasis on the trans-generational consequences of abuse could be particularly beneficial in SA community due to its collectivistic and familial cultural values. Further, historical and social factors needs to be examined critically to foster an understanding of the larger forces changing relationships between men and women. Individual-level variations need to be acknowledged as well and incorporated into the development of tailored education programs to minimize the risk of stereotyping based on one's cultural affiliation. Loss of face could be crippling if precautions are not taken because protection of one's face is highly valued in collectivist SA culture and immigrant minorities. To this end, it is salient to include examples of positive role models with demonstrated equality in spousal relationships as "success stories". The use of only negatively framed messages may lead to a defensive reaction rather than a proactive response. Thus, community education messages should be developed and delivered with the help of community members and related organizations, peer support, ethnic media and religious institutions.

Social stigma perceived by our participants for the issue of partner abuse and divorce kept them from seeking help. The level of perceived social stigma was high and one participant called it "cancer" reflecting its chronic and complex nature with perceptions of being non-curable and life threatening. It seems that interrelated cultural values of familism and collectivism contributed, at least partially, in increasing women's perceptions of social stigma. Familism places emphasis on the nuclear and extended family and relationships (Vega, 1990). It promotes a sense of privacy, attachment and identification with the family through feelings of loyalty, reciprocity, and solidarity (Triandis, Marin, Betancourt, Lisansky, & Chang, 1982). The cultural value of collectivisim, in contrast to individualism, refers to the importance of needs and goals of a collective or in-group (e.g., family or community) over an individual. Triandis and others further describe this to be either horizontal or vertical in nature (Triandis, 1995, 2001; Triandis & Suh, 2002). People with horizontal-collectivism cooperate with their in-groups, while people with vertical-collectivism accept hierarchy defined by the in-group and show a willingness to sacrifice self for the collective good. In our study, many women expressed worries about family honor and suffering of their significant others (e.g. parents and siblings) due to the shame/guilt after disclosure of domestic abuse and/or divorce. Many women described sacrificing their personal happiness and tolerating partner abuse for a long time to bring family unity and achieve a collective good for their significant others, especially their children. Their extreme willingness to sacrifice, even their lives, reflects a tendency towards vertical-collectivism with views of themselves at the bottom of the relationship hierarchy. Other studies characterize SA as high in both collectivism and power-distance or the extent to which unequal distribution of power is accepted by members of a group (Hofstede, 1980). This understanding is highly pertinent for the human service professionals in assessing the "ought versus are" options available to SA abused women who wish to bring a positive change in their lives.

The values of familism and collectivism also bring hardiness, or "strength" as one of our participant said, to cope with the domestic stress. These values have been found to have a beneficial effect in other situations, such as caring for the elderly, and vary by

characteristics of individuals (Dutta-Bergman & Wells, 2002). Our findings suggest that it is the exploitation of these values through dynamics of unequal power in the trusted relationship which brought adversity to the participant abused women through delayed help-seeking. For instance, women in our study felt that the cultural expectations of silence, subordination and obligation from women as wives, sisters and daughters increased their feelings of guilt, shame and social stigma to the extent that they felt disclosing and seeking help was not even an option for them. Future research is needed to test the mediating role of patriarchy on the association of collectivism and familism with stress in intimate relationships. Nevertheless, our data suggest that resources within a group can be mobilized to improve family relationships and reduce domestic abuse. For instance, one educated participant disclosed her husband's verbal abuse to an Indian doctor and this loss of face resulted in better behaviour of her husband. Some participants talked to other resourceful women in the community who linked them to community-based counselors. Likewise, temporary separation is sometimes practiced by SA women by visiting parents and this makes an aggressive husband worried about his "good" public image, curbing his violent behaviour. Some innovative programs incorporate the SA cultural context for victim, batterer and family intervention programs using the Cultural Context Model (Almeida & Dolan-Delvecchio, 1999). In this model, a team of therapists act together in each therapy session and involves community-based people – called sponsors – to connect the client to the collective experience of his or her gender, racial and cultural groups. Yet, effective models for individual professionals are still scarce. Further research is needed to advance our understanding about the culturally embedded protective and buffering strategies used by SA women and how these may vary by the individual-level factors, such as education, age and immigration status. These insights are essential to avoid the one-size-fits-all approach. The knowledge of "risks and buffers" will enhance cultural sensitivity of community-based interventions and training of human service professionals who have expressed a need to have culturally appropriate practical tools to help at-risk women.

After privately coping with partner abuse for several years, many participants in our study discussed their experiences with physicians. On one side, women commented that having a trusting physician with strong listening skills and cultural understanding was a facilitator of their disclosures. On the other hand, many women were not sure for a long time that they could talk to physicians despite having a regular family physician. There is a need to increase SA women's awareness about the potential role of family physicians, and other health professionals, in providing direct and indirect care to women experiencing partner abuse. Some existing studies with SA abused women report their compromised physical and mental health (Hurwitz, Gupta, Liu, Silverman, & Raj, 2006; Raj, Liu, McCleary-Sills, & Silverman, 2005) but lack of spontaneous disclosures to healthcare providers (Yoshioka et al., 2003). Provider recognition of the multiple reasons of SA women's delayed help-seeking is also essential for compassionate care, vigilance and persistent in asking about stress and abuse in intimate relationships. Healthcare providers could play a pivotal role in offering acknowledgement, empathy, needed medical care, checking on safety and appropriate referrals to abused women (O'Campo, Ahmad, & Cyriac, 2008).

Immigration and settlement challenges of the participant women contributed in their delayed help-seeking, consistent with previous research (Abraham, 2000a; Liao, 2006; Midlarsky, Venkataramani-Kothari, & Plante, 2006). Their major reasons included the loss of social support and limited knowledge about available services for the victims of violence. As discussed earlier, an understanding of the historical context of immigration is important in this regard. Financial dependency of women on men after migration increases their vulnerability to stay in the abusive relationship even if they want to leave. Even those who work outside the home are seen as fulfilling an extended domestic duty and financial matters are often under the control of men (Dasgupta, 2000). Further, the loss of an extended family system after migration puts these women at great disadvantage due to interdependence in collectivistic societies (Abraham, 2000b). Mother, sisters and cousins who were once available for emotional support and to help them in meeting their gender roles of raising children and doing housework are lost after migration to a new country. These findings highlight the continued need to develop effective social support groups and community-based services for SA immigrant women to facilitate their integration and development of social networks in the adopted country. Our previous work demonstrates that social networks and ethnic media are popular modes of health promotion among SA immigrant women (Ahmad, Shik, et al., 2004). Through enhanced knowledge and professional assistance at-risk women can make practical plans to seek helpful services for improving their quality of life.

The level of integration, acculturation, and legal status in the adopted country are also important aspects of immigration in the context of help-seeking for domestic abuse (Bhuyan, 2008; Raj, Silverman, McCleary-Sills, & Liu, 2004). Although we did not quantify the level of acculturation, our participants seemed to be moderately acculturated and all were legal immigrants. It is notable that the majority of participants reported limited social support, employment and language skills though the majority had lived several years in Canada. This questions the adequacy of current interventions in reaching this vulnerable group. Indeed, further innovation in outreach programs is needed.

The conceptual model emerging from our study makes theoretical contributions. On one side, the emergent linkages between the themes of reasons, turning points, and help-seeking by talking to professionals portray the same psychological processes as proposed by the Behavioral Reasoning Theory. On the other side, this framework reveals the high significance of socio-cultural context (i.e. patriarchy, misuse of familism and/or collectivism, and immigration) in determining the reasons for delayed help-seeking in the studied population. Such high salience for the context is unlike many existing behavioral theories for mainstream populations including the Behavioral Reasoning Theory which is a recent advancement. It seems that the role of context or social forces influencing the perceived reasons has been under-theorized. We conclude that there is a need to broaden our focus from the individual-level factors to the socio-cultural conditions in which people live, to address the issue of domestic violence. We also acknowledge that our conceptual framework may not be comprehensive because of the limited number of participants in our study and lack of stratification. To advance understanding about the points of interventions for this population, a large-sample prospective study on help-seeking (across healthy and not so healthy relationships) is needed with a greater focus on the contextual factors; perhaps an expansion of the Behavioral Reasoning Theory.

The qualitative nature of our study may limit the applicability of the results to other settings. We recruited SA women with experiences of partner abuse through counselors at community-based agencies in Toronto. The views of our participants may not represent the views of other SA abused women who are not accessing such services and are hesitant to disclose their experiences. It is also important to acknowledge that diversity exists within South Asians though many share experiences of colonization followed by socio-political and cultural breakdown. Further, immigrants from South Asia may not be alike across the globe due to country-specific

immigration policies. The Canadian immigration policy has adopted a scoring system since 1967 where a primary applicant is assessed for the professional skills required by the country. Thus, the principal migrants arriving in Canada under 'independent' category are likely to be educated and skilled and male. Although Canadian immigrants still experience more underemployment and poverty than their Canadian counterparts, this policy brings some homogeneity within Canadian immigrants and they may differ as a group from immigrants of other countries where waves of migrants arrived only during certain years under labor contracts. However, these cross-country differences within immigrants are likely to be less conspicuous for immigrant women especially from South Asia because the majority arrive as dependents with no scoring requirements for education or professional skills. Nevertheless, a future study with a larger sample is necessary to enhance the generalizability of our findings. Further, an examination of 'healthy' relationships is salient to identify culturally effective strategies for addressing relationship stress. We also wish to reflect on the implication of our unique recruitment strategy through counselors. It seemed very effective in enhancing participants' trust in the research team and, hence open-discussions about the sensitive topic of partner abuse even in a group setting. Some women encouraged others to share their experiences. The counselors perceived these group sessions as a process of ''group healing'' for isolated and stigmatized women. Thus, the use of focus group methodology for a sensitive topic should not be undervalued provided supportive environments and strict confidentiality could be created for the participants. On the other hand, it is possible that some women felt inhibited in disclosing some sensitive details in the presence of other women who might not maintain confidentiality or increase the risk of losing face.

In conclusion, the study findings indicate the need to embrace multiple primary and secondary prevention strategies to address partner abuse and delayed help-seeking among SA immigrant women. For primary prevention, efforts are needed in the areas of community education and social services to reduce women's vulnerability. Community education in collaboration with grass-root organizations, ethnic media and religious institutions, should focus on both SA men and women to address perceptions about gender equality, to question beliefs that justify wife abuse, and to increase awareness about the issue of partner abuse, its consequences and available services along with examples of ''success stories'' as positive role models. To reduce the vulnerability of immigrant SA women, continued efforts are needed to enhance women's opportunities for social networking, career counseling, and language proficiency through community-based organizations. For secondary prevention, cultural training and competency of human service professionals is at the core. Service professionals should work closely with community advisors to learn and provide culturally competent interventions to victims of abuse. However, there is dearth of scientific knowledge about what works and how it works for SA immigrant abused women. Further research and program evaluation is needed for the efficient use of resources and improved outcomes. Finally, we hope that our interpretation of the findings in light of the socio-cultural context will stimulate scholarly research on help-seeking by abused women of diverse and immigrant cultures.

Acknowledgments

The study was conducted at the Women's Health Program, University Health Network. The project funds were provided by the Women's Health in the Community Program, Toronto Western Hospital. We thank Ms. Reena Vanza and Ms. Zeenat Malam for their diligent research assistance.

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