EXPERIENCES OF ARAB IMMIGRANT AND ARAB-AMERICAN SURVIVORS OF SEXUAL VIOLENCE: AN EXPLORATORY STUDY

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ABSTRACT

Sexual violence (SV) is considered to be a serious public health problem, with far-reaching and enduring ramifications on the physical and psychological well-being of survivors (Basile, Chen, Black, & Saltzman, 2007). The extent to which factors such as family support, religiosity, and mental health services are relied upon as coping strategies by survivors of SV is greatly affected by cultural values (Bryant-Davis, Chung, & Tillman, 2009; Ullman, 2010). Arab immigrant and Arab-American survivors of SV are a significantly under-researched population, despite the increasing numbers of Arab immigrant and Arab-American individuals in the United States population (Abdulrahim & Baker, 2009). The central role of family in Arab culture, as well as traditional values regarding gender roles, may influence help-seeking behaviors (Erickson & Al-Timimi, 2001; Raj and Silverman, 2002). Mental health service delivery may also be subject to a number of specific barriers for this population, including socioeconomic difficulties, discrimination and language barriers (Ali, Liu, & Humedian, 2004). The purpose of this exploratory study was to collect preliminary data on the experiences of Arab immigrant and Arab American survivors of sexual violence. Participants of this study (n=12) were recruited through domestic violence shelters and Arab American community agencies located in different US cities. Given the linguistic, transportation, confidentiality, and shame-based obstacles to accessing this population, an on-line survey was developed in English and Arabic. Data were gathered on various facets, including incident(s) of SV, coping strategies, the extent of help-seeking and posttraumatic growth. The majority of participants identified the perpetrator as a family member, and reported disclosure experiences as unhelpful. Survey results indicated that participants relied most upon coping strategies related to emotional support, self-distraction and religion, and

participants reported positive changes related to personal strength, faith in one's self and spirituality. Respondents to the Arabic version of the study endorsed greater levels of nondisclosure, religiosity and collectivist values. Recommendations for future research include further sampling, conducting interviews with participants and investigating potential relationships between variables. Recommendations for professional practice include enhancing education about Arab culture, empowering the survivor within the context of family, and engaging in advocacy and outreach efforts with both formal and informal systems in the community.

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INTRODUCTION

Sexual violence is considered to be a serious public health problem, with far-reaching and enduring ramifications on the physical and psychological well-being of survivors (Basile et al., 2007; Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002). Results from a National Violence Against Women Survey reveal that 3% of men and 17.6% of women report having experienced forced sexual encounters in their lifetime (Martsolf, Draucker, Cook, Ross, & Stidham, 2010). Childhood sexual abuse (CSA) has been documented across all racial, cultural, ethnic and socioeconomic groups, with an estimated prevalence rate of approximately 25.3 % for girls and 7.5% for boys in the United States (Fontes, Cruz, & Tabachnick, 2001; Pereda, Guilera, Forns, & Gomez-Benito, 2009). These figures are likely an underrepresentation of the true occurrence of sexual violence, as it is often hidden and therefore underreported (Basile and Saltzman, 2002; Krug et al., 2002).

The term sexual violence (SV) encompasses both sexual assaults (SA) endured in adulthood and childhood sexual abuse (CSA). What specifically constitutes “rape” or "sexual assault" varies depending on the legal statutes of a particular locale (Ullman, 2010). While some consider sexual assault to include CSA (Office of Crime Victims Advocacy), others consider the definition to be reserved for adolescents and adults (Ullman, 2010). Generally speaking, sexual assault is considered to include rape, attempted rape, incest, sexual harassment, exhibitionism and fondling; similarly, there is general consensus that CSA involves inappropriate sexual contact perpetrated by an adult or older adolescent upon a dependent child (Kenny and McEachern, 2000).

SV can have a devastating effect on the lives of survivors. Reporting of SV is thought to be mediated by cultural variables (Futa, Hsu, & Hansen, 2001; Kenny and McEachern, 2000; Korbin, 2002; Terao, Borrego, & Urquiza, 2001). Moreover, the extent to which factors such as family support, religiosity, and mental health services are relied upon as coping strategies by survivors of SV is greatly affected by cultural values (Bryant-Davis et al., 2009; Ullman, 2010). As such, there is a need to adopt an ecological approach, which takes into account the interplay of multiple factors in determining an individual's well-being, when considering the best way to provide supportive and appropriate services for survivors of SV, particularly those who are members of minority and/or immigrant populations.

Arab immigrant and Arab-American survivors of SV are a significantly under-researched population, despite the increasing numbers of Arab immigrant and Arab-American individuals in the United States population (Abdulrahim & Baker, 2009). While the US Census classifies persons of Arab ancestry as White/Caucasian, there is a considerable difference between the collectivist values often found in Arab and Arab-American culture, and the individualist values which characterizes Western culture (Abdulrahim & Baker, 2009; Ajrouch, 2004; Nassar-McMillan and Hakim-Larson, 2003). The central role of family in Arab culture, particularly in maintaining familial harmony and preserving familial honor, plays a part in discouraging discussion of sexual issues, including sexual violence (Erickson and Al-Timimi, 2001; Raj and Silverman, 2002). Furthermore, traditional values regarding gender roles may influence help-seeking behaviors (Raj and Silverman, 2002).

Help-seeking and mental health service delivery may also be subject to a number of specific barriers for this population. Since the September 11th terrorist attacks, Arab immigrants and Arab-Americans have faced considerable challenges in receiving appropriate medical and mental health care, including socioeconomic difficulties, discrimination and language barriers (Ali, Liu, and Humedian, 2004; Inhorn and Serour, 2011). The media's perpetuation of certain stereotypes continues to paint a negative picture of Arab culture (Erickson and Al-Timimi, 2001).

This review will delve into the literature on sexual violence, particularly as experienced by members of the Arab immigrant and Arab-American population. An overview of the demographics of this population will be provided, as well as a discussion of various features of Arab culture. Mental health issues that often arise within this population will be delineated, including views on sexuality and sexual violence, mental health treatment, and current treatment models, such as community-based interventions, will be surveyed. This literature review will conclude with a discussion on the need for culturally competent treatment, including exploration of the experiences of Arab immigrant and Arab-American survivors of SV.

CHAPTER I

REVIEW OF THE LITERATURE

Sexual Violence

Mental Health Impact of Sexual Violence

Sexual violence can have enduring and damaging mental consequences for survivors, which may be compounded by the repercussion of "reliving" the trauma (Hodges and Meyers, 2010). There are several characteristic factors which may influence outcome of survivors, including the type of coping strategies employed following the abuse or assault. Coping is considered to be the myriad cognitive, behavioral and emotional techniques relied upon to mediate and alleviate demands of stressors that appear to challenge one's internal resource capacity (Spaccarelli, 1994). Culture is considered to play a considerable role in the process of coping with SV (Chun, Moos, and Cronkite, 2006; Markus and Kitayama, 1991).

As such, when an individual is faced with a traumatic event such as SV, s/he first appraises the event and then surveys the coping options, both of which are done through a cultural lens (Chun et al., 2006). Once the event has been appraised, the coping goals vary with respect to a focus on the self versus others, maintaining interdependency versus staking out independence, controlling the self versus the environment and maximizing gain versus minimizing loss (Chun et al., 2006). This is particularly relevant when studying SV with a minority group such as Arab Americans and Arab immigrants, where values are often more consistent with collectivism than individualism. Collectivism is a mark of cultures which place higher importance on the interests of the group than the interests of the individual (Joseph, 1996); often, the "group" includes the family or the

tribe. Individualism, on the other hand, is found in societies, such as many Western ones, where the individual's advancement and self-sufficiency is considered to be the priority (Dwairy and Van Sickle, 1996).

It is possible that, due to these collectivist values, members may rely more upon compromising the individual well-being, out of fear of destroying all-important relationships (Markus and Kitayama, 1991). Not surprisingly, members of individualist cultures are inclined to employ behavioral and task-based coping strategies, with the aim being to influence the environment; conversely, collectivist societies utilize cognitive and avoidance-based coping strategies, often with the aim of changing and controlling oneself (Chun et al., 2006). One can see the significance of this when it is considered that, for CSA survivors in general, emotion-focused coping is more strongly relied upon than problem-focused coping (Brand and Alexander, 2003). Such emotion-focused techniques can include distancing, self-blame and avoidance.

Reliance upon such coping strategies can contribute to the variety of behavioral and psychiatric conditions that SV survivors report. These include depression, anxiety, phobic reactions, suicide, substance abuse and PTSD (Silverman, Reinherz, and Giaconia, 1996; Wilson, 2010). The most common PTSD responses amongst female survivors of CSA, for instance, are those of memory difficulties, sleep disturbances, irrational guilt and dissociation (Wilson, 2010). Outcome is also influenced by the severity of the SV, as well as parental responsiveness to disclosure; it has been shown that adult survivors with severe histories of CSA (i.e. vaginal, oral or anal penetration) reported significantly higher levels of depression than those with moderate histories (i.e. unwanted touching, kissing, fondling) (Lee, Lyvers, and Edwards, 2008; Straus, 1988).

Physical Health Impact of SV

Survivors of SV may also experience a number of physical difficulties. It has been noted that the traumatic nature of CSA may influence the physiology of the child's developing brain (Heim, Newport, Wagner, Wilcox, Miller, and Nemeroff, 2002), as well as severely compromise normative sexual development. It has also been maintained that adult survivors of CSA often report disorders of multiple systems, including gynecological, gastrointestinal, respiratory tract, and neurological (Wilson, 2010).

In addition, survivors of early sexual trauma have a greater likelihood of developing disordered eating behaviors, specifically bulimia nervosa and anorexia nervosa disorders (Romans, Gendall, Martin, and Mullen, 2001; Sanci, Coffey, Olsson, Reid, Carlin, and Patton, 2008). Recent adult sexual assault has also been shown to be significantly associated with current eating disorder symptomology (Fischer, Stojek, and Hartzell, 2010). While the mechanism for this interaction is not yet completely understood, it is possible survivors of SV experience body image disturbances as a result of the association of their bodies with feelings of shame and powerlessness; eating disordered behaviors may reflect those feelings.

SV Recovery

Recovery for survivors of SV can sometimes seem as a far-reaching and unattainable goal; the multiple physical, mental and emotional consequences of enduring such a devastating experience may render the individual not only overwhelmed, but also incapable of processing their experience. Fortunately, there are several treatment models that have been empirically shown to ameliorate the symptomology and distress of SV survivors. It has been shown that "healthy" coping of CSA includes seeking support and

disclosing the abuse, making meaning of the abuse, and developing supportive relationships (Anderson and Hiersteiner, 2008; Phanichrat and Townshend, 2010). Avenues of social support may include individual/group psychotherapy, discussing the experience with loved ones, and attending support groups. Often, psychotherapeutic approaches for this population are trauma-focused, emotion-focused, and/or centered on cognitive-behavioral techniques (Wise, Florio, Benz, and Geier, 2007).

Disclosure and Secondary Victimization

Disclosure of SV has the capacity to empower survivors and help them begin their recovery process (Ullman, 2010). Several factors may influence the likelihood of disclosure, including gender, as men are less likely to disclose SV experiences to anyone (Ullman, 2010). Moreover, older victims of sexual assault are more likely to report than younger victims (Ullman, 2010), and non-White victims are less likely to report sexual assault than White victims (Thompson, Sitterle, Clay, and Kingree, 2007). Thompson et al. (2007) identifies potential reasons as fear of being blamed and a reluctance to involve police officers. This may possibly be heightened for Arabs living in post-9/11 America, where the perception of law enforcement may be something to be feared, not trusted.

Cultural issues are also relevant when considering the race and ethnicity of the perpetrator of SV. Ullman (2010) notes that women who are raped or sexually assaulted by someone of a different ethnicity than their own may be ashamed to disclose to family and culture members, because of pre-outlined conditions on marriage or dating. This is particularly relevant in the case of Arab communities, where families often stress not only intra-ethnic marriages, but also intra-faith ones. Acculturation can influence disclosure (Ullman, 2010), with factors such as linguistic skills and immigration status

bearing weight on the comfort of an individual with the American legal and medical systems.

There is a great deal of emphasis placed on the importance of disclosure, and the potential for empowerment and healing that lies therein (Anderson and Hiersteiner, 2008; Phanichrat and Townshend, 2010; Wise et al., 2007). However, it is vital to bear in mind that disclosure may also contribute to the trauma of the SV (Ullman, 2010). Sexual violence is a devastating act and it does not end at the abuse or assault; namely, reporting can result in a secondary traumatization process, depending on the quality of the individual's and family's experiences with the legal, medical, and even previous mental health systems (Campbell, 2008). Martsolf et al. (2010) note that considerable studies have revealed that the training and knowledge of professionals such as educators, police officers, medical residents, and emergency room personnel can play a role in the subsequent recovery of victims. This is a population for whom the clinician may also have to adopt the role of advocate and emphasize the rights of the client; this may include the provision of accurate information about what the processes of prosecution and medical examinations entail (Campbell, 2008).

In American society, nearly every report of sexual abuse results in some form of contact with legal and medical systems, including child protective services, emergency room medical forensic examinations and prosecution procedures. While an increase in advocacy in recent decades has aided in ameliorating the process for survivors, these systems still have the capacity to be a source of familial disruption and individual distress (Campbell, 2008). Similarly, negative responses from the formal system (i.e. judgment, blaming the victim, perpetuating rape myths) significantly exacerbates PTSD

symptomology in sexual assault survivors (Campbell, 2008; Ullman, 2010). One can surmise that such a response would be particularly deleterious in the case of Arab American and Arab immigrant survivors, many of whom may also be experiencing such a reaction from family or community members.

Ecological Approach

Campbell, Dworkin, and Cabral (2009) utilized Bronfenbrenner's ecological theory of development to explore how various factors of the sexual assault experience influenced the mental health outcomes of the survivor. Namely, they examined: individual-level factors (i.e. nature of coping strategies), assault characteristics (i.e. presence of life threat), microsystem factors (i.e. response from family/friends), meso/exosystem factors (i.e. response from legal, medical, mental health care systems following the assault), macrosystem factors (i.e. cultural attitudes about sexual assault), and chronosystem factors (i.e. cumulative trauma) to reveal that the development of self-blame is a result of these various levels (Campbell et al., 2009).There is no single characteristic that can singlehandedly dictate outcome; rather, it is the interaction of multiple factors.

As such, the nature of the SV, the experience of the disclosure, the perceptions (or lack thereof) of social support and, of course, the sociocultural norms that contextualize the SV, all affect the survivor's well-being. Considering Arab American and Arab immigrant survivors through the lens of ecology increases the likelihood that the clinician will take into account the impact of multiple systems on the intervention process and therefore allow for their influence on the process of treatment (Mourad and Carolan, 2010).

Arabs in America

US Census

Arab American individuals, as described by the 2000 US Census, are those whose ancestry can be traced back to Arabic speaking countries (Abdulrahim and Baker, 2009; Amer and Hovey, 2007; Brittingham and de la Cruz, 2005). In particular, the Arab American community constitutes individuals who have recently immigrated from, or are the descendants of those who immigrated from, any of the 22 members of the Arab League (Abdulrahim and Baker, 2009), including: Algeria, Bahrain, Comoros, Djibouti, Egypt, Iraq, Kuwait, Jordan, Lebanon, Libya, Mauritania, Morocco, Oman, Palestinian Territories, Qatar, Saudi Arabia, Somalia, Syria, Sudan, Tunisia, United Arab Emirates, and Yemen. While the US Census estimates the figure of Arab Americans to be approximately 1.2 million, reports from the Arab American Institute (AAI) claim the figure is approximately 3.5 million (AAI, 2004; Erickson and Al-Timimi, 2001). This discrepancy can in part be accounted for by discrimination, and the subsequent avoidance of classifying one's self as "Arab American" on the Census form, which neglects to provide a separate box for Arab Americans (Erickson and Al-Timimi, 2001).

Religion

With the exception of Lebanon, the majority of Arab countries are predominately Muslim; it is worth noting, however, that while there is overlap between Arab populations and Muslim populations, religious diversity exists amongst Arab immigrant and Arab American individuals (Abdulrahim and Baker, 2009; Ali et al., 2004). Judaism and Hinduism are practiced in Arab countries, although the Christian, Druze and Islam

faiths are considerably more prevalent (Abdulrahim and Baker, 2009). In the United States, the largest percentage of Arab Americans are Lebanese Christians (AAI, 2011); it has been posited that Christian Arabs are more successful in their adaptation to American society than Muslim Arabs, which may be linked to the prevalence of Christianity within American culture (Amer and Hovey, 2007). Islam is considered to be a way for life, with customs and rules prescribing lifestyle practices as well as religious rituals (Ali et al., 2004; Hodge, 2005; Weatherhead and Daiches, 2010), which may lead to greater dissonance with mainstream American culture.

Socioeconomic Status and Education

Arab Americans display considerable diversity with respect to socioeconomic status (Abdulrahim and Baker, 2009), although the US Census indicates that, on average, this population demonstrates higher levels of education and income relative to other groups. Brittingham et al. (2005) notes that the majority of Arab Americans are employed in professional and managerial occupations, with over 41% of this population attaining at least a college degree.

Differences and Commonalities

There is a considerable amount of disunity and political rupturing amongst, and within, Arab nation-states (Al-Krenawi and Graham, 2000), as evidenced by the recent "Arab Spring" events (Haboush and Barakat, in press); this fragmentation naturally accompanies immigrants to the US. Moreover, Western cultural values have infiltrated much of the Arab world (Al-Krenawi and Graham, 2000), through popular entertainment, foreign policy and the general effects of globalization. The ways in which such divisions manifest depends greatly on the community (Al-Krenawi and Graham, 2000). Still, Arab

and Arab-American individuals often share more than just the language. This population is often united by shared facets of Arab culture, such as a collective historical memory (Al-Krenawi and Graham, 2000).

Immigration

Three waves of Arab immigration have been noted (Amer and Hovey, 2007; El-Sayed and Galea, 2009; Erickson and Al-Timimi, 2001; Nassar-McMillan et al., 2003). The first consisted largely of Syrian and Lebanese Christian immigrants in the late 1800s; the majority of these individuals were uneducated and settled into unskilled jobs in the US (El-Sayed and Galea, 2009). This wave of Arab immigration concluded with the 1924 Quota and Johnson-Reed Acts, which limited the yearly number of individuals allowed entry into the US (El-Sayed and Galea, 2009). The second wave of Arab immigration took place following the pro-immigration policy which cropped up after World War II; this time around, immigrants were often fleeing the political turmoil in Syria, Iraq and Palestine, and tended to arrive with higher levels of formal education (Amer and Hovey, 2007; El-Sayed and Galea, 2009). Individuals with even higher levels of education arrived during the third wave of Arab immigration, which began in the mid-1960s and continued through the Arab-Israeli conflict and the Lebanese Civil War (El-Sayed and Galea, 2009; Erickson and Al-Timimi, 2001).

Recent immigration waves, beginning in the 1990s, have tended to be more politically motivated, with a greater number of Muslims seeking asylum or refugee status in the US (Amer and Hovey, 2007). This has resulted in an increased number of recent immigrants arriving with less formal education and higher levels of trauma (Britto and Amer, 2007; Nasser-McMillan and Hakim-Larson, 2003). This issue may have

implications when considering barriers that exist for mental health service delivery with this population; levels of acculturation, beliefs about healing and therapy, and experiences of discrimination may all influence the likelihood of help-seeking. Currently, nearly 95% of Arab Americans in the US reside in metropolitan areas (Al-Krenawi and Graham, 2000), including Detroit, Los Angeles and the New York City/New Jersey area. Lebanese Christians, Egyptians and Syrians represent the largest percentage of Arab Americans (AAI, 2011), while Moroccans and Iraqis have among the highest proportion of recent arrivals to the US (Brittingham and de la Cruz, 2005).

Features of Arab Culture

Collectivism and the Family

Collectivism is an essential component of Arab culture (Erickson and Al-Timimi, 2001; Joseph, 1996). Like other collectivist cultures, the welfare of the group, particularly the family, is often prioritized before personal good (Joseph, 1996); this varies from individualist cultures, such as those found in many Western countries, wherein autonomy and personal achievement is more strongly valued (Dwairy and Van Sickle, 1996). In Arab culture, the importance of the family is believed to be an echo of former nomadic and tribal existence (Joseph, 1996); group solidarity has also played a significant role in safeguarding against the devastation of political upheaval and loss of land, as evidenced by various pan-Arab movements in the twentieth century.

In terms of the family, unity and the maintenance of the family system serves the function of providing protection and support for members during painful events (Dwairy, 2006); one offshoot of such a value is the considerable emphasis on behavior which

allows for the flourishing of the family system. Actions, or even individual beliefs, that challenge the honor and strength of the family are often discouraged (Abu-Ras, 2007; Dwairy, 2006). In terms of SV, Arab collectivism can be a double-edged sword. On one hand, the realization that a family member has experienced SV can mobilize a considerable amount of loyalty and support from other members. On the other hand, the realization may never come. Survivors may feel obligated to make a personal sacrifice in order to avoid "dishonoring" the family, and fail to report or share the experience. If it is shared, there is the possibility that prioritizing familial cohesion and honor may complicate of responses of support, and possibly shielding from future harm, from the family system to the victim.

Gender Roles and Patriarchy

Arab culture often emphasizes the concept of filial piety, which involves the duty of children and younger generational members to respect and provide care for parents, grandparents, and other elder family members (Khalaila, 2010). Filial duty and reciprocity amongst daughters is particularly significant, as they are expected to consider the requests and needs of other family members before their own; at times, particularly depending on level of acculturation, these needs may be at odds (Mourad and Carolan, 2010).

While both daughters and sons are monitored for appropriate behavior within Arab and Arab American families, it appears that sons may have a considerable stake in the sister's behavior (Ajrouch, 2004). How one conducts oneself is a reflection of the family and, for daughters, this is particularly true; from an early age, sons learn that their reputations, as well as the effectiveness of their roles as "men of the house", are linked

with that of the females in the family (Kulwicki, 2002). Arab and Arab American parents may engage in differential treatment of daughters and sons (Britto, 2008; Mourad and Carolan, 2010), with daughters facing additional stressors regarding their chastity and "goodness" as a girl. Family honor, then, might be strengthened by the integrity of all members, but it is the sexual and behavioral immodesty of daughters, sisters and wives which most swiftly collapses it (Ajrouch, 2004; Kulwicki, 2002; Mourad and Carolan, 2010).

Arab families have been traditionally characterized as patriarchal in structure (Al-Krenawi and Graham, 2000), with the male members, particularly the father, portrayed as representatives of the family (Mourad and Carolan, 2010). Fathers are often expected to provide for and protect women and children, while mothers may hold dominion over childrearing and domestic issues (Kulwicki, 2002; Mourad and Carolan, 2010). Female members are expected to take on a less visible role, particularly when visibility is equated with display of sexuality. Acculturation and religiosity may mediate the degree of such familial structure.

Sexuality

Attitudes towards sexuality within Arab culture are often shaped by religiosity (Read, 2003). Both Christianity and Islam prohibit premarital sex (Weatherhead and Daiches, 2010), although Islam views sexuality positively when it occurs within the sanctity of marriage. It is only if it occurs externally is it considered sinful and disruptive to the morality of society as a whole (Obermeyer, 2000). In observant Muslim families, socializing with members of the opposite sex is often inhibited, as is immodesty in dress (Ali et al., 2004; Hodge, 2005; Sheikh, 2009; Weatherhead and Daiches, 2010).

Within the Arab culture, sexual matters are very rarely discussed, and "masculine" and "feminine" stereotypes may be encouraged in an attempt to control sexual behavior. This often gives rise to dichotomized thinking in terms of what is acceptable and what is shameful (i.e. "virgin" versus "whore"). Being "decent" or "clean" can become equated with remaining virginal, which can complicate the experience of a SV survivor. In a culture where sexual infidelity or promiscuity can spur honor killings as a way to restore familial honor (Abu-Ras, 2007), experiences of sexuality, even those that are unwanted or forced, can result in a complex response of shame and self-blame.

Tensions may emerge when issues of acculturation permeate the realm of sexuality, as sexual interactions (including those which are premarital and initiated by females) are considerably more common in Western society (Obermeyer, 2000). The fear for a daughter's "ruined" reputation is not limited to any particular developmental stage; it is an ongoing threat to the familial honor (Mourad and Carolan, 2010). As such, devotion and fidelity to the family and its honor is a particularly esteemed quality amongst daughters (Nassar-McMillan et al., 2003). Equally, norms of assertiveness and toughness are desired amongst sons (Rebeiz and Harb, 2010); this may have implications for Arab males who experience SV.

Acculturation

Many of the features discussed above are mediated by levels of acculturation. Immigration, and the subsequent process of adapting to a novel culture, comes with a considerable amount of tension and pressures, referred to as acculturative stress (Amer and Hovey, 2007; Barkho, Fakhouri, and Arnetz, 2010; Euser, van IJzendoom, Prinzie,

and Bakermans-Kranenburg, 2010). Reasons for immigration, socioeconomic status, and discrimination received in the host country can all influence the degree to which acculturative stress is experienced (Barkho et al., 2010). Moreover, how smoothly acculturation is dealt with, and the extent to which there is a successfully integrated identification with both the traditional and new sets of values, can be influenced by a number of factors (Abu-Ras and Abu-Bader, 2008; Al-Krenawi and Graham, 2000; Ortiz and Flanagan, 2002). For Arab immigrants, acculturation can be complicated by perceived or real instances of discrimination in the US, particularly following the 9/11 attacks and heightened biases (Amer and Hovey, 2007; Britto and Amer, 2007; Erickson and Al-Timimi, 2001).

Arab Culture and Mental Health

Trauma

Culture is considered to be a highly complex system of meaning that is shared and transmitted through intergenerational channels (Chun et al., 2006). As such, this meaning is often manifested into a set of norms and beliefs that provide individuals with a blueprint for behavior. Certain reactions to stressors can be shaped by the values of the culture to which that person belongs; in particular, the notion of the self is defined and considered differently depending upon the society. The very definition of self can be affected by the language of the culture at hand, since language can influence the description of self-concept, the connotations of certain values and even the fluidity (and suppression) of certain emotions (Hong, Morris, Chiu and Benet-Martfnez, 2000). This is true for Arab immigrants and Arab Americans.

Trauma is considered to be something which threatens one or more facets of human security (Bajpai, 2001), namely environmental, food, health, personal, community and/or political safety. Examples of trauma can include events experienced by a community, such as natural disasters or a civil war, or by the individual, such as abuse or violence. Immigration involves geographic, emotional, interpersonal and cultural changes, all of which can involve a considerable amount of trauma (Khawaja, White, Schweitzer, and Greenslade, J., 2008; Tsoi Hoshmand, 2007). In terms of political refugees, the pre-migratory stage may be marked, particularly in times of war, by a lack of basic necessities, political trauma, and loss of loved ones (Khawaja et al., 2008). The post-migratory phase often involves a new environment, financial difficulty, social isolation and a novel set of values, norms and language. Trauma can manifest in feelings of anger and depression; difficulties in interpersonal interactions; physical illness; and spiritual crises (Davidson and Baum, 2001; Khawaja et al., 2008).

When it comes to practical applications of intervention and prevention work in the field of trauma, certain concepts must be kept in mind. Traumatic events often not only deplete personal emotional resources, but also communal capacities. The reality of trauma on a global scale reflects a need for rapid and efficient trauma assessment and insight that reflects cultural variance (Tsoi Hoshmand, 2007). It is noteworthy to consider that pre-trauma levels of normalcy differ amongst cultures (Tsoi Hoshmand, 2007); for instance, a group that has had a recent history of wars or political oppression will dissect and react to an additional violent act differently than a group without such recent local history. This is particularly relevant when considering Arab survivors of SV who have recent immigration histories due to political turmoil.

How an individual copes with trauma may be influenced by their perceived locus of control, be that internal or external, with respect to their life and environment (Chun et al., 2006). Collectivist societies, such as Arab ones, may rely upon altering one's emotions and behaviors in order to fit into the group, while individualist cultures tend to promote altering the environment to better suit their needs. Many Arab immigrants have experienced, firsthand, war or its by-products (Abu Ras and Abu-Bader, 2008); making meaning of such trauma, or any subsequent trauma encountered in the US, may be strongly influenced by their perceived locus of control.

Somatization

Somatization as an expression of distress is common with Arab culture; psychosocial concerns or emotional suffering may be expressed somatically, via heart disease, fatigue, chronic pain, loss of appetite and other symptoms. This is in part due to the stigma and shame that is often attached with emotional distress and troubles (Dwairy, 2006; Kobeisy, 2004; Yunesia, Aslani, Vash, and Yazdi, 2008). It is easier, and less shameful, to complain about an aching body part than divulge emotional anguish, particularly since this a culturally sanctioned expression of pain. As such, the discomfort associated with discussing personal difficulties often results in Arab clients' preference to seek help from doctors and medical professionals rather than mental health workers, such as counselors or therapists (Al-Krenawi and Graham, 2000; Kobeisy, 2004; Nassar-McMillan et al., 2003). Arab clients may consider affective disorders and other mental health concerns to have somatic origins. Moreover, the medical doctor's tendency to take a directive, "expert" stance during consultation might feel more reassuring to the Arab client, who may find the exploratory, collaborative nature of therapy too disquieting

(Najeh, 2004).

Attitudes towards Help-Seeking

As mentioned, the strong sense of shame and/or dishonor that might be mobilized by disclosing personal matters can serve as a deterrent to help-seeking for Arab and Arab American clients (Haboush, 2005; Mourad and Carolan, 2010; Najeh, 2004). Many clients of Arab ethnicity have negative associations when it comes to mental health service delivery, and feel a considerable amount of mistrust towards psychologists, psychiatrists and counselors (Al-Krenawi and Graham, 2000; Nobles and Sciarra, 2000). In particular, these individuals may consider mental health services as reserved for those who are "majnoon," or insane, or morally weak (Sabbah, Dinsmore, and Hoff, 2009). Being "majnoon" implies having feeble or insufficient faith within the Muslim religion (Erickson and Al-Timimi, 2001; Hodge, 2005; Kobeisy, 2004), suggesting that mental health problems can be triggered by supernatural forces. Amongst Arab nations, there continues to be inadequate mental health services (Al-Krenawi, 2006).

The reluctance towards seeking counseling and psychotherapy may be attributed to the associations that many Arab Americans have with the inherent "Western-ness" of psychotherapy. Arabs tend to prefer turning to informal resources such as family members and friends, or traditional community leaders such as imams (Al-Krenawi and Graham, 2009). When Arabs do seek psychotherapy or counseling, the ultimate goals of self-awareness and autonomy-building may be in direct conflict with familial and cultural values. Moreover, clients from this population may remain passive in session, particularly if the therapist is perceived as the "expert" (Najeh, 2004; Sabeh et al., 2009).

It is important to bear in mind that culture "influences the help seeking behavior" of an individual, due in part to the fact that culture ultimately governs "what is seen as private and public pain" (Drožđek, 2007, pp. 8). As such, the issues of shame that are sometimes inherent with reactions to trauma may be compounded by the vivid shame felt by someone who fiercely believes in the privacy of sorrow or grief. This may be the case with survivors of SV who come from a culture where discussing personal matters, or one's reactions to them, is discouraged.

Role of Religion

The importance of spirituality and/or religion for many Arab individuals has been noted (Hall and Livingston, 2006); Arab clients may rely on religious activities, such as prayer, reading holy books, and consulting with religious leaders, as a primary coping strategy (Abu Raiya and Pargament, 2010). Failure to acknowledge and convey respect towards the Arab client's belief system may ultimately be damaging to the therapeutic relationship (Hall and Livingston, 2006). Hodge (2005) observes that the five pillars of Islam are considered to be far-reaching in the believer's life, communicating a certain way of life intrapersonally, as well as within the community and the family. Fully grasping the significance and role of religion, if any, in the Arab client's life can help inform the therapeutic process. Members of the Arab American community have traditionally turned to religious institutions, such as mosques and churches, and leaders in times of need (Abu-Ras and Abu-Bader, 2008). In New York City, a considerable amount of Muslims seek mental health counseling at NYC mosques (Abu-Ras and Abu-Bader, 2008). It has been shown that Muslim religious leaders consider incorporation of

religious values in mental health services to be desirable (Abu-Ras and Abu-Bader, 2008).

Structural Issues

There are several structural issues that may be of particular importance when considering mental health services with this population. As mentioned previously, when Arab clients do reach out for mental health resources, they are likely to view their therapist as fulfilling a similar role as a medical doctor (Al-Krenawi and Graham, 2000; Sabbah et al., 2009). Therapy which takes a directive and concrete tone, combined with a client-centered approach aimed at assisting rapport, may work best, at least in initial stages.

Moreover, Arab clients who develop trust in their therapist may invite him/her to their home, a mark of the generosity and reception that is common within Arab culture (Nobles and Sciarra, 2000). In terms of communication styles, Arabs tend to be less candid and personal than Western clients in therapy (Nobles and Sciarra, 2000), possibly as a result of viewing such disclosures as disloyal or inappropriate to non-family members. Indirect references may be more suitable when discussing difficult and painful events with Arab clients (Nobles and Sciarra, 2000). Issues of time are also important to bear in mind, as notions of time within Arab culture tend to be more fluid and interactions may be more leisurely than in the West; as such, there may be structural difficulties that come up in therapy around starting and ending sessions promptly (Al-Krenawi and Graham, 2000; Nobles and Sciarra, 2000; Sabbah et al., 2009).

Arab Culture and Sexual Violence

Attitudes towards SV

When SV is perpetrated against a victim, the cultural context within which this act occurs is significant, particularly insofar as an individual may take cues towards how to register and feel about the experience (Hong et al., 2000). As such, attitudes towards sexual violence amongst Arab Americans and Arab immigrants are just as important as those towards sexuality in general. Once again, acculturation can play a role in mediating such belief systems. Arab individuals residing in Western society may, depending on the level of acculturation, engage in behaviors that are considered "taboo" in the country of origin, such as casually dating or having premarital sex. However, even if an individual is engaging in these behaviors, there may still be a lingering sense of ambivalence about their acceptability, particularly if the larger familial system espouses more conservative values. As such, a victim's likelihood to report SV or seek help may be influenced by such values and opinions, including those towards what constitutes SV, what influences it and, even, what justifies it.

A US study on dating violence revealed that 7% of adolescent women reported having been forced into sexual intercourse by their dating partner (Raghavan, Bogart, Elliott, Vestal, and Schuster, 2004). Dating violence, which may encompass SV, is found to be related to both partner's attitudes towards violence in general (Sherer, 2010). Such attitudes may be gleaned from social values and cultural norms dictating what constitutes appropriate behavior for a woman and a man in a relationship. It has been found that Arab men reveal significantly greater support of dating violence than Arab females

(Sherer, 2010), something which may be mediated by the degree to which one maintains a conservative outlook on masculinity, sexual chastity and traditional gender roles.

Wehbi (2002, 2003), who explored the conceptualization of rape within Lebanese culture, observed that "myths" and beliefs about rape may be inexorably linked with characteristics of rape victims. In particular, females who are considered to have "something to lose," often in the form of virginity, are more likely to be considered rape victims than those who do not (Wehbi, 2003). Such an outlook is reflected in the Lebanese penal code, with harsher sentencing of perpetrators if the victim is a virgin (Al-Zein, 2004, as cited in Rebeiz and Harb, 2010).

A study by Rebeiz et al. (2010) revealed that, amongst Lebanese university students, the likelihood to endorse rape myths was correlated with the presence of values such as tradition and conformity. Interestingly, while sexist attitudes and religiosity were also found to be positively correlated with rape myths, it was determined that the strongest predictor of rape myths was *attitudes towards rape victims* (Rebeiz and Harb, 2010). These included issues of integrity and responsibility of blame; promiscuity also factored in the credibility that claims were accorded (Rebeiz and Harb, 2010).

Reactions to SV and Reporting

As mentioned, attitudes towards SV may be influenced by how newly immigrated Arab families and individuals are, as well as their degree of acculturation. Tensions may arise in families where children are first-generation Americans, and endorse less traditional values than parents. It is possible that value-related conflicts may not only influence receptiveness to receiving mental health services (Nassar-McMillan et al., 2003), but also the readiness to expose SV, such as disclosing childhood sexual assault or

encouraging a family member to report a rape to an authority figure. It is also possible that more traditional, rigid familial structures may discourage the sharing of SV, both within and outside of the family system, as survivors may utilize self-blame, shame and justification to rationalize the SV (Abu-Ras, 2007) instead of risk dishonoring or unhinging the family system. Keeping SV experiences to one's self may also be motivated out of fear of being blamed by family members for bringing scandal upon the family (Abu Baker and Dwairy, 2003). On the other hand, the close-knit, loyal character of Arab American families may result in a substantial protective and supportive reaction towards the survivor.

Fatalism, as expressed within both the Christian and Muslim faith's emphasis on belief in the role of fate and divine will, may also inhibit reporting among Arabs with high degrees of religiosity (Nasser-McMillan and Hakim-Larson, 2003). In Islam, for instance, a good event is considered to be a blessing, something sent by Allah, while painful or difficult events might be attributed to lapses in faith or failure to be a "good" Muslim (Hodge, 2005; Weatherhead and Daiches, 2010). This is related to the earlier discussion on perceived locus of control, as Arab individuals may be less likely to try and change a situation of abuse, or seek justice for an act of assault. Finally, as discussed further in the following section, there are certain institutional and systemic factors that may discourage reporting of SV to external authorities, particularly by Arab immigrants and Arab Americans.

Institutional Barriers for Arabs in America

Perceived Systemic Discrimination

The 9/11 attacks have seen a rise of reported ethnicity-related discrimination against Arab Americans, particularly among Muslims (AAI, 2011; Ali et al., 2004; Amer and Hovey, 2007). Newly immigrated Arabs are more likely to experience discrimination (Abu-Ras and Abu-Bader, 2008); such individuals may still be unaccustomed to the mainstream American society and social norms, which may target them as "different." Recently immigrated Arab families tend to have lower levels of trust in American society (Nasser-McMillan and Hakim-Larson, 2003). All of these factors can lead to a disinclination to interact with formal systems, and a subsequent underuse of various services, including medical, legal and mental health systems.

The unfortunate irony is that such individuals are particularly in need of such services. Experiencing discrimination and social mistreatment is significantly associated with higher levels of psychological distress, lower levels of happiness and overall worse health status (Padela and Heisler, 2010). These experiences may result in further associations of discrimination with an entire institution, such as an individual's mistrust of all police officers following one experience of discrimination. Alternatively, it is worth noting that the likelihood for Arabs in the US to turn to informal support networks such as friends and religious leaders, as well as community based networks (Douki, Nacef, Belhadi, & Ghachem, 2003), such as community centers and religious institutions, can help inform intervention strategies for SV, particularly through increasing mobility of resources and communication with such venues. As these are the sources to which Arabs in the US are often most comfortable turning to in times of distress and/or need, it is

worth emphasizing their potential effectiveness in promoting mental health services. An individual who may shirk from the prospect of having to find and reach out to a therapist, particularly on his/her own, may more readily accept receiving mental health services if they are offered at a community care center s/he is already acquainted with, and possibly receives other services at.

Cultural Barriers

Arab Americans may experience certain barriers to seeking and the utilization of various legal, mental health and medical services that are unique to this population (Abdullah and Brown, 2011; Dwairy and Van Sickle, 1996). These may include features of Arab culture discussed in the earlier section. Religious and spiritual beliefs that give rise to the fatalistic attitude that things happen because "God wills it" is one such cultural barrier (Nasser-McMillan and Hakim-Larson, 2003). Moreover, gender roles and the silence around sexuality may make discussion of such topics with a stranger even more painful or shameful (Kulwicki, Miller, and Schim; 2000); being considered immodest or dishonorable may potentially deter a pious Arab American woman, for instance, from reporting a sexual assault.

Another cultural barrier may be related to immigration. As mentioned above, recent immigration trends, including the Yemeni civil war, the US invasion in Iraq and, potentially, the recent, ongoing events of the Arab Spring, are resulting in a different demographic makeup (Amer and Hovey, 2007; El-Sayed and Galea, 2009). Recently displaced immigrants often come from less technologically and educationally advanced backgrounds (El-Sayed and Galea, 2009; Erickson and Al-Timimi, 2001). As a result, it

is possible that more recent immigrants face particular challenges in terms of accessing services, not the least of which is linguistic difficulties.

Role of Family and Community

Traditionally, it is the family, not the state, which takes informal responsibility for its members in Arab societies. Such roles of family unit as protector may give rise to tensions vis-à-vis US legal enforcement (Abu Baker and Dwairy, 2003). Ultimately, the requirement of legal authorities to take action against and persecute perpetrators of SV may be viewed as shaming the family by threatening familial reputation and harmony. It has been noted that blaming the victim for bringing legal and social troubles "upon the family" is a potential reaction to reportage of childhood sexual abuse in Arab families (Abu Baker and Dwairy, 2003). As such, survivors may wish to save themselves the anticipated heartache and avoid sharing their experiences. For instance, one study found that a significant proportion of Bedouin-Arab female adolescents did not seek help in part out of fear of the community's reaction (Elbedour, Abu-Bader, Onwuegbuzie, Abu-Rabia, and El-Aassam, 2006).

Implications for SV Survivors

Reporting any instance of SV to authorities sets into motion a myriad of systemic interactions, including legal, medical and social (Ullman, 2010). The very act of *interacting* with authorities, however, may be strongly influenced by previous experiences with authorities. Prior experiences of discrimination and bias, perceived or real, in the legal, mental healthcare, or medical system, will influence help-seeking behaviors (Ullman, 2010). The barriers discussed above may have very real implications on the likelihood of an Arab survivor of SV reporting or sharing his/her experiences.

Role of the Therapist

Cultural Competence

Psychologists are ethically obligated to foster understanding of and respect for different cultures (American Psychological Association, 2002). Doing this involves acquiring the knowledge, sensitivity and various skills that enhance one's cultural competence (Sue, Arrendondo, and McDavis, 1992; Erickson and Al-Timimi, 2001; Haboush, 2007), particularly regarding the cultural groups that one serves. Better understanding the worldview and cultural background of one's client can result in stronger therapeutic alliance, and decrease the likelihood of unintentional harm (Sue et al., 1992). Cultural competence, ultimately, involves not merely the passive intake of facts and country profiles, but rather encouraging the client to teach clinicians about their culture (Brown, 2009). As Brown (2009) notes, "the therapist never achieves cultural competence but is always moving toward it" (pp. 181).

In relation to SV experiences amongst Arab populations, such cultural competence involves an understanding of various facets of Arab culture which may mediate the effect of SV, as well as a monitoring of one's own personal attitudes (Ortiz and Flanagan, 2002). The negative portrayal of Arab communities in mainstream American mass media and society may influence a clinician's attitude towards Arab clients, and remaining cognizant of such reactions is vital (Ortiz and Flanagan, 2002; Sabah et al., 2009). Taking into account all of the institutional, cultural and personal barriers that may exist when it comes to discussing SV in this population, clinicians need to take special precautions in order to deliver relevant, sensitive and culturally competent services. It is also the responsibility of the clinician to try and counter institutional

discrimination the client may have encountered elsewhere. Considering the heightened levels of shame that are likely to accompany SV in general (Ullman, 2010), conveying a nonjudgmental and supportive stance is of particular importance.

Outreach to Community Resources

Arab clients may underuse mental health services in part because of reliance on more traditional sources of support such as religious institutions and Arab community agencies geared towards providing advocacy, education, and legal services (Haboush, 2007; Sabbah et al., 2009). It is possible that these community-based groups, along with religious institutions, are an excellent way to ensure greater acceptance of mental health services amongst Arab individuals in the US. Many of these agencies have begun providing counseling and mental health resources (i.e. Arab-American Family Support Center; Arab Community Center for Economic and Social Services), and may prove to be the ideal source for instating new mental health programs. Such agencies and religious institutions have the advantage of being trusted and accepted within the Arab American community, as well as potentially being the place people turn to in crisis. Therefore, they may be considered a "safer" option in terms of the systemic discrimination perceived elsewhere. In recent years, there has been a trend towards the expansion of Arab American community care center programming to address the problem of domestic violence amongst this population (Kulwicki et al., 2000; Kulwicki, Aswad, Carmona, and Ballout, 2010); this has often taken the form of incorporating a DV program and/or crisis hotline. This suggests that there is a growing recognition of this problem, although barriers to utilization still exist (Kulwicki et al., 2010). Still, the expanded programming

of community centers and agencies such as ACCESS and AAFSC may prove to be an excellent way to increase survivor's comfort level and likelihood of accessing services.

Furthermore, the strong sense of family and community that many Arabs value may lend itself nicely to campaigns which advocate for strengthening communal coping strategies. As discussed earlier, this population is exposed to a considerable amount of discrimination and stressors in post-9/11 America, not to mention that additional trauma that immigration may have incurred; finding ways to promote adaptive and culturally appropriate mental health resources may be more successful if the community aspect is kept as a common denominator. Turning mental health service delivery into something other than a last resort is no simple feat; it involves the transformation of how the realm of mental health is perceived by and portrayed to this population, as well as making accessible and acceptable services available. This may involve the education and training of various members of informal resource networks, such as religious leaders and community care providers, on various intervention and referral processes.

Rationale for Present Study

Sexual violence as experienced by Arab immigrant and Arab American individuals is a severely under researched topic, despite the devastating effect that SV can have on survivors (Campbell et al., 2009). Enhancing understanding of the experiences of Arab survivors of SV can help better equip mental health professionals in providing appropriate and valuable services. The present study will aim to begin generating data on such survivors. The hope is that, in working with community agencies and shelters to

receive participant referrals, this study, and future ones, will provide some data to support the expansion of such programs to meet survivor's needs.

The focus will be on gathering information on various facets of their experience, including incident(s) of sexual violence, coping strategies, the extent of help-seeking, and posttraumatic growth. In order to remain faithful to the ecological model (Campbell, Dworkin, and Cabral, 2009) of sexual violence, acculturation, religiosity, and familial values will be explored as well. The aim of this study is to explore the following research questions:

1. How does a small sample of Arab-American and Arab immigrant adults in the United States describe their experiences of sexual violence?
2. What coping strategies do these individuals report utilizing?
3. To what extent did posttraumatic growth (positive psychological change) occur as a result of the struggle with sexual violence experience(s)?

CHAPTER II

METHODOLOGY

Participants

Participants of this study were Arab immigrant and Arab American adult survivors of sexual violence (n=12). The participants were recruited by reaching out to several domestic violence shelters and Arab American community agencies, located in different US cities. Personalized emails were sent to the various agencies explaining the study and inquiring about their willingness to recruit participants (see APPENDIX A).

The following sites agreed to refer participants for this study: 1.) a support center based in the Northeast which offers a range of services for victims of domestic violence; 2.) a Northeastern immigrant service agency; 3.) a community center based in the Northeast which offers a range of services, including counseling, education and assistance, for Arab immigrant and Arab-American individuals; 3.) a non-profit agency in a Midwestern city offering advocacy for individuals and families of this community; 4.) a program offering culturally sensitive and free of charge mental health services to individuals of Arab descent in a Northeastern city; 5.) a Southwestern non-profit organization aimed at supporting and empowering domestic violence survivors; and 6.) a nonprofit social service agency based in the Midwest.

Agency representatives at these sites were then emailed the two links to the online survey, one in English and one in Arabic. Representatives from these agencies, specifically counselors, therapists and case managers, helped in the selection and recruitment of participants. Namely, only clients who had disclosed information regarding their experiences of sexual violence were approached with information about

the study. These experiences may include childhood sexual abuse, sexual assault, rape, or any form of unwanted sexual contact; the sexual violence may have been endured in the past or still ongoing. This disclosure may have taken place during counseling or in case management sessions; only the case manager, counselor, or therapist to whom the disclosure was made broached the topic of the study with the client.

Agency representatives informed clients above the age of 18 who fit these criteria, and who had one or both parents of Arab descent, of the online study. They informed clients that a study was being done to explore the experiences of Arab immigrant and Arab American survivors of sexual violence, with the hope of learning more about how to better serve these survivors. Representatives stated that they were informing the client of this study because the client's own experiences might make them eligible candidates for the study. Representatives told clients that the study will be an online survey, with the responses remaining completely anonymous. Representatives informed clients that they were under no obligation to complete, or access, the survey, and that their participation, or lack thereof, would in no way affect the services they receive at the agency. Representatives then asked clients if they were interested in receiving more information about the study. If the response was no, no more information about the study was provided. If the response was yes or maybe, the client was asked if they preferred the web link to the survey to be written down on a piece of paper or emailed to the client. The representative then, accordingly, wrote down or emailed the web link to the client. Agency representatives did not have access to the online surveys or the data set.

Study participants then entered the link, where they were given the option of an English or Arabic consent form (see APPENDIX B). By clicking "I Accept," participants

agreed to participate in the study. Although the study was designed to be completed in 30-50 minutes, participants were able to take as long as they wished on each question. In addition, participants could skip any questions of their choosing and discontinue participation whenever they wished. They could not stop and resume the survey at a later time. There was no compensation for completing the survey. The online survey was hosted by a private account on SurveyMonkey. Since IP address information was not included in the dataset, participation was anonymous. The data was downloaded onto password-protected files on the investigator's SurveyMonkey account, to which only the investigator and dissertation committee members had access.

Sample

A total of 23 surveys were initiated, but not all of them were completed. After unfinished surveys were removed, 12 surveys were analyzed for this study.

Procedures

Questionnaire

The questionnaire was created specifically for this study and is comprised of 44 close-ended items, featuring a drop down menu of responses (see APPENDIX C). Given the lack of available questionnaires on sexual violence in the Arab American population, the investigator developed the questionnaire in order to obtain information specific to Arab culture, as well as incidents of SV. Participants were first asked several questions that provided non-identifying demographic information, such as age, gender, relationship status, employment status, education and country of birth/country of origin. They then

answered questions regarding religiosity, and the extent to which religious beliefs play a significant role, if at all, in their life. Following that, participants answered a series of questions on their experiences of immigration (if applicable), as well as issues of acculturation. Next, participants were asked about the incident(s) of sexual violence, including the age(s) at which it occurred, the nature of the SV, perpetrator information, and experience of disclosure (if relevant).

Ratings Scales

The online survey also included two established instruments (see APPENDIX D). The first is the Brief COPE (Carver, 1997), which was utilized to explore the coping strategies employed in terms of the SV experiences. The Brief COPE is a 28-item instrument which measures coping strategies in the following four areas: religion, substance use, humor, and behavioral disengagement. The following is the internal consistency of the four *a priori* scales: religion: a = .82; substance use: a = .90; humor: a = .73; and behavioral disengagement: a = .65; (Carver, 1997). Responses to this measure indicated the extent to which participants relied upon and endorsed particular coping strategies as a response to their experience(s) of sexual violence.

The second instrument utilized in this study is the Posttraumatic Growth Inventory (PTGI), a 21-item measure which gauges the extent of growth perceived in oneself following a substantially stressful experience (Tedeschi and Calhoun, 1996). Growth may take the form of heightened spirituality, an increasingly positive outlook on life and self, and improved interpersonal relationships (Tedeschi and Calhoun, 1996). This instrument was employed in this study to explore participant perceptions of such positive changes following the otherwise negative experience of SV. Ratings are done

utilizing a 0 to 5 Likert scale; participants are asked to rate a variety of items, yielding scores on five subscales: New Possibilities, Relating to Others, Personal Strength, Spiritual Change, and Appreciation of Life (Tedeschi and Calhoun, 1996). Responses to this measure indicated the extent to which participants perceive growth having occurred following their experience(s) of sexual violence. In terms of the psychometric properties of the PTGI, internal consistency ranges from .67 to .85 (Tedeschi and Calhoun, 1996).

Translation

The entire online survey was translated by the investigator's mother into Arabic, who is fluent in both English and Arabic and has done a considerable amount of work-related translation. This decision was made to ensure the highest quality of translation.

Data Analysis

In terms of data analysis, detailed descriptive statistics was used extensively as the study is largely exploratory in nature, and little data exists examining this phenomenon within this population. Further analyses, such as analysis of variance and/or multivariate analysis of variance, were dependent upon whether there would be an adequate sample size to support it. The exact types of statistical analysis utilized ultimately depended upon the final sample size.

CHAPTER III

RESULTS

Overview

Results will be discussed according to the following outline:

I. Demographics

II. Religiosity

III. Immigration/Acculturation

IV. Abuse

V. Coping

    i. Coping and Age of Onset

VI. Post-Traumatic Growth

    i. Post-Traumatic Growth and Age of Onset

Demographics

Participants of this study were Arab immigrant and Arab American adult survivors of sexual violence (n=12). As there is no way of knowing how many people were referred to the study due to the anonymous nature of the study design, the response rate is unknown. Twenty-three surveys were started, and twelve surveys were completed. Nine participants completed the English version of the survey, while three participants completed the Arabic version. Accordingly, demographic information gleaned from each version of the survey has been presented in Tables 1, 2, and 3. It is worth noting that the data organized in the tables in this chapter reflect percentages which have been rounded up; moreover, some percentages may reflect questions which allowed for multiple

responses. When combining the data for both versions of the survey, the majority of participants were female (91.6%), between the ages of 18 and 29 (66.7%), who worked at least part time (66.7%) and had at least a college degree (58.3%).

Most participants were born outside the United States (75%). Countries of birth included Jordan (25%); Morocco (16.6%); Palestine (8.3%); Lebanon (8.3%); Saudi Arabia (8.3%); Libya (8.3%); and the United States (25%). All participants had at least one parent of Arab origin. In terms of mother's family of origin, responses included Moroccan (16.6%); Palestinian (58.3%); Libyan (8.3%); and Jordanian (8.3%). In terms of father's family of origin, responses included North American (8.3%); Palestinian (50%); Lebanese (16.6%); Libyan (8.3%); Moroccan (8.3%); and Jordanian (8.3%).

As noted earlier, the majority of participants reported having completed at least a college degree as their highest degree, while 25% completed a graduate degree. Approximately 16.6% of participants completed some college, and 25% indicated that a high school degree or GED was their highest level of education. In terms of mother's highest level of education, this included less than high school (25%); a high school diploma or GED (25%); some college (8.3%); and a graduate degree (41.6%). For father's highest level of education, responses included a high school diploma or GED (25%); some college (33.3%); a college degree (8.3%); and a graduate degree (33.3%).

With respect to the household characteristics, participants responded to questions about household income, relationship status, number of children (if any) and with whom they currently resided. Approximately 8.3% of participants reported a household income of less than $10,000, while 50% reported incomes between $25,000 and $49,999. Approximately 33.3% reported household incomes of $50,000 and higher. In terms of

relationship status, 41.6% of participants described themselves as single, while 16.6% reported being in a relationship. Approximately 16.6% reported being married, while the same percentage identified themselves as divorced, and 8.3% reported being separated. The majority of participants (66.7%) reported having no children. Other responses included one child (8.3%); two children (8.3%); three children (8.3%); and five children (8.3%). Participants reported residing with roommates (16.6%); friends (8.3%); a spouse (8.3%); siblings (16.6%); children (25%); parents (41.6%); other family members (83%); and living alone (8.3%).

Table 1*
Participant characteristics

Characteristic	English Survey %	Arabic Survey %
Gender		
Female	89%	100%
Male	11%	0%
Age		
18-20	22%	33%
21-29	33%	67%
30-39	11%	0%
40-49	33%	0%
Country of Birth		
United States	33%	0%
Palestine	11%	0%
Jordan	22%	33%
Morocco	11%	33%
Lebanon	11%	0%
Saudi Arabia	11%	0%
Libya	0%	33%
Mother's Family of Origin		
Morocco	11%	33%
Palestine	78%	0%
Libya	0%	33%
Jordan	0%	33%
Other (Unspecified)	11%	0%
Father's Family of Origin		
United States	11%	0%
Morocco	11%	33%
Palestine	67%	0%
Lebanon	22%	0%
Libya	0%	33%

Table 1 Continued

Participant Characteristics

Characteristic	English Survey %	Arabic Survey %
Jordan	0%	33%

* Data in all tables reflect percentages which have been rounded up. In addition, some percentages may reflect questions which allowed for multiple responses.

Table 2

Participant characteristics

Characteristic	English Survey %	Arabic Survey %
Employment Status		
Part-Time	33%	67%
Full-Time	33%	0%
Student	22%	0%
Homemaker	11%	33%
Highest Level of Education		
High School/GED	22%	33%
Some College	22%	0%
College Degree	22%	67%
Graduate Degree	33%	0%
Mother's Level of Education		
Less than High School	11%	67%
High School/GED	22%	33%
Some College	11%	0%
Graduate Degree	56%	0%
Father's Highest Level of Education		
High School/GED	22%	33%
Some College	33%	33%
College Degree	11%	0%
Graduate Degree	33%	33%

Table 3

Participant characteristics

Characteristic	English Survey %	Arabic Survey %
Household Income		
<$10,000	0%	33%
$15,000-24,999	0%	33%
$25,000-34,999	44%	0%
$35,000-49,999	11%	33%
$50,000-74,999	22%	0%
$75,000-99,999	11%	0%
<$100,000	11%	0%
Relationship Status		
Single	44%	33%
In a Relationship	22%	0%
Married	11%	33%
Separated	0%	33%
Divorced	22%	0%
Children		
None	67%	67%
One	0%	33%
Two	11%	0%
Three	11%	0%
Four	0%	0%
Five	11%	0%
Currently Residing With		
Roommates	11%	33%
Friends	11%	0%
Spouse	11%	0%
Siblings	22%	0%
Children	33%	0%

Table 3 Continued

Participant Characteristics

Characteristic	English Survey %	Arabic Survey %
Parents	44%	33%
Other Family Members	11%	0%
Alone	0%	33%

Religiosity

Participants responded to a series of questions regarding religiosity, and the extent to which religious beliefs play a significant role, if at all, in their life. Religiosity information gleaned from each version of the survey has been presented in Table 4. Across both versions of the survey, the majority of participants identified themselves as members of a sect of Islam (91.6%), particularly Sunni Muslim (50%). Approximately 41% identified as non-Sunni Muslims and 8.3% identified as Agnostic. Respondents did not identify with any other religious groups. When asked about the frequency of religious mention in their households during childhood, the majority (66.6%) reported that religion was mentioned at least once a week. Approximately 16.6% reported that religion was mentioned less than once a week in their childhood households, and the same percentage reported that religion was rarely mentioned. With respect to the frequency of religious services currently attended, 33.3% attend four or more religious services per month. The same percentage of participants reported not attending any religious services at all.

The majority (66.6%) of participants described their religious beliefs as "Important" or "Extremely important" to them. Approximately 16.6% stated that their religious beliefs are "Somewhat important," while the same percentage reported that they do not have any religious beliefs. Similarly, the majority (83.3%) of participants stated are that they are "Extremely certain" or "Certain" about their religious beliefs, while 8.3% are "Uncertain" about their religious beliefs. When asked about what activities, if any, participants engage in when faced with difficulty in their lives, the majority (58.3%) identified turning to prayer. Other answers were speaking with a religious leader (16.6%) and meditating (8.3%). Twenty-five percent of participants reported not engaging in any

of these activities when faced with difficulty in their lives. Participants were asked to what extent, if any, they agreed with the following statement: “I believe that God watches over me and protects my life.” Responses included “Strongly agree” (41.6%); “Agree” (41.6%); and “Strongly disagree” (16.6%). There was a higher degree of religiosity endorsed amongst the respondents of the Arabic version of the survey, all of whom described being certain about their religious beliefs, and attended religious services at least once a month.

Table 4
Religiosity

Characteristic	English Survey %	Arabic Survey %
Religion		
Shi'aa	11%	0%
Sunni	44%	67%
Muslim—Other	33%	33%
Christian	0%	0%
Agnostic	11%	0%
Frequency of religion mentioned in household		
Once a week	56%	100%
Less than once a week	22%	0%
Rarely	22%	0%
Frequency of religious services attended		
Five times a month or more	11%	33%
Four to five times a month	11%	33%
One to two times a month	0%	33%
Once every few months	11%	0%
Once or twice a year	22%	0%
Do not attend services	44%	0%
Importance of religious beliefs		
Extremely important	22%	33%
Important	33%	67%
Somewhat important	22%	0%
Do not have religious beliefs	22%	0%
Certainty about religious beliefs		
Extremely certain	22%	33%
Certain	56%	67%
Uncertain	11%	0%
Do not have religious beliefs	22%	0%
Activities when faced with difficulty		
Speak with a religious leader	11%	0%
Meditate	11%	0%
Pray	56%	67%
Do not do any of these activities	33%	0%

Immigration and Acculturation

Participants responded to a series of questions regarding their immigration, if applicable, and acculturation. Responses to statements related to acculturation have been presented in Table 5, according to the English and Arabic versions of the questionnaire. Taking both surveys as an aggregate, approximately 41.6% of participants identified themselves as first generation immigrants to the United States, while the same percentage characterized themselves as second generation. Amongst the respondents of the Arabic version, all of the respondents identified as first generation immigrants. Approximately 8.3% of respondents described themselves as sojourners, residing in the United States temporarily, with plans to return to their home country.

While 33.3% of participants reported being born in the United States, the remainder reported immigrating to the United States from their home country; of these participants, 75% identified their immigration as voluntary, while 25% characterized it as involuntary, due to reasons such as persecution or asylum seeking. In terms of legal status in the United States, 66.6% of participants are US citizens, 25% are green card holders and 8.3% are visa holders.

In order to gauge acculturation levels, participants were asked about the languages spoken in their household; 8.3% identified only English as being spoken, 8.3% identified only Arabic as being spoken, and 83.3% identified both English and Arabic as being spoken. When asked about the proficiency of their English, 66.6% characterized themselves as fluent, 16.6% reported that they spoke well or very well, and 16.6% reported that they did not speak English well.

When presented with statements that discussed one's identity as Arab and/or American, 50% of participants endorsed the statement identifying them as equally Arab and American, while the other 50% of participants endorsed the statement identifying them as more Arab than American or Arab-American. Participants were also given two statements and asked to what extent, if any, they agreed with them. The first statement was: "It is important to avoid doing things my family disapproves of." Approximately 41.6% of participants agreed or strongly agreed with the statement, 33.3% were uncertain, and 25% disagreed or strongly disagreed with the statement. The second statement was: "I believe that an individual's actions can bring shame upon his/her family." The majority of participants (58.3%) agreed or strongly agreed with this statement, while 16.6% were uncertain and 25% disagreed or strongly disagreed.

Table 5

Acculturation

Characteristic	English Survey %	Arabic Survey %
Statement about identity which best describes you		
I consider myself to be equally American and Arab	44%	67%
I consider myself as American rather than Arab or Arab-American	0%	0%
I consider myself as Arab rather than American or Arab-American	56%	33%
"It is important to avoid doing things my family disapproves of"		
Strongly agree	11%	67%
Agree	11%	33%
Uncertain	44%	0%
Disagree	22%	0%
Strongly disagree	11%	0%
"I believe that an individual's actions can bring shame upon his/her family"		
Strongly agree	11%	67%
Agree	33%	33%
Uncertain	22%	0%
Disagree	22%	0%
Strongly disagree	11%	0%

Abuse/Assault Incident(s)

Participants were asked a series of questions about their experience(s) of sexual violence. Responses pertinent to the characteristics of the abuse and/or assault incident(s) have been presented in Table 6, according to the English and Arabic versions of the questionnaire. Responses related to the participants' experiences of disclosure, if applicable, have been presented in Table 7, according to the English and Arabic versions of the questionnaire.

With respect to the age(s) during which the sexual violence took place, across both surveys, 16.6% reported between the ages of 1 and 4; 58.3% reported between the ages of 5 and 8; 33.3% reported between the ages of 9 and 12; and 41.6% reported between the ages of 13 and 17. When asked about the age at which sexual violence first occurred, 11% of participants reported they could not recall; 16.6% reported between the ages of 1 and 4; 41.6% reported between the ages of 5 and 8; 16.6% reported between the ages of 9 and 12; and 25% reported between the ages of 13 and 17. When asked about the age at which the sexual violence last took place, 25% reported between the ages of 5 and 8, 25% reported between the ages of 9 and 12, and 50% reported between the ages of 13 and 17.

The majority of participants (58.3%) reported that the sexual violence incidents took place between six to ten times. Other responses included the sexual violence occurring once (8.3%); two to five times (8.3%); over ten times (16.6%); and being unable to recall (8.3%). Regarding characteristics of the abuse/assault, the majority of participants (66.6%) reported being touched inappropriately by the perpetrator. Half the participants reported being forced to perform sexual acts on the perpetrator, 25% reported

vaginal and/or anal penetration as occurring during the incident(s), and 8.3% reported having their life threatened by the perpetrator.

Participants identified the perpetrator(s) as follows: family friend (25%); father (16.6%); brother/sister (8.3%); grandparent (16.6%); uncle/aunt (41.6%); cousin (8.3%); other family member (8.3%); and stranger (16.6%). The majority of participants (66.6%) still see the perpetrator at family events or social outings, and most (83.3%) stated that the abuse was never reported to the police. In the instances where the abuse was reported to the abuse, no arrests were made.

With respect to disclosing the abuse incident(s), participants reported making the initial disclosure to the following: mother or father (41.6%); sibling (8.3%); cousin (8.3%); friend (16.6%); and never disclosed (25%). Twenty-five percent of participants reported finding this initial disclosure experience to be "Somewhat helpful," while 33.3% of participants found it "Neither helpful nor unhelpful." Approximately 33.3% found the first disclosure experience to be "Somewhat unhelpful," and 8.3% found it to be "Very unhelpful." Participants identified the following as other people they disclosed the abuse incident(s) to: mother or father (25%); sibling (8.3%); grandparent (16.6%); aunt or uncle (16.6%); other family member (16.6%); friend (41.6%); counselor or therapist (25%); spouse (16.6%); and girlfriend or boyfriend (16.6%).

Of those participants who are in therapy or counseling, 77.7% have disclosed the abuse to their therapist or counselor. Of those participants who disclosed the abuse in therapy or counseling, 28.5% found the disclosure to be very helpful; 42.8% found the disclosure to be somewhat helpful; 14.2% found it neither helpful nor unhelpful; and 14.2% found the disclosure to be very unhelpful.

Of those that disclosed their abuse to others, participants identified that they found receiving support (50%) and being referred for services (16.6%) to be the most helpful outcomes of disclosure. Twenty-five percent of participants stated that they were helped as a result of disclosure, while 16.6% reported that nothing changed as a result of disclosure. Approximately 16.6% of participants noted that they were not believed after disclosing abuse, while 33.3% reported that they were told to keep the abuse a secret. Approximately 16.6% asked that the abuse be kept a secret following disclosure.

Table 6

Abuse/Assault Incident(s)

Characteristic	English Survey %	Arabic Survey %
Age(s) during which abuse took place		
1-4	22%	0%
5-8	56%	33%
9-12	44%	0%
13-17	33%	67%
Number of times abuse took place		
Once	11%	11%
Two to five times	11%	11%
Six to ten times	44%	100%
Over ten times	22%	22%
Cannot recall	11%	11%
Characteristics of the abuse/assault		
Having one's life threatened	11%	0%
Being touched inappropriately	89%	0%
Being forced to perform sexual acts	33%	100%
Vaginal/anal penetration	33%	0%
Perpetrator(s) of the abuse		
Family friend	22%	33%
Father	22%	0%
Mother	0%	0%
Brother/sister	11%	0%
Grandparent	22%	0%
Uncle/aunt	44%	33%
Cousin	0%	33%
Other family member	11%	0%
Stranger	22%	0%

Table 7

Disclosure

Characteristic	English Survey %	Arabic Survey %
First disclosure of abuse/assault		
Mother or father	44%	33%
Sibling	11%	0%
Cousin	11%	0%
Friend	22%	0%
Never disclosed	11%	67%
Helpfulness of first disclosure		
Very helpful	0%	0%
Somewhat helpful	33%	0%
Neither helpful nor unhelpful	33%	33%
Somewhat unhelpful	33%	33%
Very unhelpful	0%	33%
Other people disclosed to		
Mother or father	38%	0%
Sibling	12.5%	0%
Grandparent	25%	0%
Aunt or uncle	12.5%	33%
Other family member	25%	0%
Friend	50%	33%

Table 7 Continued

Disclosure

Characteristic	English Survey %	Arabic Survey %
Counselor or therapist	38%	0%
Spouse	25%	0%
Girlfriend or boyfriend	25%	0%
Never disclosed	12.5%	33%
Disclosed in therapy		
Yes	78%	0%
No	11%	33%
Not in therapy	11%	67%
Therapy disclosure helpful		
Very helpful	22%	0%
Somewhat helpful	33%	0%
Neither helpful nor unhelpful	11%	0%
Very unhelpful	11%	0%
Have never been in therapy	22%	67%
Not disclosed in therapy	0%	33%
Helpful during disclosures		
Support	67%	0%
Being referred for services	22%	0%
Nothing helpful occurred	22%	33%

Table 7 Continued

Disclosure

Characteristic	English Survey %	Arabic Survey %
Never disclosed	11%	67%
Occurred during disclosure		
"I was helped."	38%	0%
"I was not believed."	25%	0%
"I was told to keep it a secret."	38%	33%
"I asked that it be kept a secret."	25%	0%
"Nothing changed."	25%	0%
"I have never discussed my sexual abuse."	25%	67%

Coping

Participants were given the Brief COPE to explore the coping strategies they relied upon as a response to their experience(s) of sexual violence. The twenty-eight coping strategies which participants had the opportunity to endorse have been presented in Table 8, according to the English and Arabic versions of the questionnaire. Subjects could endorse doing these coping strategies using the following indicators: 1="I haven't been doing this at all;" 2="I've been doing this a little bit;" 3="I've been doing this a medium amount;" 4="I've been doing this a lot."

Different coping strategies were endorsed by a majority of respondents in each version of the survey. Respondents of the Arabic survey endorsed coping strategies that relied upon humor ("I've been making fun of the situation") and religion ("I've been praying or meditating"; "I've been trying to find comfort in my religion or spiritual beliefs"), which were not significantly endorsed amongst the English version respondents. Furthermore, the Arabic version respondents endorsed strategies that relied upon self-blame ("I've been blaming myself for things that happened"; "I've been criticizing myself"). Respondents of the English version endorsed coping strategies that relied upon acceptance ("I've been accepting the reality of the fact that it has happened"; "I've been learning to live with it") and use of emotional support ("I've been getting comfort and understanding from someone"), which were not endorsed amongst the respondents of the Arabic version.

Despite these differences, there are several coping strategies that appear to be strongly endorsed when the responses of both versions of the survey are taken as an aggregate. One such coping strategy ("I've been turning to work or other activities to take

my mind off of things") is marked by reliance on self-distraction, and was endorsed by 75% of participants. In addition, another strategy which relies on self-distraction ("I've been doing something to think about it less, such as going to movies, watching TV, reading daydreaming, sleeping, or shopping") was endorsed by 50% of respondents. Another coping strategy ("I've been saying things to let my unpleasant feelings escape"), which is a form of venting, was endorsed by 66.6% of participants. Across both surveys, two coping strategies that relied upon acceptance ("I've been accepting the reality of the fact that it has happened"; "I've been learning to live with it") were endorsed by, respectively, 75% and 58.3% of participants.

Table 8

Brief COPE

Coping Strategies	English Survey %	Arabic Survey %
1. I've been turning to work or other activities to take my mind off of things.		
I haven't been doing this at all	11%	0%
I've been doing this a little bit	22%	0%
I've been doing this a medium amount	11%	67%
I've been doing this a lot	56%	33%
2. I've been concentrating my efforts on doing something about the situation I'm in.		
I haven't been doing this at all	56%	33%
I've been doing this a little bit	22%	0%
I've been doing this a medium amount	11%	67%
I've been doing this a lot	11%	0%
3. I've been saying to myself "this isn't real."		
I haven't been doing this at all	78%	33%
I've been doing this a little bit	0%	0%
I've been doing this a medium amount	0%	33%
I've been doing this a lot	22%	33%
4. I've been using alcohol or other drugs to make myself feel better.		
I haven't been doing this at all	67%	100%
I've been doing this a little bit	0%	0%
I've been doing this a medium amount	0%	0%
I've been doing this a lot	33%	0%
5. I've been getting emotional support from others.		
I haven't been doing this at all	33%	100%
I've been doing this a little bit	33%	0%
I've been doing this a medium amount	22%	0%
I've been doing this a lot	11%	0%

Table 8 Continued

Brief COPE

Characteristic	English Survey %	Arabic Survey %
6. I've been giving up trying to deal with it.		
I haven't been doing this at all	4%	33%
I've been doing this a little bit	11%	0%
I've been doing this a medium amount	22%	33%
I've been doing this a lot	22%	33%
7. I've been taking action to try to make the situation better.		
I haven't been doing this at all	44%	100%
I've been doing this a little bit	11%	0%
I've been doing this a medium amount	22%	0%
I've been doing this a lot	22%	0%
8. I've been refusing to believe that it has happened.		
I haven't been doing this at all	56%	33%
I've been doing this a little bit	11%	0%
I've been doing this a medium amount	22%	33%
I've been doing this a lot	11%	33%
9. I've been saying things to let my unpleasant feelings escape.		
I haven't been doing this at all	33%	0%
I've been doing this a little bit	11%	0%
I've been doing this a medium amount	22%	67%
I've been doing this a lot	11%	33%
10. I've been getting help and advice from other people.		
I haven't been doing this at all	22%	100%
I've been doing this a little bit	44%	0%
I've been doing this a medium amount	33%	0%
I've been doing this a lot	0%	0%

Table 8 Continued

Brief COPE

Characteristic	English Survey %	Arabic Survey %
11. I've been using alcohol or other drugs to help me get through it.		
I haven't been doing this at all	56%	100%
I've been doing this a little bit	11%	0%
I've been doing this a medium amount	0%	0%
I've been doing this a lot	33%	0%
12. I've been trying to see it in a different light, to make it seem more positive.		
I haven't been doing this at all	44%	67%
I've been doing this a little bit	11%	0%
I've been doing this a medium amount	22%	33%
I've been doing this a lot	22%	0%
13. I've been criticizing myself.		
I haven't been doing this at all	44%	33%
I've been doing this a little bit	33%	0%
I've been doing this a medium amount	22%	0%
I've been doing this a lot	0%	67%
14. I've been trying to come up with a strategy about what to do.		
I haven't been doing this at all	44%	33%
I've been doing this a little bit	22%	33%
I've been doing this a medium amount	22%	0%
I've been doing this a lot	11%	33%
15. I've been getting comfort and understanding from someone.		
I haven't been doing this at all	22%	67%
I've been doing this a little bit	11%	33%
I've been doing this a medium amount	11%	0%
I've been doing this a lot	56%	0%

Table 8 Continued

Brief COPE

Characteristic	English Survey %	Arabic Survey %
16. I've been giving up the attempt to cope.		
I haven't been doing this at all	67%	100%
I've been doing this a little bit	22%	0%
I've been doing this a medium amount	11%	0%
I've been doing this a lot	0%	0%
17. I've been looking for something good in what is happening.		
I haven't been doing this at all	44%	67%
I've been doing this a little bit	11%	0%
I've been doing this a medium amount	11%	0%
I've been doing this a lot	33%	33%
18. I've been making jokes about it.		
I haven't been doing this at all	89%	100%
I've been doing this a little bit	0%	0%
I've been doing this a medium amount	0%	0%
I've been doing this a lot	11%	0%
19. I've been doing something to think about it less, such as going to movies, watching TV, reading, daydreaming, sleeping, or shopping.		
I haven't been doing this at all	11%	67%
I've been doing this a little bit	22%	33%
I've been doing this a medium amount	33%	0%
I've been doing this a lot	33%	0%
20. I've been accepting the reality of the fact that it has happened.		
I haven't been doing this at all	0%	33%
I've been doing this a little bit	0%	33%
I've been doing this a medium amount	56%	33%
I've been doing this a lot	44%	0%

Table 8 Continued

Brief COPE

Characteristic	English Survey %	Arabic Survey %
21. I've been expressing my negative feelings.		
I haven't been doing this at all	33%	67%
I've been doing this a little bit	33%	0%
I've been doing this a medium amount	11%	33%
I've been doing this a lot	22%	0%
22. I've been trying to find comfort in my religion or spiritual beliefs.		
I haven't been doing this at all	56%	0%
I've been doing this a little bit	11%	33%
I've been doing this a medium amount	0%	33%
I've been doing this a lot	33%	33%
23. I've been trying to get advice or help from other people about what to do.		
I haven't been doing this at all	44%	33%
I've been doing this a little bit	22%	33%
I've been doing this a medium amount	22%	33%
I've been doing this a lot	11%	0%
24. I've been learning to live with it.		
I haven't been doing this at all	0%	33%
I've been doing this a little bit	22%	0%
I've been doing this a medium amount	11%	33%
I've been doing this a lot	67%	33%
25. I've been thinking hard about what steps to take.		
I haven't been doing this at all	33%	0%
I've been doing this a little bit	44%	33%
I've been doing this a medium amount	11%	33%
I've been doing this a lot	11%	33%

Table 8 Continued

Brief COPE

Characteristic	English Survey %	Arabic Survey %
26. I've been blaming myself for things that happened.		
I haven't been doing this at all	78%	0%
I've been doing this a little bit	22%	0%
I've been doing this a medium amount	0%	67%
I've been doing this a lot	0%	33%
27. I've been praying or meditating.		
I haven't been doing this at all	33%	0%
I've been doing this a little bit	22%	33%
I've been doing this a medium amount	11%	67%
I've been doing this a lot	33%	0%
28. I've been making fun of the situation.		
I haven't been doing this at all	89%	0%
I've been doing this a little bit	11%	0%
I've been doing this a medium amount	0%	100%
I've been doing this a lot	0%	0%

Coping and Age of Onset

When looking at age of onset of sexual violence incident(s), 58% of participants (n=7) were aged 8 and younger during the first incident of SV versus 42% of participants (n=5) who were aged 9 and older during the first incident of SV. As the percentages were closely split, means were calculated for each group as they related to coping with experiences for sexual violence. These means as they relate to each coping strategy on the Brief COPE are outlined in Table 9. Due to the low *n* number in each "age of onset" group, statistical significance could not be determined, but there are several findings that would appear to warrant future empirical investigation and, for the time being, clinical attention. These findings indicate that coping trends might differ depending on the age of onset of SV in a survivor's life, which may have implications for clinical and therapeutic considerations and interventions.

One such finding is the higher reliance of the group with a younger age of onset (8 and below) upon coping strategies that utilize avoidance as the main technique. These include keeping one's self physically or mentally busy, in order to avoid thinking about the SV experiences. The younger age of onset group also displayed higher rates of acceptance as a central facet of their coping, in terms of accepting the reality of the experience and finding ways to "live with it." Moreover, the younger age of onset group appeared to rely more heavily upon coping strategies related to religion, such as prayer and taking comfort in religious or spiritual beliefs. Conversely, the group with an older age of onset (9 and above) displayed higher rates of positive reframing in their coping (i.e. "I've been looking for something good in what is happening"), as well as reliance on support from others and venting.

Table 9
Brief COPE

Coping Strategies	Age of onset 8 and younger (Mean)	Age of onset 9 and older (Mean)
1. I've been turning to work or other activities to take my mind off of things.	3.7	2.4
2. I've been concentrating my efforts on doing something about the situation I'm in.	1.8	2
3. I've been saying to myself "this isn't real."	2.3	1.4
4. I've been using alcohol or other drugs to make myself feel better.	1.8	1.6
5. I've been getting emotional support from others.	1.8	1.8
6. I've been giving up trying to deal with it.	2.3	2.4
7. I've been taking action to try to make the situation better.	1.9	2
8. I've been refusing to believe that it has happened.	1.6	2.8
9. I've been saying things to let my unpleasant feelings escape.	2.4	3
10. I've been getting help and advice from other people.	1.9	1.8
11. I've been using alcohol or other drugs to help me get through it.	2	1.6
12. I've been trying to see it in a different light, to make it seem more positive.	2.1	2
13. I've been criticizing myself.	2.3	1.8
14. I've been trying to come up with a strategy about what to do.	1.6	2.8
15. I've been getting comfort and understanding from someone.	2.3	3
16. I've been giving up the attempt to cope.	1.3	1.4
17. I've been looking for something good in what is happening.	1.6	3.2
18. I've been making jokes about it.	1	1.6
19. I've been doing something to think about it less, such as going to movies, watching TV, reading daydreaming, sleeping, or shopping.	3	1.8
20. I've been accepting the reality of the fact that it has happened.	3.3	2.8

Table 9 Continued
Brief COPE

Coping Strategies	Age of onset 8 and younger (Mean)	Age of onset 9 and older (Mean)
21. I've been expressing my negative feelings.	1.9	2.4
22. I've been trying to find comfort in my religion or spiritual beliefs.	2.9	1.6
23. I've been trying to get advice or help from other people about what to do.	1.6	2.6
24. I've been learning to live with it.	3.6	2.8
25. I've been thinking hard about what steps to take.	2.4	2
26. I've been blaming myself for things that happened.	1.7	1.8
27. I've been praying or meditating.	3	1.8
28. I've been making fun of the situation.	1.1	2

Post-Traumatic Growth

Participants were given the Post-Traumatic Growth Inventory to gauge the extent of growth the participants perceived in themselves following the experience(s) of sexual violence. The twenty-one potential growths which participants had the opportunity to endorse have been presented in Table 10, according to the English and Arabic versions of the questionnaire. Subjects could endorse these changes using the following indicators: 0 = "I did not experience this change as a result of the sexual abuse/assault;" 1 = "I experienced this change to a very small degree as a result of the sexual abuse/assault;" 2 = "I experienced this change to a small degree as a result of the sexual abuse/assault;" 3 = "I experienced this change to a moderate degree as a result of the sexual abuse/assault;" 4 = "I experienced this change to a great degree as a result of the sexual abuse/assault;" and 5 = "I experienced this change to a very great degree as a result of the sexual abuse/assault."

Respondents of the Arabic survey endorsed positive changes related to religiosity and spirituality ("I have a better understanding of spiritual matters"), which were not significantly endorsed amongst the respondents of the English survey. Across both surveys, several positive changes were strongly endorsed. A positive change related to faith in one's self ("I have a greater feeling of self-reliance") was endorsed by 75% of the participants. Positive changes related to perceptions of personal strength, namely "I know better that I can handle difficulties" and "I discovered that I'm stronger than I thought I was," were endorsed by 58.3% and 50% of participants, respectively.

Table 10

Posttraumatic Growth Inventory

Positive Changes	English Survey %	Arabic Survey %
1. I changed my priorities about what is important in life		
I did not experience this change	56%	0%
I experienced this change to a very small degree	11%	0%
I experienced this change to a small degree	0%	0%
I experienced this change to a moderate degree	11%	33%
I experienced this change to a great degree	11%	33%
I experienced this change to a very great degree	11%	33%
2. I have a greater appreciation for the value of my own life		
I did not experience this change	33%	0%
I experienced this change to a very small degree	22%	33%
I experienced this change to a small degree	0%	0%
I experienced this change to a moderate degree	11%	0%
I experienced this change to a great degree	22%	0%
I experienced this change to a very great degree	11%	67%
3. I developed new interests		
I did not experience this change	44%	0%
I experienced this change to a very small degree	0%	33%
I experienced this change to a small degree	11%	33%
I experienced this change to a moderate degree	22%	0%
I experienced this change to a great degree	11%	33%
I experienced this change to a very great degree	11%	0%
4. I have a greater feeling of self-reliance		
I did not experience this change	0%	0%
I experienced this change to a very small degree	0%	0%
I experienced this change to a small degree	12.5%	33%
I experienced this change to a moderate degree	25%	0%

Table 10 Continued

Posttraumatic Growth Inventory

Positive Changes	English Survey %	Arabic Survey %
I experienced this change to a great degree	38%	33%
I experienced this change to a very great degree	25%	33%
5. I have a better understanding of spiritual matters		
I did not experience this change	33%	0%
I experienced this change to a very small degree	11%	0%
I experienced this change to a small degree	11%	0%
I experienced this change to a moderate degree	11%	67%
I experienced this change to a great degree	0%	33%
I experienced this change to a very great degree	33%	0%
6. I more clearly see that I can count on people in times of trouble		
I did not experience this change	56%	0%
I experienced this change to a very small degree	11%	67%
I experienced this change to a small degree	0%	0%
I experienced this change to a moderate degree	22%	0%
I experienced this change to a great degree	11%	33%
I experienced this change to a very great degree	0%	0%
7. I established a new path for my life		
I did not experience this change	44%	0%
I experienced this change to a very small degree	0%	33%
I experienced this change to a small degree	22%	0%
I experienced this change to a moderate degree	11%	33%
I experienced this change to a great degree	11%	33%
I experienced this change to a very great degree	11%	0%
8. I have a greater sense of closeness with others		
I did not experience this change	44%	33%
I experienced this change to a very small degree	11%	33%

Table 10 Continued

Posttraumatic Growth Inventory

Positive Changes	English Survey %	Arabic Survey %
I experienced this change to a small degree	11%	0%
I experienced this change to a moderate degree	22%	33%
I experienced this change to a great degree	0%	0%
I experienced this change to a very great degree	11%	0%
9. I am more willing to express my emotions		
I did not experience this change	62.5%	33%
I experienced this change to a very small degree	0%	33%
I experienced this change to a small degree	0%	33%
I experienced this change to a moderate degree	12.5%	0%
I experienced this change to a great degree	12.5%	0%
I experienced this change to a very great degree	12.5%	0%
10. I know better that I can handle difficulties		
I did not experience this change	12.5%	33%
I experienced this change to a very small degree	0%	0%
I experienced this change to a small degree	0%	33%
I experienced this change to a moderate degree	50%	0%
I experienced this change to a great degree	0%	33%
I experienced this change to a very great degree	37.5%	0%
11. I am able to do better things with my life		
I did not experience this change	50%	33%
I experienced this change to a very small degree	0%	33%
I experienced this change to a small degree	0%	0%
I experienced this change to a moderate degree	25%	33%
I experienced this change to a great degree	12.5%	0%
I experienced this change to a very great degree	12.5%	0%
12. I am better able to accept the way things work out		

Table 10 Continued

Posttraumatic Growth Inventory

Positive Changes	English Survey %	Arabic Survey %
I did not experience this change	25%	33%
I experienced this change to a very small degree	12.5%	33%
I experienced this change to a small degree	0%	0%
I experienced this change to a moderate degree	25%	33%
I experienced this change to a great degree	0%	0%
I experienced this change to a very great degree	37.5%	0%
13. I can better appreciate each day		
I did not experience this change	25%	33%
I experienced this change to a very small degree	0%	0%
I experienced this change to a small degree	37.5%	33%
I experienced this change to a moderate degree	12.5%	0%
I experienced this change to a great degree	12.5%	33%
I experienced this change to a very great degree	12.5%	0%
14. New opportunities are available which wouldn't have been otherwise		
I did not experience this change	62.5%	33%
I experienced this change to a very small degree	12.5%	33%
I experienced this change to a small degree	12.5%	33%
I experienced this change to a moderate degree	0%	0%
I experienced this change to a great degree	12.5%	0%
I experienced this change to a very great degree	0%	0%
15. I have more compassion for others		
I did not experience this change	33%	33%
I experienced this change to a very small degree	11%	33%
I experienced this change to a small degree	11%	33%
I experienced this change to a moderate degree	0%	0%
I experienced this change to a great degree	11%	0%

Table 10 Continued

Posttraumatic Growth Inventory

Positive Changes	English Survey %	Arabic Survey %
I experienced this change to a very great degree	33%	0%
16. I put more effort into my relationships		
I did not experience this change	33%	33%
I experienced this change to a very small degree	22%	33%
I experienced this change to a small degree	0%	33%
I experienced this change to a moderate degree	11%	0%
I experienced this change to a great degree	11%	0%
I experienced this change to a very great degree	22%	0%
17. I am more likely to try to change things which need changing		
I did not experience this change	33%	33%
I experienced this change to a very small degree	11%	33%
I experienced this change to a small degree	11%	33%
I experienced this change to a moderate degree	22%	0%
I experienced this change to a great degree	11%	0%
I experienced this change to a very great degree	11%	0%
18. I have a stronger religious faith		
I did not experience this change	56%	33%
I experienced this change to a very small degree	11%	33%
I experienced this change to a small degree	22%	33%
I experienced this change to a moderate degree	0%	0%
I experienced this change to a great degree	11%	0%
I experienced this change to a very great degree	0%	0%
19. I discovered that I'm stronger than I thought I was		
I did not experience this change	11%	33%
I experienced this change to a very small degree	22%	0%
I experienced this change to a small degree	0%	33%

Table 10 Continued

Posttraumatic Growth Inventory

Positive Changes	English Survey %	Arabic Survey %
I experienced this change to a moderate degree	0%	33%
I experienced this change to a great degree	22%	0%
I experienced this change to a very great degree	44%	0%
20. I learned a great deal about how wonderful people are		
I did not experience this change	44%	33%
I experienced this change to a very small degree	22%	33%
I experienced this change to a small degree	11%	0%
I experienced this change to a moderate degree	0%	33%
I experienced this change to a great degree	22%	0%
I experienced this change to a very great degree	0%	0%
21. I better accept needing others.		
I did not experience this change	33%	33%
I experienced this change to a very small degree	33%	33%
I experienced this change to a small degree	11%	33%
I experienced this change to a moderate degree	0%	0%
I experienced this change to a great degree	11%	0%
I experienced this change to a very great degree	11%	0%

Post-Traumatic Growth and Age of Onset

As noted above, participants were split according to the age of onset of sexual violence incident(s), and means were calculated for each group as they related to perceptions of post-traumatic growth. These means, as they relate to each positive change on the Post-Traumatic Growth Inventory, are outlined in Table 11. While statistical significance cannot be established due to the low *n* number in each group, several findings indicate potential areas for future research. Further investigation into the differing perceptions of positive changes as a result of SV experiences, depending on the age of onset of SV, may be warranted, and may reveal clinically significant differences.

Overall, the group with a younger age of onset more strongly endorsed positive changes than the group with the older age of onset in nearly every subscale of the measure. In particular, the younger age of onset group displayed much higher rates of perception of personal strength, including an enhanced sense of self-reliance and the belief in one's capacity to handle difficulties. Moreover, the younger age of onset group endorsed positive changes linked with appreciation for life to a greater degree, including a better appreciation for one's own life.

Table 11
Posttraumatic Growth Inventory

Positive Changes	Age of onset 8 and younger (Mean)	Age of onset 9 and older (Mean)
1. I changed my priorities about what is important in life	2.6	1.4
2. I have a greater appreciation for the value of my own life	3.1	1.4
3. I developed new interests	2.4	1.4
4. I have a greater feeling of self-reliance	4	3.25
5. I have a better understanding of spiritual matters	2.7	2.4
6. I more clearly see that I can count on people in times of trouble	1.3	1.6
7. I established a new path for my life	2.4	1.4
8. I have a greater sense of closeness with others	1.7	1.4
9. I am more willing to express my emotions	1.7	1.4
10. I know better that I can handle difficulties	4.2	1.4
11. I am able to do better things with my life	2.5	1
12. I am better able to accept the way things work out	2.5	2.2
13. I can better appreciate each day	3	1
14. New opportunities are available which wouldn't have been otherwise	1.2	0.8
15. I have more compassion for others	2.3	1.8
16. I put more effort into my relationships	2.1	1.4
17. I am more likely to try to change things which need changing	2	1.4
18. I have a stronger religious faith	1.3	0.6
19. I discovered that I'm stronger than I thought I was	3.1	2.6
20. I learned a great deal about how wonderful people are	1.4	1.2

CHAPTER IV

DISCUSSION

Overview

This chapter will be organized according to the following outline:

I. Interpretation of Findings
   i. Demographics
   ii. Religiosity
   iii. Immigration/Acculturation
   iv. Abuse Experiences
   v. Coping Skills
   vi. Perceptions of Post-Traumatic Growth

II. Limitations of the Study
   i. Subject Demographics
   ii. Methodology
   iii. Generalizability

III. Recommendations for Clinical Practice

IV. Future Directions for Research

V. Conclusion

Interpretation of Findings

The purpose of this study was to shed light on the experiences of Arab immigrant and Arab American survivors of sexual violence, a topic which has received limited empirical attention in the literature. This study was conceived as a preliminary

investigation intended to collect preliminary data and suggest areas for future research and possible clinical intervention. Given the linguistic, transportation, confidentiality, and shame-based obstacles to accessing this population, an online survey was developed. Data was gathered on various facets, including incident(s) of sexual violence, coping strategies, the extent of help-seeking and posttraumatic growth. Initial research questions included the following: (1) How does a small sample of Arab-American and Arab immigrant adults in the United States describe their experiences of sexual violence? (2) What coping strategies do these individuals report utilizing? (3) To what extent did posttraumatic growth (positive psychological change) emerge as one potential response to the sexual violence experience?

Due to the small sample size (n=12) of this study, caution must be exercised in generalizing with respect to these research questions. Conclusions cannot be drawn based upon the limited sample size. However, the study, taken in conjunction with the current literature, provides direction for further study and preliminary planning for clinical services.

Demographics

With respect to demographics, the majority of participants were females with a non-married relationship status and no children. This may not necessarily be representative of the Arab American population as a whole, as the US Census reports higher rates of marriage and lower rates of female family householders with no husband present (Brittingham and de la Cruz, 2005; United States Census Bureau, 2011). This is an area that warrants further exploration. Such nonconformity to general population

trends by study participants may be accounted for by a couple of factors. One potential explanation is that survivors of sexual violence might exhibit more reluctance with respect to romantic relationships, as adult survivor's attachment patterns are influenced by experiences of childhood sexual abuse (Alexander, 1992). Alternatively, the participants' relationship status might merely reflect acculturation in the US, and the subsequent shifting attitudes towards marriage and dating.

Approximately 75% of participants were born outside the United States, which might have implications for disclosure, as the recency of immigration may influence comfort with seeking out social services in the host country. The variance of participants' countries, which included Morocco, Lebanon, Libya and Saudi Arabia, may also have help-seeking implications, as Arab nations vary in terms of their cultural conservativeness and Westernization. Namely, while Arab countries share commonalities such as geography and language, differences do exist between the nations, including intensity of national identity, attitudes towards help-seeking, culture homogeneity and collectivist/individualist values (Al-Khatib, Vitell, Rexeisen, & Rawwas, 2005).

Participants were generally well-educated, with the majority holding college degrees. This corroborates with trends amongst the Arab American population, as the US Census shows that individuals within this population are more likely to have a bachelor's degree or higher than the general population (United States Census Bureau, 2011). Higher rates of part-time versus full-time work were endorsed by the Arabic survey respondents. This may suggest lower acculturation rates and a greater identification with more traditional Arab culture and values, although due to the small sample size this needs further exploration. The US Census indicates that women of Arab ancestry are less likely

to be in the labor force compared to the general population (United States Census Bureau, 2011). The English survey respondents also displayed overall higher household incomes, which may have implications for social mobility and perceptions of empowerment. It may also influence their access to various resources and social services, including mental health care services; moreover, greater economic autonomy may result in increased feelings of individuation, and less concerns about shaming the family through disclosure. This may account for the disparity in treatment seeking between English survey respondents and Arabic survey respondents.

Religiosity

All participants who identified themselves as a member of a religious faith endorsed a sect of Islam; such a lack of religious diversity might have implications for the representativeness of the sample, as various religions are espoused amongst Arab individuals, including Christianity. The Arabic survey respondents exhibited higher rates of religiosity as compared with the English survey respondents. Survey results indicated that, in terms of religiosity, the majority of participants reported a high frequency of religious mention in their households during childhood, which reflects the traditionally central role of religion in Arab culture. Moreover, two-thirds of participants characterized their religious beliefs as being important to them, which has implications for the necessity of mental health interventions which are respectful of spiritual and religious beliefs.

Prayer was identified as something which over half of the participants engaged in when faced with difficulties, while most participants concurred with the statement about God watching over and protecting one's life. The higher degree of religiosity endorsed

amongst the Arabic survey respondents might reflect a greater observance of traditional values. Individuals who are newly arrived to the United States, and who still feel close ties with their birth countries, might be more likely to turn to, and become reliant upon, religious institutions, such as mosques or churches, rather than other social service institutions. Furthermore, the centrality of religion in Arab culture further reinforces not only collectivist values, but also attitudes towards sexuality, all of which might influence a survivor's concern about disclosing abuse, and potentially shaming the family (Amer and Hovey, 2007; Erickson and Al-Timimi, 2001). Remaining cognizant of this is essential for appropriate and effective outreach.

Immigration/Acculturation

Survey results indicated that, in terms of immigration and acculturation, while the majority of the sample identified as first or second generation immigrants, most participants reported both English and Arabic were spoken equally in their homes. This may have implications for acculturation and the incorporation of both traditional and novel values, as language may significantly determine the ease with which one interacts within a culture.

When faced with a statement about the potential for an individual's actions to influence one's family ("I believe that an individual's actions can bring shame upon his/her family"), over half the participants agreed, which may have implications for the self-blame and concealing responses that may occur with sexual violence experiences. Unfortunately, in terms of future research, such factors may impede a broader and deeper examination of the experiences of SV amongst this population.

Such responses are consistent with potential cultural emphasis on shame as it relates to sexuality and behavior that is perceived to be indiscreet (Erickson and Al-Timimi, 2001). While the closeness of Arab American families may cause a protective response following disclosures of abuse, the entire disclosure process may be complicated by apprehension about shaming the family (Abu Baker and Dwairy, 2003). This is likely exacerbated if the perpetrator is a member of, or close to, the family system. Such desire to maintain homeostasis within the family system, compounded by the importance of preserving familial honor, might lead to self-blame, justification of abuse, and secrecy in order to maintain familial unity (Abdullah and Brown, 2011; Abu-Ras, 2007; Erickson and Al-Timimi, 2001).

Acculturation was also assessed through participants' reactions to statements which identified them as equally Arab and American, more American than Arab/Arab American, or more Arab than American/Arab American. While half the participants endorsed the statement identifying them as equally Arab and American, the other half endorsed the statement which identified them as more Arab; this may have implications for feelings of disconnect, as well as potential experiences of prejudice and otherness. Such experiences might intensify levels of mistrust with various American institutions, including medical, legal and mental health systems, and decrease the likelihood of reaching out to them, especially seeking mental health treatment.

Abuse Experiences

In terms of SV incident(s), survey results indicated that the sample was closely split in terms of age of onset of SV. As previously mentioned, 58 % of participants were

aged 8 or younger during the first incident of SV, while 42% of participants were aged 9 or older during the first incident of SV. Over half of the participants (58.3%) reported that the incidents of SV took place six or more times; such continuous, repeated abuse has implications for the coping and sequelae of survivors, as the literature indicates that chronic sexual abuse is related with poorer outcomes (O'Leary, Coohey, & Easton, 2010; Wilson, 2010). Such outcomes include depression, anxiety, dissociation, sleep problems, disordered eating and compromised sexual development (O'Leary et al., 2010; Romans et al., 2001; Sanci et al., 2008; Wilson, 2010).

With respect to the characteristics of the sexual violence incident(s), the majority of participants (66%) reported being touched inappropriately by the perpetrator, and half of the participants reported being forced to perform sexual acts on the perpetrator. Such direct sexual contact may have implications for outcome as well, as it involves a more jarring experience of intrusion upon and invasion of one's body, with repercussions for self-image, normative sexual development and perceptions of shame.

Certain characteristics of abuse experience, including use of force, penetration and longer duration of abuse, are correlated with more negative outcomes (Molnar, Buka, & Kessler, 2001). Severe sexual abuse is considered to be that which involves vaginal, oral or anal penetration, versus unwanted touching, kissing and fondling (O'Leary et al., 2010). In particular, adult survivors with histories of severe sexual abuse have been shown to exhibit significantly higher levels of depression than those with moderate histories (Lee et al., 2008; Straus, 1988). Moreover, more severe histories have been shown to predict greater posttraumatic stress symptoms, as well as avoidance and numbing symptomology (O'Leary et al., 2010).

Survey results revealed that the majority of participants identified the perpetrator as a family member, including a sibling, father, uncle or aunt, grandparent or cousin, which supports the literature on childhood sexual abuse (Haj-Yahi & Tamish, 2001; U.S. Department of Health & Human Services, 2005). Moreover, the majority of participants reported still seeing the perpetrator at family events or social outings. Futhermore, as continuing to live with family members is culturally sanctioned within many Arab families, survivors may find themselves continuing to interact daily and potentially reside with the perpetrator. Such proximity and protracted contact with one's perpetrator might have implications for the healing process of survivors.

Individuals who have survived abuse perpetrated by family members have been found to display significantly higher levels of psychological distress than those who were abused by a stranger (Haj-Yahi and Tamish, 2001). Such increased symptomology may have particular ramifications considering the cohesive structure of many Arab families. The implications of intrafamilial childhood sexual abuse often pervade into adulthood, including relational difficulties and attachment struggles (Courtois, 1999). This may in part be linked to the fact that intrafamilial childhood abuse is often more greatly associated with greater severity, longer duration and earlier onset, as compared with extrafamilial childhood sexual abuse (Courtois, 1999). One can only imagine that protracted contact with the perpetrator, such as at family events or social outings, only intensifies psychological distress, possibly due to the perpetrator's presence being a constant menacing reminder, not only of the sexual violence, but also of any threats and secrecy that came along with it.

Most participants reported that their first disclosure of the sexual violence was to a family member (i.e. parent, sibling, cousin), and the majority described not finding the disclosure experience helpful. Responses following disclosure were recounted to include being helped (25%); not being believed (16.6%); being asked to keep the abuse a secret (33.3%); and experiencing no change (16.6%). This has implications when considering the clinician's responsibility to counter both institutional and relational damage that has been encountered by patients as a result of disclosing their SV experiences. Working with someone who has been asked to keep their abuse a secret, for instance, might involve exploring feelings of betraying those that encouraged silence. The Arabic survey respondents displayed greater levels of nondisclosure, which may be linked to acculturation, as well as a lack of effective and linguistically appropriate services for such participants.

Of the participants who are in therapy or counseling, the majority reported disclosing the abuse to their mental health clinician, as well as finding the disclosure to be helpful. Such data has encouraging implications for the usefulness of valuable therapeutic services in facilitating the processing of SV experiences. Similarly, participants characterized the most helpful outcomes of disclosure to be receiving support and being referred for services; this has implications for outreach and providing accessible information and services not only for survivors, but also for those who may be in the survivor's support network (i.e. parents, friends, teachers).

Coping Skills

Survey results indicated that, in terms of coping strategies, it appears that survivors are likely to rely on emotional support, self-distraction and religion when it comes to coping with experiences of sexual violence. The Arabic survey respondents endorsed a greater reliance upon religion and self-criticism. This is consistent with cultural norms around maintaining familial honor and cohesion, in that the needs of the self may promptly be disowned in favor of the "greater" good of the family.

Such reliance upon self-criticism has clinical implications for the need for interventions which target such blaming of the self. Naturally, such interventions will need to be conducted within a culturally competent framework that takes into account tensions that may arise between familial cohesion and attending to the self. While the majority of participants endorsed a reliance on self-distraction as a coping strategy, further clarification would be helpful to assess whether such coping involves healthy distraction and refocusing, or trauma-related avoidance.

With respect to the splitting of the sample based on age of onset, there emerged a higher reliance on positive reframing by those with an onset after age 8, which might reflect greater emotional maturity. Conversely, there appeared to be higher reliance upon avoidance-based coping by the younger age of onset group. The literature reports an increased reliance on dissociation for coping in younger children, especially among survivors of chronic, repeated abuse (O'Leary et al., 2010), which might also account for this finding. Such differing coping trends, depending on age of onset of SV, may have implications for clinical and therapeutic considerations, including the potential imbeddedness of certain coping patterns in a survivor's life. This may indicate the need

for clinical work that attends to coping as it relates to other areas in the survivor's functioning, and examining the function and benefit, or lack thereof, of certain coping strategies.

Perceptions of Post-Traumatic Growth

The majority of respondents indicated that they experienced some positive changes following their experiences of sexual violence. Survey results reflected that, with respect to perceptions of post-traumatic growth as a result of these experiences, survivors are likely to endorse positive changes related to personal strength, faith in one's self and spirituality. Once again, the Arabic survey respondents were more likely to endorse positive changes related to religiosity than the English survey respondents. The majority of participants endorsed positive changes linked to perceptions of their own personal strength, which may have encouraging implications for the resilience of survivors of SV.

In terms of age of onset, those with an onset before age 8 more strongly endorsed positive changes in nearly every subscale of the Posttraumatic Growth Inventory. This included significantly higher perceptions of enhanced self-reliance and one's capacity to handle difficulties, as well as a greater appreciation for life. Such differences have implications for working with survivors with an older age of onset, in that the clinical work may involve a greater focus on perceptions of helplessness and a lack of personal strength. There is the possibility that experiencing SV at an older age, after one's view of the world and one's self is more well-developed, results in an abruptly diminished perception of one's capacity to control their environment or protect themselves. Likewise, it is possible that younger survivors of SV might be more resilient, or perhaps

find the SV experiences less challenging to integrate as a result of a less nuanced perception of the world and their own capacities. Treatment may involve a degree of cognitive restructuring, while remaining cognizant and respectful of the external locus of control which is often espoused within Arab culture.

Limitations of the Study

Subject Demographics

The participants were recruited by reaching out to several domestic violence shelters and Arab American community agencies, located in different US cities. Personalized emails were sent to a total of 12 agencies explaining the study and inquiring about their willingness to recruit participants. After several telephone, email and in-person conversations, six settings were ultimately determined to be appropriate referral sources. Within these six agencies, representatives, such as counselors, therapists and case managers, were identified to aid in the selection and recruitment of participants. Due to the anonymous research design, there is no way of knowing how many individuals were ultimately referred to the study, or the geographical location of those who completed it.

In terms of the subject demographics, there were considerable limitations to generalizability, which are discussed below in greater detail. One such limitation is that of gender; as there was only one male respondent, no hypotheses regarding gender can be made and it is unfeasible draw inferences about the experiences of Arab male survivors of SV. Geographically, the sample was limited to the agencies and organizations who agreed to refer clients to the study, which were located in the Northeast and central

United States. Limitations as related to subject demographics also include religion, country of origin and language.

Methodology

Contact information for potential referral agencies was found using Internet searches, a method which potentially left out agencies that did not have websites or contact information accessible over the internet. In particular, as some domestic violence shelters espouse a certain amount of anonymity, it is possible that a number of appropriate referral agencies were not found due to limited public visibility. In addition, utilizing email as a primary means of communication may have estranged the agency representatives who perhaps did not receive or carefully read the initial personalized emails. As mentioned earlier, external validity in this study was complicated by issues such as access to computers and access to the referral agencies, as well as the fact that we cannot ascertain who exactly provided responses to the survey. The study's findings are not generalizable to the greater population due to the small *n* size.

A total of 23 surveys were initiated, while 12 were completed and provided useable data. One potential limitation of the study may be that there were factors unique to these twelve participants which enabled them to complete the survey in its entirety. Such factors may have included access to a computer, literacy in either Arabic or English, willingness to discuss answer questions about SV experiences and enough time to devote to completing the survey. It is also unknown whether certain features distinguish those who elect to receive services from the representative agencies. Related to the research design is the limitation of a self-selection bias, in that participants were initially recruited

because of self-identification with meeting the study's criteria, and then elected to participate in the voluntary study. The online design of the study, while desirable in its protection of privacy and subsequent shame reduction, may have contributed to a more limited understanding of the interpretation of certain items, as there was no way to follow up with participants. Moreover, while online surveys are often convenient methods of gathering information, it cannot be ascertained how subjects understood and engaged with each questions, as opposed to in-person interviews.

Generalizability

When reflecting upon the limitations of a study, it is worth considering whether the results are transferable to the larger population (Trochim, 2006). Given the small size of this study's sample, there is naturally limited generalizability in terms of the experiences of Arab immigrant and Arab American survivors in the larger world. Moreover, there was no random sampling, resulting in the skewing of data by certain characteristics. Such limitations in terms of representativeness include the high proportion of unmarried adult females in the study, as well as the lack of religious diversity amongst participants.

This study was exploratory, with the objective to generate information related to these survivors' experiences, as well as to highlight areas that might be essential for further investigation. By sampling a greater number of Arab immigrant and Arab American survivors, with even greater geographical diversity in the United States, a clearer experiential picture would have emerged. Such sampling would ideally result in a

depiction of gender-specific patterns that may exist in terms of how SV is experienced by Arab men and women.

Recommendations for Clinical Practice

The literature indicates that Arabs in the United States represent an underserved population. As mentioned earlier, social stigma and lack of information about the value of clinical services may serve as barriers to the accessing of mental health services by Arab immigrants and Arab Americans. As such, the mental health community in the US needs to not only augment their education about the various aspects of Arab culture, but also to enhance outreach efforts to this population.

This study suggests several key themes which clinicians can use for training and clinical purposes. When working with an Arab survivor of sexual violence, it is important to understand his/her immigration experiences, religiosity, acculturation and self-identification. Moreover, the characteristics of the sexual violence incident(s) have bearings on the individual's experience and healing process. The perpetrator's relationship to the survivor, confidantes to whom the sexual violence was disclosed and the chronicity of the abuse are all crucial aspects which may influence the experience of SV. Furthermore, the survivor's experiences of disclosure, which includes both formal institutions such as the police, and informal networks such as friends, are vital to understand when conceptualizing clinical work with a survivor. The trauma, often, does not end when the sexual violence does, and it is important for the clinician to know the extent of any secondary traumatization.

It is also crucial to recognize that values such as individuation, which are extolled within the Western tradition of psychotherapy, are not necessarily as pertinent or esteemed for patients with different cultural backgrounds, including Arab patients, and it is essential to remain cognizant of the cultural importance of family and religiosity. It may also have implications for disclosure and reporting, as such processes might be perceived as threatening to the family cohesiveness. This is particularly salient in cases where the perpetrator is a family member, and/or still in contact with the victim, as was the case for the majority of this study's participants. It is equally important to consider how level of acculturation might complicate the coping of SV. This can include reliance upon shame and self-blame as coping strategies, but also on the potential familial conflicts that may develop as a result of intergenerational immigration issues. Empowering the survivor will certainly be an objective of clinical work, but it is also essential to respect the importance of family and community.

As over half of the participants reported age of onset of sexual violence occurring at age 8 or younger, this has implications both for intervention and preventative measures. Increased education on the symptoms and indications of sexual abuse amongst young children should be made accessible to parents, other family members, and educators within this population. This might include engaging in psychoeducation efforts at different settings that often serve Arab families, including religious institutions such as mosques and churches, as well as schools. Demystifying sexual violence by providing facts and clarifying information might be the first step in addressing its incidence.

Encouraging greater dialogue with children about what constitutes appropriate and inappropriate physical contact, while remaining respectful of familial and cultural

values, might increase the likelihood that a child will articulate instances of abuse, as it will increase the sense of control and jurisdiction over his/her body. Considering the role of the family vis-à-vis the sexual violence, such as whether the family system was activated in a response of protection and support or secrecy and blame, is vital in understanding any messages which might have been sent to the survivor, intentionally or not, about his/her own accountability. As such, providing accessible and culturally sensitive information for families of survivors might help prevent such damaging messages.

Due to this population's greater levels of comfort with seeking support from informal settings, it might be beneficial to focus outreach and educational efforts at places such as community centers and religious institutions. This could involve the education and training of various members of these institutions, such as religious leaders and community care providers, on issues of prevention, intervention and referral. Sowing the seeds of empowerment through such community outreach initiatives, as opposed to more individual-centered approaches, might be particularly effective in remaining loyal to certain values of collectivist culture. While working with Arab survivors, incorporating family members, a community group, or religious leaders with whom s/he might rely upon into the treatment may be beneficial; the caveat, naturally, is that such outreach efforts should only be pursued insofar as the patient is comfortable with them. More research is needed to know how level of acculturation mediates help seeking behaviors.

Given the complex ramifications of sexual violence, it is of critical importance for survivors to feel supported by their community, as well as the formal institutions that are involved in the reporting and recovery process (Campbell, 2008). As such, one task for

clinicians could be advocacy for cultural competence amongst legal and medical systems, in order to reduce the risk of further traumatization. This could include providing psychoeducation and participating in cultural competency training for medical practitioners and law enforcement. Such outreach and training could potentially reduce secondary victimization (Campbell, 2008).

In educational settings, readings on Arab culture and survivors of SV in training modules might help better equip training clinicians to address the needs of such clients and provide effective and culturally competent services. This can include an emphasis on establishing rapport and therapeutic engagement, particularly as members of this population may enter treatment with a sense of shame about having sought professional help. Remaining alert and cognizant of value systems and cultural and spiritual beliefs is imperative, as is communicating an accepting, non-judgmental stance in clinical work.

Future Directions for Research

Carrying out further sampling would strengthen the generalizability of such a study. Moreover, further empirical research could investigate potential relationships that may exist between variables such as acculturation and coping, and so forth. Data collection for future samples could be profited by enhancing the survey to include open-ended questions. Semi-structured interviews were ultimately deemed inappropriate for this study, due to agency representatives' reluctance to identify their patients; however, future studies might involve fashioning novel, innovative ways to recruit participants that do not solely rely upon referrals from agencies. Interviewing participants would allow for more in-depth exploration and a greater richness of data by allowing participants to

explain various concepts and experiences in their own words, as well as address how these experiences might have been impacted by various cultural values.

In terms of disclosure, future research could elucidate the complex, nuanced relationships between who was told about the abuse, and who the perpetrator was; it might be particularly interesting to examine any potential interactions that may exist when both the perpetrator, and the individual(s) to whom the survivor discloses, are relatives. Future research might also help inform prevention and psychoeducation efforts, possibly in conjunction with religious institutions like mosques, or community centers. This might include looking at existing health education for children, and the portrayal of help-seeking amongst this population.

While this study involved looking at the coping skills survivors employed, it did not gauge the effectiveness of them, namely the participants' perception of how much certain coping strategies mediated or ameliorated their experiences. It would be interesting to explore which subscales of coping were linked with a higher sense of healing, or having integrated the SV experiences into one's narrative. For instance, a sizable percentage of subjects indicated reliance upon self-distraction as a mode of coping, but it is not clear whether this refers to dissociation or a more conscious, integrated process. In addition, it would be helpful to further explore the family's role in shielding or exacerbating SV incident(s), particularly when the perpetrator is a family member. For the participants that endorsed wanting to keep the SV a secret, it would be beneficial to understand the motivation behind this—to shield the family? To protect one's self? Finally, future studies might ask follow up questions regarding the helpfulness

of certain disclosures, such that we can further understand what characterizes a supportive response, and incorporate that into clinical work.

Conclusion

As the population of Arab immigrants and Arab Americans continues to grow in the United States, it will become increasingly important for mental health practitioners to become skilled at culturally competent work that is respectful of Arab culture and values. In the case of Arab immigrant and Arab American survivors of sexual violence, this further necessitates a nuanced understanding of the devastating, and far-reaching, effects that sexual assault and abuse can have on an individual's life. Ultimately, there is a need to adopt an ecological approach, which takes into account the interplay of multiple factors in determining an individual's well-being, when considering the best way to provide supportive and appropriate services for these individuals.

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APPENDIX A

Copy of Sample Email Sent to Potential Referral Site

Hello,

Please allow me to introduce myself. My name is Hala Alyan and I am a female Palestinian-American doctoral student within the Clinical Psychology department of the Graduate School of Applied and Professional Psychology, at Rutgers University. I am currently formulating my dissertation proposal and, as part of that, exploring various programs, shelters and community centers that might be able to refer individuals to be participants of this study. I came across the [ONLINE, IN PRINT] description for [POTENTIAL REFERRAL SITE], and believe there may be a good fit.

Namely, I am working on a dissertation proposal aimed at Arab-American and Arab immigrants living in the US who are adult survivors of either childhood or adulthood sexual abuse/assault. It appears that one way to collect information regarding this sensitive topic is through an online survey. Namely, I intend to draft a survey which gathers certain non-identifying demographic information, asks questions about the sexual abuse/assault incident(s), and explores the coping mechanisms that these individuals employed, while also assessing for various buffering factors (i.e. religiosity, familial support, help-seeking behaviors) which may have promoted resiliency. Ultimately, the study will seek to hopefully shed a little light on how sexual abuse/assault may be experienced by members of this population.

This survey will be made accessible through an online link, which the individual can click, respond to, and exit from. As such, the interview will remain completely anonymous, which will hopefully increase the likelihood of completion and decrease any shame or reluctance that face-to-face interviewing may elicit.

Do you think it would be possible to refer some of the clients you work with for participation in such a survey (if you have clients that fit these criteria)? I know how devastating this topic can be, and so I would want to proceed in the best manner possible for the participants. This is such an important subject that is severely under-researched, particularly with Arab and Arab-American populations, and I would love to at least start generating some work on it.

I would be happy to discuss this matter further, or answer any questions you may have, via telephone or email. I very much look forward to hearing back from you.

Thank you so much for your time!

Best,
Hala
917-600-5461

APPENDIX B

Consent Form

Before taking part in this study, please read the informed consent form below and click the "I Agree" button at the bottom of the page if you understand the statements and freely consent to participate in the study.

Title of Study: Experiences of Arab Immigrant and Arab-American Survivors of Sexual Violence: An Exploratory Study

Principal Investigator: Hala Alyan, MA

INVITATION TO PARTICIPATE
You are kindly invited to participate in research that is being conducted by Hala Alyan, MA, a doctoral student in the Department of Clinical Psychology at the Graduate School of Applied and Professional Psychology, Rutgers University. This research study is part of a dissertation.

PURPOSE
This research project is being done to look at the ways in which Arab immigrant and Arab-American men and women experience sexual abuse and/or sexual assault. The goal of this research project is to provide information on their experiences. This information may assist mental health professionals working with Arab immigrant and Arab-American individuals who have experienced such abuse/assault.

SUBJECT SELECTION
1) You must be 18 years or older
2) You must currently reside in the United States
3) One or both of your parents must have ethnic heritage from one or more of the following states: Algeria, Bahrain, Comoros, Djibouti, Egypt, Iraq, Kuwait, Jordan, Lebanon, Libya, Mauritania, Morocco, Oman, Palestine, Qatar, Saudi Arabia, Somalia, Syria, Sudan, Tunisia, United Arab Emirates, or Yemen
4.) You must understand either written English or Arabic

PROCEDURES
Your participation in this study will last for approximately 30 minutes to an hour, which is the estimated completion time; however, you may take as long as you wish. You will be asked to answer a series of questions, which will begin once you press 'I Accept' below. The survey sections proceed in the following order: Demographics; Religion; Immigration, Acculturation & Values; Abuse/Assault Incident(s). You will then be asked to complete two questionnaires: Brief COPE Scale; and Posttraumatic Growth Inventory. These questionnaires will ask about ways in which you may have coped with your experience of abuse/assault, and ways in which your experience of abuse/assault may have changed your life.

BENEFITS
You will not receive any direct benefit for participating in this research. However, the knowledge we gain from voluntary participation in this research project may help us improve our understanding of Arab immigrant and Arab-American survivors of sexual abuse/assault. This understanding may help mental health practitioners better serve the men and women who have survived such abuse/assault.

RISK
There are some questions in the survey, particularly those related to past sexual abuse and/or assault, that may trigger memories of the abuse/assault and make you feel anxious or distressed. If this occurs, you will be able to access support services like those listed below. You will be able to access counseling services at these sites free of charge.

SUPPORT SERVICES
The following are some support services that may be helpful to you:

National Sexual Assault Hotline
1-800-656-HOPE (4673)

The Arab-American Family Support Center
Brooklyn, New York
(718) 643 – 8000

Cross Cultural Counseling Center
International Institute of New Jersey
Jersey City, New Jersey
(201) 653-3888

Arab American Family Services
Chicago, Illinois
(708) 599-AAFS (2237)

Wafa House
Clifton, NJ
1-800-930-WAFA (9232)

COMPENSATION
You will receive a $5 online gift card to Dunkin Donuts for participating in this research project as a small token of appreciation for your time. If you decide to withdraw from the survey prior to completion, you will not receive the gift card.

COST
There is no cost to you for participating in this research project.

ALTERNATIVES

Your alternative is to not participate in this research project.

CONFIDENTIALITY
This research is anonymous. Anonymous means that no information about you will be recorded which could be used to identify you. This includes things such as name, address, phone number, date of birth, and so on. Your responses will be sent over a secure, encrypted connection (SSL), and no IP addresses will be listed anywhere. There will be no way to link your responses back to you. Therefore, data collection is anonymous. Data will be seen only by the researcher and the researcher's dissertation team. Results from this study, once complete, may be shared with relevant agencies in order to hopefully improve service delivery. Data from individual surveys will not be shared, only the aggregate of all surveys.

WITHDRAWAL
Participation in this study is voluntary. You may withdraw from the study at any time without penalty, and you may refuse to answer any questions that you are not comfortable with.

RESEARCH QUESTIONS
If you have any questions about the study, you may contact Hala Alyan by email at: halyan@rutgers.edu.

SUBJECT RIGHTS
If you have any questions about your rights as a research subject, you may contact the IRB Administrator at Rutgers University at:

Rutgers University Institutional Review Board for the Protection of Human Subjects
Office of Research and Sponsored Programs
3 Rutgers Plaza
New Brunswick, NJ 08901-8559
Tel: 848 932 4058
Email: humansubjects@orsp.rutgers.edu

If you are 18 years of age or older, understand the statements above, and freely consent to participate in the study, click on the 'I Agree' button to begin the survey. If not, thank you for your time.

- I Agree
- I Do Not Agree

APPENDIX C

Online Survey

DEMOGRAPHICS

This section of the survey will contain general information questions.

1. *Age:*
   ___ *years*

2. *Gender:*
   _____

3. *What is your country of birth*?
   _____

4. *My mother's family origin is:*
   [drop down list of the following]: Algeria, Bahrain, Comoros, Djibouti, Egypt, Iraq, Kuwait, Jordan, Lebanon, Libya, Mauritania, Morocco, Oman, Palestine, Qatar, Saudi Arabia, Somalia, Syria, Sudan, Tunisia, United Arab Emirates, Yemen, United States, More than one Arab state, Arab state + non-Arab state, Other]

5. *My father's family origin is*:
   [drop down list of the following]: Algeria, Bahrain, Comoros, Djibouti, Egypt, Iraq, Kuwait, Jordan, Lebanon, Libya, Mauritania, Morocco, Oman, Palestine, Qatar, Saudi Arabia, Somalia, Syria, Sudan, Tunisia, United Arab Emirates, Yemen, United States, More than one Arab state, Arab state + non-Arab state, Other]

6. *What is your current employment status?*

- Employed Part-Time
- Employed Full-Time
- Not Currently Employed
- Student
- Homemaker

- Retired
- Unable to Work

7. What is the highest level of education you have reached?

- Less than High School
- High School or GED
- Some-College
- College Degree
- Graduate/Professional Degree (MA/MS, PhD, MD, JD, etc)
- I prefer not to respond

8. What is the highest level of education reached by your mother?

- Less than High School
- High School or GED
- Some-College
- College Degree
- Graduate/Professional Degree (MA/MS, PhD, MD, JD, etc)
- I prefer not to respond

9. What is the highest level of education reached by your father?

- Less than High School
- High School or GED
- Some-College
- College Degree
- Graduate/Professional Degree (MA/MS, PhD, MD, JD, etc)
- I prefer not to respond

10. What was your household income last year?

- <$10,000
- $10,000-14,999
- $15,000-24,999

- [x] $25,000-34,999
- [ ] $35,000-49,999
- [ ] $50,000-74,999
- [ ] $75,000-99,999
- [ ] ≥$100,000
- [ ] I prefer not to respond

11. What is your relationship status?

- [ ] Single
- [ ] In a relationship
- [ ] Engaged
- [x] Married
- [ ] Divorced
- [ ] Separated
- [ ] Widowed
- [ ] Other _____

12. How many children, if any, do you have?

- [ ] None
- [ ] 1
- [ ] 2
- [x] 3
- [ ] 4
- [ ] 5
- [ ] 6+

13. With whom do you currently live? (Please select all that apply.)

- [ ] Roommates
- [ ] Friends
- [ ] Romantic partner
- [ ] Spouse

- Siblings
- Children
- Parents
- Cousins
- Grandparents
- Other family members
- I live alone

RELIGION

In this section, you will be asked some questions about religion and its role, if any, in your life.

14. What is your religious affiliation, if any?

- Muslim—Shi'aa
- Muslim—Sunni
- Muslim—Other
- Druze
- Christian—Maronite
- Christian—Greek Orthodox
- Christian—Catholic
- Christian—Other
- Jewish
- Buddhist
- Hindu
- Agnostic
- Atheist
- Other _____

15. How often was religion, God and/or prayer discussed in your home growing up, if at all?

- At least once a week
- Less than once a week
- Rarely
- It was not discussed

16. How often do you attend religious services?

- More than 5 times a month
- About 4 to 5 times a month
- About 1 to 2 times a month
- Once every few months
- About 1 to 2 times a year
- I do not attend religious services

17. How important to you are your religious beliefs?

- Extremely important
- Important
- Somewhat important
- Not at all important
- I do not have religious beliefs

18. How certain are you about your religious beliefs?

- Extremely certain
- Certain
- Somewhat uncertain
- Uncertain
- I do not have religious beliefs

19. To what extent, if at all, do you agree with the following statement: I believe that God watches over me and protects my life.

- Strongly agree
- Agree
- Uncertain
- Disagree
- Strongly disagree

20. *Which of the following, if any, do you do when faced with difficulty in your life? Please select all that apply.*

- Speak with a religious leader (i.e. imam, priest)
- Meditate
- Read holy books (i.e. Quran, Bible)
- Pray
- Other _____
- I do not do any of these things when faced with difficulty in my life

IMMIGRATION EXPERIENCE (IF RELEVANT), ACCULTURATION, & VALUES

In this section, you will be asked some questions about your immigration experience in the United States, if relevant. You will also be asked some questions about things you may value.

21. What of the following best describes you?

- Sojourner: I am living in the United States temporarily (i.e. for work or education) and plan to return to my home country
- First generation: I am the first of my family to immigrate to the U.S.
- Second generation: My parents were the first to immigrate to the U.S.
- Third generation: My grandparents were the first to immigrate to the U.S.
- Fourth or fifth generation
- Other_____

22. Which of the following best describes your immigration or visitation to the U.S.?

- Voluntary (i.e. for education, better opportunities)
- Involuntary (i.e. political persecution, asylum seeking, refugee)
- I was born in the U.S.
- Other_____

23. Which of the following best describes your legal status in the U.S.?

- U.S. Citizen
- Green Card holder
- Temporary visa holder
- Refugee, asylum seeker
- I prefer not to answer

- Other_____

24. What language(s) do you speak at home?

- Only English
- Both English and Arabic
- Only Arabic
- Other_____

25. How well do you speak English?

- I am fluent in English
- I speak English very well
- I speak English well
- I do not speak English well
- I do not speak English at all

26. Which of the following statements best describes you?

- I consider myself as American rather than Arab or Arab-American
- I consider myself to be equally American and Arab
- I consider myself as Arab rather than American or Arab-American
- Other_____

27. To what extent, if at all, do you agree with the following statement: It is important to avoid doing things my family disapproves of.

- Strongly agree
- Agree
- Uncertain
- Disagree
- Strongly disagree

28. To what extent, if at all, do you agree with the following statement: I believe that an individual's actions can bring shame on to his/her family.

- Strongly agree
- Agree
- Uncertain
- Disagree
- Strongly disagree

ABUSE/ASSAULT INCIDENT(S)

In this section, you will be asked some questions about your experience(s) of sexual abuse/assault. Sexual abuse/assault is any unwanted sexual contact that an individual does not consent to, and may be afraid to protest against. This may occured in childhood or adulthood.

29. At what age(s) did the incident(s) take place? (Please select all that apply.)

- I cannot recall
- 1-5
- 5-8
- 9-12
- 13-17
- 18+

30. How many times did the incident(s) take place?

- I cannot recall
- Once
- Between 2 and 5 times
- Between 6 and 10 times
- Over 10 times

31. How old were you when the sexual abuse/assault took place the first time?

- I cannot recall
- 1-5
- 5-8
- 9-12
- 13-17

- 18+

32. How old were you when the sexual abuse/assault took place the last time?

- I cannot recall
- 1-5
- 5-8
- 9-12
- 13-17
- 18 and beyond
- It is still taking place

33. Which of the following occurred during the sexual abuse/assault, if any? (Please select all that apply.)

- Threatening one's safety or life
- Being touched inappropriately by the perpetrator
- Being forced to perform sexual acts on the perpetrator
- Vaginal/anal penetration
- Other

34. Who carried out the sexual abuse/assault against you? (Please select all that apply.)

- Stranger
- Family friend
- Father
- Mother
- Brother or sister
- Stepfather
- Stepmother
- Stepbrother or stepsister
- Grandparent
- Uncle or aunt
- Cousin
- Other family member

- Teacher
- Babysitter
- Peer
- Other _____

35. Do you still see the perpetrator (i.e. at family functions, academic setting, social events, etc)?

- Yes
- No
- Other _____

36. Was the abuse/assault reported to the police?

- Yes
- No
- Other _____

37. If reported, was the perpetrator arrested and/or put in prison?

- Yes
- No
- Other _____
- It was not reported

38. Who did you <u>first</u> tell about the sexual abuse/assault?

- Father or mother
- Sibling
- Grandparent
- Uncle or aunt
- Cousin
- Other family member
- Teacher
- Counselor or therapist
- Friend

- Spouse
- Girlfriend of boyfriend
- Doctor
- Imam
- Priest
- Other _____
- I have not told anyone

39. How helpful did you find it to tell that <u>first</u> person about the sexual abuse/assault?

- Very helpful
- Somewhat helpful
- Neither helpful nor unhelpful
- Somewhat unhelpful
- Very unhelpful

40. Who else have you told about the sexual abuse/assault? (Please select all that apply.)

- Father or mother
- Sibling
- Grandparent
- Uncle or aunt
- Cousin
- Other family member
- Friend
- Teacher
- Spouse
- Girlfriend of boyfriend
- Doctor
- Imam
- Priest
- Counselor or therapist
- Other _____

- I have not told anyone

41. *If you have ever been in therapy or counseling, have you discussed the sexual abuse/assault with your therapist/counselor?*

- Yes
- No
- I have never been in therapy or counseling

42. *How helpful did you find it to discuss the sexual abuse/assault with your therapist/counselor?*

- Very helpful
- Somewhat helpful
- Neither helpful nor unhelpful
- Somewhat unhelpful
- Very unhelpful
- I have not discussed it with my therapist/counselor
- I have never been in therapy or counseling

43. *Which of the following, if any, did you find helpful when you discussed your sexual abuse/assault? (Please select all that apply.)*

- Support
- Being referred to services (i.e. mental health, medical, legal)
- Religious counsel
- Other
- None of these things occurred when I discussed my sexual abuse/assault
- I have never discussed my sexual abuse/assault

44. *Which of the following took place when you discussed your sexual abuse/assault? (Please select all that apply.)*

- I was helped
- I was not believed
- I was told to keep it a secret
- I asked that it be kept secret

- Nothing changed
- I have never discussed my sexual abuse/assault

APPENDIX D

BRIEF COPE INVENTORY

These items deal with ways you've been coping with the stress in your life since you have experienced the sexual abuse/assault incident(s). There are many ways to try to deal with problems. These items ask what you've been doing to cope with this one. Obviously, different people deal with things in different ways, but I'm interested in how you've tried to deal with it. Each item says something about a particular way of coping. I want to know to what extent you've been doing what the item says. How much or how frequently? Don't answer on the basis of whether it seems to be working or not—just whether or not you're doing it. Please use the following scale to indicate this. Try to rate each item separately in your mind from the others. Make your answers as true FOR YOU as you can.

1 = I haven't been doing this at all.
2 = I've been doing this a little bit.
3 = I've been doing this a medium amount.
4 = I've been doing this a lot.

1. I've been turning to work or other activities to take my mind off things.
   [drop down list of the following: 1, 2, 3, 4]

2. I've been concentrating my efforts on doing something about the situation I'm in.
   [drop down list of the following: 1, 2, 3, 4]

3. I've been saying to myself "this isn't real."
   [drop down list of the following: 1, 2, 3, 4]

4. I've been using alcohol or other drugs to make myself feel better.
   [drop down list of the following: 1, 2, 3, 4]

5. I've been getting social support from others.
   [drop down list of the following: 1, 2, 3, 4]

6. I've been giving up trying to deal with it.
   [drop down list of the following: 1, 2, 3, 4]

7. I've been taking action to try to make the situation better.
   [drop down list of the following: 1, 2, 3, 4]

8. I've been refusing to believe it has happened.
   [drop down list of the following: 1, 2, 3, 4]

9. I've been saying things to let my unpleasant feelings escape.
   [drop down list of the following: 1, 2, 3, 4]

10. I've been getting help and advice from other people.

[drop down list of the following: 1, 2, 3, 4]

11. I've been using alcohol or other drugs to help me through it.
    [drop down list of the following: 1, 2, 3, 4]

12. I've been trying to see it in a different light to make it seem more positive.
    [drop down list of the following: 1, 2, 3, 4]

13. I've been criticizing myself.
    [drop down list of the following: 1, 2, 3, 4]

14. I've been trying to come up with a strategy about what to do.
    [drop down list of the following: 1, 2, 3, 4]

15. I've been getting comfort and understanding from someone.
    [drop down list of the following: 1, 2, 3, 4]

16. I've been giving up the attempt to cope.
    [drop down list of the following: 1, 2, 3, 4]

17. I've been looking for something good in what is happening.
    [drop down list of the following: 1, 2, 3, 4]

18. I've been making jokes about it.
    [drop down list of the following: 1, 2, 3, 4]

19. I've been doing something to think about it less, such as going to movies, watching TV, reading daydreaming, sleeping, or shopping.
    [drop down list of the following: 1, 2, 3, 4]

20. I've been accepting the reality of the fact that it has happened.
    [drop down list of the following: 1, 2, 3, 4]

21. I've been expressing my negative feelings.
    [drop down list of the following: 1, 2, 3, 4]

22. I've been trying to find comfort in my religion or spiritual beliefs.
    [drop down list of the following: 1, 2, 3, 4]

23. I've been trying to get advice or help from other people about what to do.
    [drop down list of the following: 1, 2, 3, 4]

24. I've been learning to live with it.
    [drop down list of the following: 1, 2, 3, 4]

25. I've been thinking hard about what steps to take.
    [drop down list of the following: 1, 2, 3, 4]

26. I've been blaming myself for things that happened.
    [drop down list of the following: 1, 2, 3, 4]

27. I've been praying or meditating.
    [drop down list of the following: 1, 2, 3, 4]

28. I've been making fun of the situation.
    [drop down list of the following: 1, 2, 3, 4]

POSTTRAUMATIC GROWTH INVENTORY

This section consists of a series of statements. For each statement, consider the degree to which the change described is true in your life as a result of the sexual abuse/assault. Please use the following scale to indicate this.

0 = I did not experience this change as a result of the sexual abuse/assault.
1 = I experienced this change to a very small degree as a result of the sexual abuse/assault.
2 = I experienced this change to a small degree as a result of the sexual abuse/assault.
3 = I experienced this change to a moderate degree as a result of the sexual abuse/assault.
4 = I experienced this change to a great degree as a result of the sexual abuse/assault.
5 = I experienced this change to a very great degree as a result of the sexual abuse/assault.

1. I changed my priorities about what is important in life.
   [drop down list of the following: 0, 1, 2, 3, 4, 5]

2. I have a greater appreciation for the value of my own life.
   [drop down list of the following: 0, 1, 2, 3, 4, 5]

3. I developed new interests.
   [drop down list of the following: 0, 1, 2, 3, 4, 5]

4. I have a greater feeling of self-reliance.
   [drop down list of the following: 0, 1, 2, 3, 4, 5]

5. I have a better understanding of spiritual matters.
   [drop down list of the following: 0, 1, 2, 3, 4, 5]

6. I more clearly see that I can count on people in times of trouble.
   [drop down list of the following: 0, 1, 2, 3, 4, 5]

7. I established a new path for my life.
   [drop down list of the following: 0, 1, 2, 3, 4, 5]

8. I have a greater sense of closeness with others.
   [drop down list of the following: 0, 1, 2, 3, 4, 5]

9. I am more willing to express my emotions.
   [drop down list of the following: 0, 1, 2, 3, 4, 5]

10. I know better that I can handle difficulties.
    [drop down list of the following: 0, 1, 2, 3, 4, 5]

11. I am able to do better things with my life.
    [drop down list of the following: 0, 1, 2, 3, 4, 5]

12. I am better able to accept the way things work out.
    [drop down list of the following: 0, 1, 2, 3, 4, 5]

13. I can better appreciate each day.
    [drop down list of the following: 0, 1, 2, 3, 4, 5]

14. New opportunities are available which wouldn't have been otherwise.
    [drop down list of the following: 0, 1, 2, 3, 4, 5]

15. I have more compassion for others.
    [drop down list of the following: 0, 1, 2, 3, 4, 5]

16. I put more effort into my relationships.
    [drop down list of the following: 0, 1, 2, 3, 4, 5]

17. I am more likely to try to change things which need changing.
    [drop down list of the following: 0, 1, 2, 3, 4, 5]

18. I have a stronger religious faith.
    [drop down list of the following: 0, 1, 2, 3, 4, 5]

19. I discovered that I'm stronger than I thought I was.
    [drop down list of the following: 0, 1, 2, 3, 4, 5]

20. I learned a great deal about how wonderful people are.
    [drop down list of the following: 0, 1, 2, 3, 4, 5]

21. I better accept needing others.
    [drop down list of the following: 0, 1, 2, 3, 4, 5]