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Prevalence of Domestic Violence and Mental Health Symptoms among South Asian women in the United States

By Shreya Bhandari¹ & Uma Chandrika Millner²

Abstract

This study examines the prevalence of domestic violence, mental health outcomes and help-seeking behaviors among a cross section of 155 South Asians that participated in an anonymous survey. The findings indicate that 31% of the participants experienced some form of domestic violence; physical, emotional, financial or sexual abuse and about 88% of those abused experienced emotional abuse. Results indicate that the abused participants experienced mental health symptoms of sleeplessness, frequent crying spells, panic, feelings of helplessness and hopelessness, high stress, bouts of uncontrollable anger and loneliness. The results emphasize culturally sensitive services that address domestic violence as well as mental health symptoms should be made available and accessible to South Asians in the United States of America.

Keywords: Mental health, South Asian women, Domestic violence, Women, United States

Introduction

The South Asian population in the United States (US) belongs to the Indian subcontinent of India, Pakistan, Bangladesh, Sri Lanka, Bhutan and Maldives. It is important to emphasize that with the massive migration of South Asians all over the world, this group also includes members of the South Asian diaspora who had originally settled in other parts of the world, including the Caribbean, Africa, Europe, Canada and the Middle East, and other parts of Asia and the Pacific Islands and are now in the United States. South Asians are an Asian minority and one of the fastest growing ethnic groups in the US that has grown from 3.5 million in 2010 to 5.4 million in 2017 (as much as 40%); (South Asian Americans Leading Together [SAALT] 2019). Domestic Violence (DV) in the South Asian community includes but is not limited to physical, sexual, or emotional threats or actions, economic control, isolation, or other kinds of coercive behavior designed to control individuals in relationships (Raj & Silverman, 2002; Jordan & Bhandari, 2016; Mahapatra, 2012). The prevalence of domestic violence (DV) is a major issue in the South Asian community living in the US with rates being as high as 40%, while the lifetime prevalence of DV in the United States is 20% (Devries et al., 2013). Similar to other populations, South Asian women who have experienced interpersonal violence report poor health outcomes and greater levels of depression, anxiety, and suicidal ideation in comparison to those who did not have such experiences (Hurwitz, et al., 2006). However, there is scant empirical literature on the mental health of abused South Asian women in the US and the research in this realm has not developed

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in proportion to the growth in South Asian population in the United States (Rahman & Rollock, 2004). The need for in-depth understanding of mental health effects of DV on South Asian women and the lack of adequate empirical literature to support culturally grounded interventions informs the rationale for the current research study.

Literature Review

The majority of South Asians living in the United States are Asian Indians (AI), about 4,094,539. California, New York, New Jersey and Texas are most densely populated with South Asians. The South Asians are not a homogenous group; among Asian Indians alone, there is diversity in language, religion, food, culture and holidays celebrated (South Asian American Leaders of Tomorrow, 2019). The South Asian family in general is hierarchical, patriarchal and patrilineal in nature. Emphasis is placed on values of family obligation, interdependence, mutual support, cooperation, harmony and honor (Durvasula & Mylvaganam, 1994; Lum 2011). South Asian men are socialized to think that they are dominant partners who are the primary bread earners whereas women are socialized to be subordinate partners in marriage mainly responsible for homemaking (Dasgupta & Warriar, 1996; Finfgeld & Johnson, 2013). Most South Asians believe in fatalism, and values like 'karma' (destiny) (Bhandari, 2018). South Asian women are considered to be responsible to hold the marriage intact and inability to do so is considered a personal failure. There is also an incredible amount of shame and self-blame that women go through when marriages result in divorce. South Asian women who are divorced are held responsible for bringing bad name to the family's reputation (Ahmed et al., 2009; Anitha, 2010, 2011). The mainstream community labels the Asians in general and South Asians in particular as 'model minority' due to the rapid financial and educational success they have achieved in the United States (Midlarsky, 2006). Due to all the factors mentioned above, the South Asian community denies the problem of domestic violence in order to maintain the 'model minority' image, i.e., a community free of all problems.

There are multiple physical and mental health consequences of DV that have been documented thus far. The adverse physical health consequences of DV include but are not limited to chronic pain and arthritis (Plichta, 2004); gastrointestinal illness (Coker, Smith, Bethea, King, McKeown, 2000) hypertension (Tollestrup, Sklar, Frost, Olson, Weybright, Sandvig, Larson, 1999), sleeping disorders (Hathaway, Mucci, Silverman, Brooks, Matthews, Pavlos, 2000), homicide (Parsons & Harper, 1999), and HIV/AIDS (Zierler, 2000). Research also highlights the poorer mental health symptoms among DV survivors. Relentless exposure to DV can have far reaching effects on mental health, including but not limited to depression, generalized anxiety disorder, suicidality, post-traumatic stress disorder, eating disorders, among others (Hurwitz et al., 2006; Heise, Ellsberg, Gottermoeller, 1999; Kallivayalil, 2010). The serious health consequences of DV have been well documented with White, African American and Latino populations (Wu, El-Bassel, Witte, Gilbert, & Chang, 2003; Wingood, DiClemente, 1997; Golding, 1999; Campbell, 2002). There is very little research done on the adverse mental health effects of DV on South Asian women in the US. (Hurwitz et al., 2006).

Purpose of the Study

There have been a few studies assessing the prevalence of DV in South Asian communities in the US. Adam (2000) found a lifetime prevalence of abuse of 77% among South Asian women. Raj and Silverman (2002) found a prevalence rate of 41% in a non-probability sample of South Asians in the Greater Boston region. Mahapatra (2012) had a more representative sample from all

across the United States and the prevalence rate of DV among South Asians was 38%. There is ample literature on help-seeking and coping strategies among South Asian women experiencing domestic violence in the United States (Mahapatra, 2012; Raj & Silverman, 2002; Bhandari, 2018; Dasgupta, 1998). Very few studies have however utilized quantitative methods (Adam 2000; Ahmad et al. 2004; Raj and Silverman 2002, 2003, 2007; Rianon and Shelton 2003; Yoshioka et al., 2003; Mahapatra, 2012), with most using qualitative methodologies with small sample sizes (Abraham 1999, 2000; Dasgupta 2000; Dasgupta and Warriar 1996; Kallivayalil 2010; Mehrotra 1999; Bhandari, 2018; Jordan & Bhandari, 2016). Fewer domestic violence studies with South Asians have investigated the effect of abuse on mental health of South Asian women, and hence little is known about this topic (Hurwitz, et. al; 2006; Patel & Gw, 1996; Hicks, Bhugra, 2003; Raj, Liu, McCleary-Sills, Silverman, 2005). The current study is therefore an update on prevalence of DV in the South Asian population in the US and an initial exploration of mental health symptoms and service utilization among South Asian individuals experiencing DV.

Method

The current study assessed the prevalence of DV among South Asians, mental health outcomes of experiencing abuse in intimate relationships and what kind of services were accessed for help and support. This study was a university-agency partnership designed to inform the services of a community-based South Asian women's organization (SAWO) in the United States. Thus, the present study was driven by the need for and value of including community-based partners in the development and design of the research study, sample and sources of recruitment, instrument development, implementation of the research, analysis of the data, and finally interpretation of the findings. Study questions were determined by what the agency identified as being most helpful for service provision. Once the survey was developed, study questions were pilot tested by the agency to ensure sensitivity and applicability. All study procedures were reviewed and approved by the university's institutional review board.

Participants were recruited by a variety of methods including flier distribution and snowball sampling. Agency administrators from SAWO assisted with data collection whereas university researchers monitored data collection and data entry. Flyers were distributed at an event organized by SAWO where hard copies of the surveys were completed. SAWO staff shared the flyers with their extensive networks of South Asian individuals. Survey links were included in flyers and in advertising emails for participants to complete. Thirty participants completed the survey in person while the remainder completed it online. The surveys were uploaded utilizing Qualtrics. This mixed method approach allowed us to collect data from diverse groups of South Asian individuals. Each individual protocol took between 10 - 30 minutes to complete. Both surveys were accompanied by additional links to access resources for domestic violence. University-based researchers received de-identified data from the SAWO to analyze. A national sample of 155 South Asian individuals living in the United States completed the survey.

A demographic questionnaire included questions related to age, sex, and location in the US, self-reported identification with the South Asian community, marital /relationship status, educational level, living situation, and immigration status.

The survey was designed to address the main study questions that were developed using a two-step approach. First, an initial list of relevant questions were formulated based on a literature review on DV and mental health in the South Asian community. Second, the protocol was refined through discussions with leaders in a local SAWO. The final survey included 19 closed questions (e.g. yes/no; multiple-choice options) and 4 follow-up open-ended questions attached to the closed

questions. These questions focused on personal experience of DV (including types, reactions to DV including mental health consequences, services and supports received), knowledge of close friends or family experiencing DV (including types, reactions to DV, mental health consequences, services and supports received), knowledge of DV in the South Asian community including barriers to help-seeking), and knowledge of available resources and supports related to DV. The items of the survey are provided in table 1, 2, 3 and 4. All responses were included in the analysis. However, several participants left certain questions blank. The authors utilized descriptive statistics such as percentages to assess the prevalence of DV in the community. The results are presented below.

Results

Sample Characteristics

Participants in the current study (n=155), 134 of whom identified as females, 17 identified as males, one participant chose “other” and three did not report their gender. The participants were from 13 states across the United States with ages ranging from 19-80 years (mean age = 40). About 13% of the participants were U.S citizens while 84% were immigrants. About 60% of the participants had graduate degrees, 25.2% had a Bachelor's degree. About 2% participants had Associates degrees and 2.6% participants did not attend any school. Majority of the participants, about 75% were from India, 17% were from Pakistan, 2% were from Sri Lanka, 1.3% from Bangladesh, 0.6% was from Nepal, and 0.6% identified as Indo-Caribbean. About 4% of the participants did not report their country of origin. In terms of relationship status, about 74% reported being married or living with a partner, 13.6% individuals reported being single, 3.2% participants reported being in a dating relationship, 3.2% participants reported being divorced or separated, 3.2% reported being widowed, .6 % living with a partner or significant other and 2% had missing information.

Extent of Abuse

While around 31% of participants reported experiencing some form of domestic violence, about 54% reported that they knew somebody who had experienced DV. 50% of the participants knew a South Asian individual who had experienced DV. Among individuals who reported experiencing DV, the majority reported emotional abuse, control, and/or manipulation which was about 88%. About 47% experienced physical violence and 54% reported being threatened and intimidated. Further, 33% reported financial control and/or withholding of financial support. About 21% reported sexual violence (see table 1).

Table 1: Rates of sexual violence

Type of Abuse	Percentage
Physical violence or aggression	46.7
Emotional abuse, control, or manipulation	87.5
Threats or intimidation	54.2
Financial control or withholding of financial support	33.3
Sexual abuse	20.8
Social isolation	31.25
Injury that required medical attention	6.3
Loss of pregnancy due to fights and emotional abuse	2.1
Verbal abuse/insults	2.1

Percentages do not add to 100 as several participants 'experienced more than one form of domestic violence.

Mental Health Symptoms

The participants that disclosed abuse were asked about their mental health symptoms and more than 50% reported experiencing high stress levels and about 48% reported loneliness or isolation following the abuse. About 48% reported excessive worrying, and a third of the abused participants reported frequent crying spells, recurring memories of the experience, feeling hopeless and helplessness, bouts of uncontrollable anger and panic. About 38% of the participants reported sleeplessness. A little less than a quarter about 23% reported headaches and body aches. (See table 2).

Table 2: Rates of mental health symptoms

Mental Health symptoms	Percentage
High Stress	56.25
Frequent Crying Spells	29.2
Recurring memories of the experience	29.2
Numbness	16.7
Sleeplessness	37.5
Frequent use of alcohol or drugs	8.3
Helplessness and Hopelessness	31.3
Low Appetite	8.4
Excessive Worrying	48
Bouts of uncontrollable anger	29.2
Headaches or body aches	23
Suicidal thoughts	14.6
Panic	31.3
Loneliness	43.8

Percentages do not add to 100 as several participants experienced more than one form of domestic violence

Services Sought and Received

About 33% of the abused participants reported accessing psychological counseling or therapy and about 27% utilized internet-based resources. About 25% of the abused participants did not access any services. The usage of the formal support systems like the police, legal assistance (16.7%), housing (4.2%) and job assistance (8.3%) has been low. Utilizing domestic violence counseling service was also low (10.4%). About 33% of the abused participants reported utilizing the help of family and friends (see tables 3 & 4).

Table 3: Services provided to victims of abuse

Formal services received	Percentage
None	25
Domestic violence counseling	10.4
Psychological counseling or therapy	33.3
Medical evaluation and intervention	4.2
Legal assistance or counseling	16.7
Immigration assistance	4.2
Involvement of police and court	10.4
Housing or shelter assistance	4.2
Financial assistance	6.3
Job or career assistance	8.3
Internet based resources	27.1
Other	25

Only a quarter of the participants seeking services found them useful.

Table 4: Informal support to victims

Informal Support Received	Percentage
Self	37.5
Friend	33.3
Family	31.3

Discussion

The current sample in the study consisting of 75% Indians followed by Pakistanis, Bangladeshis and other groups is close to the representation of South Asian sub-groups in the US. Indians are the largest South Asian group in the US about 80% followed by Pakistanis, Bangladeshis, Nepali, Sri Lankans, and Bhutanese (SAALT, 2019). Studies in the past with South Asians have reported rates of domestic violence as high as 40% to 60% (Mahapatra, 2012; Raj & Silverman, 2002). The overall prevalence of domestic violence in the current study was 31% and among the abused the rate of physical DV was about 46% which is higher than reported in other studies (Raj & Silverman which was 30%; Mahapatra which was 27%) (Mahapatra, 2012; Raj & Silverman, 2002). Further breakdown highlights that among the abused about 88% experienced emotional abuse, control and/or manipulation. The rates of psychological abuse have been reported higher in other studies as well. Mahapatra (2012) reported 94% of their abused participants 'experienced emotional abuse. The high rates of emotional abuse are an area of serious concern. High rates of psychological abuse can have severe as well as long term mental and physical health effects (Hurwitz et al., 2006) and several of the participants in the current study reported a variety of mental health symptoms like frequent crying spells, high stress, sleeplessness, feelings of hopelessness and helplessness, among others. Abuse in intimate relationships can have mental health effects like anxiety, depression, loss of self-esteem, post-traumatic stress disorder (Midlarsky et al.; 2006; Swan & Snow, 2003). Emotional abuse can also cause sleep and somatic problems along with respiratory issues (Hathaway, et al., 2000). South Asian cultures in general values collectivism where priority is placed on keeping issues within the family. Seeking help outside the close-knit group of family and friends is associated with shame and losing face. Also, filial piety is an important value, and it is looked down upon to confront an elder person in the family even if they are abusive (Jordan & Bhandari, 2016; Midlarsky et al., 2006). Furthermore, the South Asian community may not take emotional abuse seriously. There is also evidence to support that women experiencing emotional abuse take longer to escape abuse and are less likely to recover their mental health (Blasco-Ros et al., 2010; Mahapatra, 2012).

The variety of mental health symptoms clearly show that there is a need for mental health outreach in the South Asian community. About 30% of the participants accessing therapy is a small step in the right direction and needs to be built further. Specifically, from the perspective of service provision, it is extremely important for mental health providers to not over emphasize the DSM that is built on the biomedical, male model and is Eurocentric. South Asians in general may also have a cultural mistrust of seeking help from White European systems that have historically contributed to their oppression through colonization. The cultural mismatch between the individualistic values of psychological services and the collectivistic South Asian culture creates more barriers to seek help for their mental health needs. More precisely, therapeutic approaches emphasize verbal expressiveness and direct communication which are distinct from the South Asian cultural values of indirect communication and somatic expression of emotional pain and conflict. Therefore, keeping in mind the cultural values of South Asian clients, and their mistrust of mental health systems, therapists and counselors should approach South Asians differently as it could have a direct impact on their disclosure of mental health issues or utilization of help for it all together. For example, South Asians may shy away from group therapy as they may not want to talk about their problems in groups where they may not trust maintenance of confidentiality or feel judged. Even with individual therapy, some of them may be more comfortable with another family member participating in the therapy process (somebody that the client trusts). There may be instances when some South Asians may not be comfortable rebelling and hence may not clearly

and openly express disagreements while seeking help. However, disagreements may be communicated through passive aggressive behavior, and/or premature termination. It is important for service providers to be aware of these unique characteristics of South Asians (Juthani, 2002).

About 20% of the abused participants reported sexual abuse by their intimate partners which was similar to rates reported in other studies (Raj & Silverman, 2002). Mahapatra (2012) reported slightly higher rate of sexual abuse by their intimate partners which was at 33%. It is not a surprise that the rates of reported sexual abuse are not as high as compared to other forms of abuse as there may be shame among South Asians with regard to admitting to sexual abuse in marriages or even lack of awareness of what constitutes as sexual violence. Further, South Asian women are expected to submit their bodies to their husbands and the concept of 'forced sex' in marriage may sound alien to them (Abraham, 1999; Jordan & Bhandari, 2016).

In the current study, financial abuse was reported at 33% which was not explored by other studies (Raj & Silverman, 2002; Mahapatra, 2012). While the current study asked the participants about financial control or withholding financial support, it would be worthwhile to explore in-depth the financial abuse in future studies. The rates of financial abuse also emphasize the importance of interventions with South Asian survivors to include social as well as economic empowerment (Tripathi & Azhar, 2020). Anitha (2019) explored the concept of financial abuse among a group of abused women in India and South Asian women in the United Kingdom and recommends that countries like the United States that has a considerable number of South Asian diaspora should have mutual arrangements with home countries to ensure enforcement of legal decisions concerning divorce, custody, financial settlements upon divorce, residence, and contact with children across borders. Often abused South Asian women are either abandoned in the foreign country or are sent back deceptively to their home country without any form of financial compensation (Anitha, 2019; Bhandari, 2020).

The rates of accessing formal services to deal with abuse and mental health symptoms is very low in the current study as reported in other studies (Mahapatra & DiNitto 2013). Other research studies have reported similar results where South Asian women first tend to utilize the informal means and then access formal networks (Mahapatra & DiNitto, 2013; Jordan & Bhandari, 2016). One of the reasons for not accessing formal services could be due to lack of availability of culturally and linguistically compatible mental health as well as domestic violence services. Further, out of the participants who accessed the various services, only a quarter of the participants found them useful. This is concerning and there is an urgent need for culturally tailored mental health services that also address DV. It is also important to explain in detail the meaning behind culturally tailored services. In a nutshell, a culturally competent/tailored service should be able to provide a safe space for South Asian abused women where they do not feel the burden to explain the dynamics of abuse in South Asian culture. They also should not feel fearful that disclosing abuse will cut them off from their own community, or even sensationalize the abusers as in several cases the abusive men are well-renowned in the community. It is also crucial that culturally competent approaches focus on coping strategies that are utilized to decrease the burden of mental distress as well as abuse (Tonsing, Tonsing & Orbuch, 2020).

Limitations

The reliance on self-reported data makes it subject to social desirability as well as recall bias. One of the limitations of this study is that the sample may be biased as data is only gathered from South Asians who volunteered to take this survey and hence this might not accurately represent the entire population of South Asians in the United States. There could be many factors

for lower rates of DV reported in this study. One of the main reasons could be that the current sample was not representative in nature. Participants were largely recruited through South Asian women's organizations through surveys that were emailed. Finally, this study captured quantitative data. It would be worthwhile to capture the qualitative data on the experiences with mental health.

Conclusion

This study contributes to existing literature on prevalence of different types of domestic violence among South Asians in the US as well as the myriad mental health symptoms reported by them. The uniqueness of reporting financial abuse in this study emphasizes the importance of exploring it in-depth in future studies as well as gearing interventions that address economic empowerment for South Asian survivors of DV in the US. Further, with high rates of mental health symptoms reported in the current study, there is an urgent need for mental health providers to deliver culturally tailored services that meet the needs of the South Asian community.

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References

- Abraham, M. (1999). Sexual abuse in South Asian immigrant marriages. *Violence Against Women, 5*, 587–590.
- Abraham, M. (2000a). Isolation a form of marital violence: the south asian immigrant experience. *Journal of Social Distress and the Homeless, 9*, 221–236.
- Adam, N. M. (2000). Domestic violence against women within immigrant Indian and Pakistani communities in the U.S. *Dissertation Abstracts International, 61*(11), 4547A.
- Ahmad, F., Riaz, S., Barata, P., & Stewart, D. E. (2004). Patriarchal beliefs and perceptions of abuse among South Asian immigrant women. *Violence Against Women, 10*, 262–282.
- Ahmad, F., Driver, N., McNally, M., & Stewart, D. E. (2009). “Why doesn't she seek help for partner abuse?” An exploratory study with South Asian immigrant women. *Social Science Medicine, 69*, 613–622.
- Anitha, S. (2010) No recourse, no support: State Policy and practice towards South Asian women facing Domestic Violence in the UK. *The British Journal of Social Work, 40*(2), 462-479. doi: <https://doi.org/10.1093/bjsw/bcn160>
- Anitha, S. (2011) Legislating Gender Inequalities: The Nature and Patterns of Domestic Violence Experienced by South Asian women with insecure immigration status in the United Kingdom. *Violence Against Women, 17*, 1260-1285.
- Anitha, S. (2019). Understanding Economic abuse through an intersectional lens: financial abuse, control, and exploitation of women's productive and reproductive labor. *Violence Against Women, 25*(15), 1854-1877.
- Bhandari S. (2018). South Asian domestic violence and karma. In M. Guggisberg & J. Henricksen (Eds.), *Violence against women in the 21st century: Challenges and future directions* (pp. 57–85). New York, NY: Nova.

- Bhandari, S. (2020) Identification of abuse experiences of south asian women in the US and women in Mumbai, India. *Health Care for Women International*, 41(6), 649-672. <https://doi.org/10.1080/07399332.2020.1725765>.
- Blasco-Ros, C., Sánchez-Lorente, S., & Martinez, M. (2010). Recovery from depressive symptoms, state anxiety and post-traumatic stress disorder in women exposed to physical and psychological, but not to psychological intimate partner violence alone: a longitudinal study. *BioMedical Central Psychiatry*, 10, 98-109.
- Campbell, J.C. (2002). Health consequences of intimate partner violence. *Lancet*, 359, 1334–1336.
- Coker, A.L., Davis, K.E., Arias, I., Desai, S., Sanderson, M., Brandt, H.M., Smith, P.H. (2000). Physical and mental health effects of intimate partner violence for men and women. *American Journal of Preventive Medicine*, 23(4), 260-268. doi: 10.1016/s0749-3797(02)00514-7
- Dasgupta, S., & Warriar, S. (1996). In the footsteps of “Arundhati”: Asian Indian women’s experience of domestic violence in the United States. *Violence Against Women*, 2, 238–259. doi:10.1177/1077801296002003002
- Dasgupta, S. D. (2000). Charting the course: an overview of domestic violence in the South Asian community in the U.S. *Journal of Social Distress and the Homeless*, 9(3), 173–185.
- Devries, K. M., Mak, J. Y. T., Garcia-Moreno, C., Petzold, M., Child, J. C., Falder, G., . . . Watts, C. H. (2013). The global prevalence of intimate partner violence against women. *Science*, 340, 1527–1528. doi:10.1126/science.1240937.
- Durvasula, R. S., & Mylvaganam, G. A. (1994). Mental health of Asian Indians: Relevant issues and community implications. *Journal of Community Psychology*, 22(2), 97–108.
- Finfgeld-Connett, D. & Johnson, E.D. (2013). Abused South Asian Women in Westernized Countries and Their Experiences Seeking Help. *Issues in Mental Health Nursing*, 34,
- Golding, J. M. (1999). Intimate partner violence as a risk factor for mental disorders: A meta-analysis. *Journal of Family Violence*, 14(2), 99–132.
- Hathaway, J. E., Mucci, L. A., Silverman, J. G., Brooks, D. R., Mathews, R., & Pavlos, C. A. (2000). Health status and health care use of Massachusetts women reporting partner abuse. *American Journal of Preventive Medicine*, 19(4), 302–307. [https://doi.org/10.1016/S0749-3797\(00\)00236-1](https://doi.org/10.1016/S0749-3797(00)00236-1)
- Heise, L., Ellsberg, M. and Gottemoeller, M. (1999) Ending Violence Against Women. Population Reports, Series L, No.11. http://www.vawnet.org/assoc_files_vawnet/populationreports.pdf
- Hicks, M.H. & Bhugra, D. (2003) Perceived causes of suicide attempts by U.K. South Asian women. *American Journal of Orthopsychiatry*, 73(4),455–462.
- Hurwitz, E.J.H., Gupta, J. & Liu, R. Silverman, J. & Raj, A. (2006). Intimate partner violence associated with poor health outcomes in U.S. South asian women. *Journal of Immigrant and Minority Health*, 8, (3), 251-261. doi: 10.1007/s10903-006-9330-1,2
- Jordan, A., & Bhandari, S. (2016) ‘Lived Experiences of South Asian Women Facing domestic violence in the United States’. *Journal of Ethnic and Cultural Diversity in Social Work* 25(3), 227–46.
- Juthani, N. V. (2002). Psychiatric treatment of Hindus. *International Review of Psychiatry*, 12, 125-131.

- Kallivayalil, D. (2010). Narratives of suffering of South Asian immigrant survivors of domestic violence. *Violence against Women, 16*, 789–811. doi:10.1177/1077801210374209
- Lum, D. (2011) Culturally Competent Practice: A Framework for Understanding Diverse Groups and Justice Issues. Brooks/Cole, Cengage: CA
- Mahapatra, N. (2012) South Asian Women in the US and their Experience of Domestic Violence', *Journal of Family Violence, 27*, 381–390.
- Mahapatra, N., & DiNitto, D. M. (2013). Help-seeking behaviors of South Asian Women experiencing domestic violence in the United States. *Partner Abuse, 4*(3), 295–313.
- Mehrotra, M. (1999). The social construction of wife abuse: experiences of asian Indian women in the U.S. *Violence Against Women, 5*, 619–640.
- Midlarsky, E., Venkataramani-Kothari, A., & Plante, M. (2006). Domestic violence in the Chinese and South Asian immigrant communities. *Annals of the New York Academy of Sciences, 1087*, 279–300. doi:10.1196/annals.1385.003
- Parsons, L.H., & Harper, M.A. (1999). Violent maternal deaths in North Carolina. *Obstetrics Gynecology, 94*, 990–993.
- Patel, S.P., & Gaw, A.C (1996). Suicide among immigrants from the Indian Sub-continent: A review. *Psychiatric Services, 47*, 517–521.
- Plichta, S. B. (2004). Intimate partner violence and physical health consequences: policy and practice implications. *Journal of Interpersonal Violence, 19*(11), 1296-323.
- Raj, A. & Silverman, J.G. (2002) Intimate Partner Violence against South Asian Women in Greater Boston. *Journal of the American Medical Women's Association, 57*(2), 111–114.
- Rahman, O., & Rollock, D. (2004). Acculturation, competence, and mental health among South Asian students in the United States. *Journal of Multicultural Counseling and Development, 32*(3), 130–142. 10.1002/j.2161-1912.2004.tb00366.
- Raj, A., & Silverman, J. G. (2002). Intimate partner violence against South Asian women residing in greater Boston. *Journal of the American Medical Women's Association, 57*(2), 111–114.
- Raj, A., & Silverman, J. G. (2003). Immigrant South Asian women at greater risk for injury from intimate partner violence. *American Journal of Public Health, 93*, 435–437.
- Raj, A., Liu, R., McCleary-Sills, J., Silverman J.G. (2005). South Asian Victims of IPV more likely than non-victims to report sexual health concerns. *Journal of Immigrant Health, 7*(2), 85–91.
- Raj, A., & Silverman, J. G. (2007). Domestic violence help-seeking behaviors of South Asian battered women residing in the U.S. *International Review of Victimology, 14*(1), 143–170.
- Rianon, N. J., & Shelton, A. J. (2003). Perception of spousal abuse expressed by married Bangladeshi immigrant women in Houston, Texas, U.S.A. *Journal of Immigrant Health, 5*(1), 37–44.
- Swan, S. C., & Snow, D. L. (2003). Behavioral and psychological differences among abused women who use violence in intimate partner relationships. *Violence Against Women, 9*, 75–109.
- South Asian American Leading together [SAALT] (2019). Retrieved May 16, 2020 from <http://saalt.org/wp-content/uploads/2019/04/SAALT-Demographic-Snapshot-2019.pdf>
- Tollestrup, K., Sklar, D., Frost, F. J., Olson, L., Weybright, J., Sandvig, J., & Larson, M. (1999). Health indicators and intimate partner violence among women who are members of a managed care organization. *Preventive Medicine: An International Journal Devoted to*

- Practice and Theory*, 29(5), 431–440. <https://doi.org/10.1006/pmed.1999.0552>
- Tonsing, K., Tonsing, J., Orbuch, T. (2020) Domestic Violence, social support, coping and depressive symptomatology among south asian women in Hong Kong. *Journal of Loss and Trauma*. DOI: 10.1080/15325024.2020.1738056.
- Tripathi, S. & Azhar, S. (2020) A systematic review of Intimate Partner Violence interventions impacting South Asian Women in the United States. *Trauma, Violence & Abuse*, 1-18 <https://doi.org/10.1177/1524838020957987>
- U.S. Department of Commerce, Bureau of the Census. (2010). The Asian population: 2010. Retrieved from <http://www.census.gov/prod/cen2010/briefs/c2010br-11.pdf>
- Wingood, G., DiClemente, R. (1997) The effects of an abusive primary partner on the condom use and sexual negotiation practices of African-American women. *American Journal of Public Health*, 87,1016–1018.
- Wu, E., El-Bassel, N., Witte, S.S., Gilbert, L., Chang, M. (2003). Intimate partner violence and HIV risk among urban minority women in primary health care settings. *AIDS Behavior*, 7(3), 291–301.
- Yoshioka, M., Gilbert, L., El-Bassel, N., & Baib-Amin, H. (2003). Social support and disclosure of abuse: Comparing South Asian, African American, and Hispanic battered women. *Journal of Family Violence*, 18(3), 171–180.
- Zierler, S., Cunningham, W., Andersen, R., Shapiro, M.F., Nakazono, T., Morton, S., Crystal, S., Stein, M., Turner, B., St. Clair, P., Bozette, S.A. (2000). Violence victimization after HIV infection in a U.S. probability sample of adult patients in primary care. *American Journal of Public Health* 2000; 90, 208–215.
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