Spring 6-2022

Analyzing Perceptions and Outcomes of Intimate Partner Violence Within Muslim Communities

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by

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An undergraduate honors thesis submitted in partial fulfillment of the

requirements for the degree of

Bachelor of Science

in

University Honors

and

Psychology

Thesis Adviser

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Portland State University

2022

Abstract

Intimate partner violence is a complex issue that involves gender, race, sexuality, religion, and culture. Muslim communities are a combination of many identities and to be able to support the community, there needs to be a better understanding of how IPV is expressed within this population. This thesis reports findings from a survey distributed throughout Muslim networks and IPV organizations in the US. The results are based on 200 responses and demonstrate that individuals with a history of IPV have worse social and health outcomes. In addition, the source of IPV disclosure (e.g., healthcare provider, religious leader) depended on whether the IPV perpetrator was Muslim or non-Muslim. The top three barriers to seeking support for IPV were losing children, afraid of children getting hurt, and not wanting anyone to know.

Dedication

This is for the Muslims who couldn't speak up, for those who weren't able to get support, and for those who are waiting for change**.**

Acknowledgements

I want to thank my adviser, who helped bring my ideas to life. I want to thank members of the community, who provided constant feedback. I want to thank my family and friends, who I constantly nagged. And I want to thank my Muslim community, for having these difficult conversations.

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Chapter 1: Introduction

Intimate partner violence (IPV) is a global issue that crosses the boundaries of gender, race, sexuality, religion, and culture. In the U.S. alone, around 80 million individuals have experienced psychological aggression by an intimate partner in their lifetime (CDC, 2021). To understand and support different communities, it is important to understand how an individual's identity plays a role in IPV. It is known that individuals with intersectional identities are impacted by IPV disproportionally (see Smith et al., 2017; Walters et al., 2013). However, one relatively understudied factor is regarding religious identity, hence the need for a deeper understanding of IPV within Muslim communities. IPV is often an unacknowledged topic in Muslim communities which makes it difficult to address, thus limiting the discussion in the community (Jayasundara et al., 2014). Even if acknowledged, the lack of resources and barriers Muslims face in the West make it difficult to receive support (e.g., Idriss, 2020). Further research needs to be done on the different factors that contribute to the way Muslims experience IPV to better understand how to support the community.

This study contributes to the literature in multiple ways. First, this research complements broader IPV research by investigating how an individual's history of IPV impacts social and health outcomes among U.S. Muslims. Second, this work examines likely sources for IPV disclosure (e.g., healthcare providers), and explores whether the religious identity of IPV perpetrators impacts IPV disclosure. Third, this study explores which barriers are perceived as most important in seeking support.

Chapter 2: Literature Review

The CDC defines IPV as "physical violence, sexual violence, stalking and psychological aggression by a current or former intimate partner (i.e., spouse, boyfriend/girlfriend, dating partner, or ongoing sexual partner)" (Breiding et al., 2015, p. 11). Individuals with a history of IPV can be physically and mentally impacted. Possible outcomes include suicidality, depression, lower mental well-being, mood disorders, sleeping problems, substance abuse, PTSD, and physical injuries (Karakurt et al., 2014). Depending on the type of violence and severity, outcomes can differ from situation to situation.

When considering the impacts of IPV, it's important to acknowledge the disproportional rate of IPV faced among individuals with intersectional identities, such as among gender, sexuality, racial/ethnic, and religious minorities. Roughly 1 in 10 men have experienced some form of IPV in their lifetime, while 1 in 4 women report some form of IPV (CDC, 2021). Additionally, 1 in 6 transgender individuals have experienced physical violence by an intimate partner (Peitzmeier et al., 2020). Regarding sexual orientation, 46% of bisexual women have been raped compared to 13% of lesbian women and 17% of heterosexual women; 47% of bisexual men and 40% of gay men have been sexually assaulted (other than raped) compared to 21% of heterosexual men (Walters et al., 2013). Among racial/ethnic minorities, Black, American Indian, Alaskan Native, and multi-racial women experience IPV 30 to 50% more than white non-Hispanic, Hispanic, and Asian women (Smith et al., 2017).

One characteristic that receives less attention in the literature is religious identity. This is important to examine as studies have shown that one's religion plays a role in

IPV, especially among Muslims due to the intersectional characteristics of this community (see Jayasundara et al., 2014). The Muslim population consists of immigrants (63%), second generation Americans (15%), and then 22% consist of third generation and onwards. There is also racial diversity consisting of White (30%), Black (23%), Asian (21%), other/mixed (19%), and Hispanic (6%) identifying Muslims (Kohut et al., 2011). The combination of these identities impacts the way Muslims experience IPV.

IPV needs to be first acknowledged as an issue by the community, which often is not the case. In their review, Jayasundara et al. (2014) found that around 72% of Muslim women identified IPV as an issue within their community, yet only about 34% of Muslim men identified IPV as an issue within their community. Nevertheless, the majority (82%) felt that their local mosques weren't properly addressing these issues. In a U.K.-based study, Muslim women explained that current mosque systems do not allow space for women's involvement and are often led by older Imams who do not know how to respond to the needs of Western-Muslim communities (Idriss, 2020). Additionally, immigrant Muslims identified a few belief patterns common in Muslim countries, such as acceptance of violence, husband supremacy, disapproval of divorce, and family unity as a priority (Gennari et al., 2017). While these factors do not cause IPV, they do contribute to the response of it. Such issues are not specific to immigrants, as many Muslim women have expressed fearing the response of the community if they decided to speak up or to leave their abusive relationship, which has resulted in staying in unsafe situations (Alghamdi et al., 2021). In addition, religious leaders have been identified as playing a negative role in situations of IPV (Ghafournia, 2017) and as least likely to disclose to, indicating a need for open discussion regarding these issues (Hansia & Merolla, 2021).

Even if IPV is acknowledged, those who are wanting support are often unable to access support systems because of dependence on the abuser, lack of resources, and not having anywhere else to go (Fineran & Kohli, 2020). Specifically, Muslim immigrant women have been found to be less likely to contact the police than victims who are non-Muslim immigrant women (Ammar et al., 2013). Hesitance and barriers to support is seen in several minority groups, not only in immigrants and/or Muslims (Stockman et al., 2015). In addition, the identity of the abuser has been found to impact the way Muslim victims get support. Prior researchers have found that Muslims are more likely to contact non-Muslim resources (law enforcement, IPV organizations, non-Muslim friends etc.) if their abuser is non-Muslim and they are more likely to contact Muslim resources (Muslim IPV organizations, Muslim friends, religious leaders etc.) if the abuser is Muslim (Hansia & Merolla, 2021). Such findings are troublesome as there is a lack of resources and support for those experiencing IPV within the Muslim community.

In comparing the experiences of Muslim and non-Muslim women, it was found that 40.1% more Muslim women expected negative reactions from the community if they decided to leave the abusive relationship (Ammar et al., 2013). This finding is in line with other research, which has linked IPV with loneliness (Boyda et al., 2015), and greater expectations of prejudice and discrimination (Carvalho et al., 2011). Taken together, these findings suggest that experiencing IPV results in feelings of disconnection from one's social environment and community. As such, *Hypothesis 1* predicts that Muslims with a history of IPV will experience worse social outcomes.

Hypothesis 1: Those who report a history of IPV will report worse social outcomes, including more negative attitudes towards religion (*H1a*), higher

perceived marginalization (*H1b*), lower sense of community (*H1c*), and higher loneliness (*H1d*), compared to those who do not report a history of IPV.

In addition, having a history of IPV may also influence important health factors. Examining the symptoms of IPV and sexual assault victims has shown higher rates of depression, PTSD, anxiety, and eating disorders (Ellsberg & Emmelin, 2014). Additionally, a study investigating the impacts of IPV on ethnic minority women found that common outcomes of IPV included mental health disorders such as PTSD, depression, lower mental functioning, and suicidality (Stockman et al., 2015). In line with this prior work, *Hypothesis 2* predicts that Muslims with a history of IPV will also experience worse health outcomes.

Hypothesis 2: Those who report a history of IPV will report worse health outcomes, including higher perceived stress (*H2a*), higher perceived PTSD symptoms (*H2b*), and lower general health perceptions (*H2c*), compared to those who do not report a history of IPV.

To better understand how to support the community, it's important to understand who Muslims feel comfortable talking to. Although Hansia & Merolla (2021) offer initial insights into disclosure sources, there is still additional research needed to understand this issue more comprehensively. As such, I propose the following research question:

Research Question 1: What are Muslims' beliefs concerning which sources of support to disclose IPV to? Will this pattern substantially differ when perpetrators of IPV are Muslim versus non-Muslim?

There is also a lack of resources and education on IPV along with limited knowledge of available resources in the Muslim community (Fineran & Kohli, 2020). To

establish proper supports and protocols, it's important to understand what Muslim communities perceive as barriers to seeking help. To further understand this, I propose the following research question:

> *Research Question 2*: What are Muslims' beliefs concerning barriers to seeking help for IPV?

Chapter 3: Study Methods

Participants and Procedure

The survey was designed through consultation with community partners and was then advertised through the social network of mosques, domestic violence organizations (Muslim and non-Muslim), mailing lists, Muslim student associations, and other Muslim organizations across America. Advertising was done primarily through organizations located in Oregon. Participation criteria required that participants were individuals who identified as Muslim, were 18 years or older, and currently lived in the US. Participants were also provided an incentive to participate in a raffle for one of three $50 Amazon gift cards.

In all, 200 participants provided usable responses to the survey. In terms of demographic characteristics, the average age was 33.94 (*SD* = 10.09) years old. Most participants (71%) identified as Female, 28% identified as Male, and 1% identified as Transgender. Regarding race/ethnicity, 24% identified as White/Caucasian, 22% as South Asian, 18% as Asian, 12% as Middle Eastern, 12% selected more than one race/ethnicity, 9% as Black/African American, 2% as Hispanic/Latin(x), 2% as Pacific Islander, and 1% as Native American. In terms of highest level of education completed, 1% had less than high school, 11% earned a high school diploma/GED, 15% attended some college or technical school, 16% completed a 2-year degree, 29% completed a 4-year degree, 22% completed a Master's degree, and 7% completed a Doctoral or professional degree. In terms of current relationship status, 63% were married; 24% were single, never married; 5% were in a committed relationship, not married; 5% were divorced; 2% were separated; and 1% were widowed. Among those who had been married at least once, 83%

indicated that they had been married once, 14% had been married twice, 2% had been married three times, and 1% indicated that they had been married five or more times. In terms of sexual orientation, 91% identified as straight/heterosexual, 4% bisexual, 1% lesbian, 1% gay, 1% pansexual, 1% asexual, and 1% questioning. See Table 1 for a full report of sociodemographics. Participants responded from a total of 34 states (see Table 2 and Figure 1).

Measures

IPV History. To examine the participants' history of IPV, the Barrett and colleagues' (2009) 3-item scale was used. Participants were presented with three questions and were provided with the option to respond to each item as (0) No or (1) Yes. First, "Has an intimate partner ever threatened you with physical violence?" Second, "Has an intimate partner ever hit, slapped, pushed, kicked, or physically hurt you in any way?" Third, "Have you ever experienced any unwanted sex by a current or former intimate partner." As Barrett et al. (2009), participants were screened to report a history of IPV if they answered "yes" to any of the three questions.

Attitudes Towards Religion. To measure attitudes towards religion, a revised and shortened version of Wilde and Joseph's (1997) scale was used. Participants were asked to rate the extent to which they agreed with 7 items presented on a 5-point unipolar scale from (1) Not at all to (5) Very much. These items were selected and modified from the original scale based on feedback from community partners and to enhance clarity. An example item included: "Allah helps me." This scale was found to demonstrate acceptable levels of reliability (α = .87).

Perceived Marginalization. Perceived marginalization was measured using five items. To do so, the four items Hansia and Merolla (2021) selected from Issmer and Wagner's (2015) scale were used, and the scale was adapted by adding one item based on recommendations from community partners. The scale was presented on a 7-point bipolar scale from (1) Strongly Disagree to (7) Strongly Agree. An example item included: "Muslims like me are worth less than others in American society." This scale was found to demonstrate acceptable levels of reliability (α = .78).

Sense of Community. Sense of community was measured with Peterson and colleagues' (2008) eight-item scale. The scale was presented on a 7-point bipolar scale from (1) Strongly Disagree to (7) Strongly Agree. Participants were instructed to "Please think about these questions within the context of your Muslim community," and the scale was adapted to refer to "community" rather than "neighborhood" to align with the directions. An example item included: "I feel like a member of this community." This scale was found to demonstrate acceptable levels of reliability (α = .90).

Loneliness. Loneliness was measured with Hughes and colleagues (2004) three-item loneliness scale. The scale was presented on a 5-point unipolar scale from (1) Never to (5) Always. The items included: "How often do you feel that you lack companionship?" "How often do you feel left out?" and "How often do you feel isolated from others?" This scale was found to demonstrate acceptable levels of reliability (α = .75).

Perceived Stress Scale. Cohen's (1988) four-item scale was used to measure perceived stress. The scale was presented on a 5-point unipolar scale from (1) Never to (5) Always. Participants were provided with the following instructions, "Please rate the

following items to the best of your abilities." An example item included: "In the last month, how often have you felt that you were unable to control the important things in your life?" This scale was found to demonstrate close to acceptable levels of reliability (α = .63).

PTSD Symptoms. PTSD symptoms were measured with Price and colleagues' (2016) measure. This four-item measure was presented on a 5-point unipolar scale from (1) Never to (5) Always. Participants were provided with the following directions: "Indicate how much you have been bothered by each problem in the past month. The list of problems and complaints are sometimes responses to stressful life experiences." An example item included: "Repeated, disturbing, and unwanted memories of the stressful experience. This scale was found to demonstrate acceptable levels of reliability (α = .78).

General Health. Perceived general health was measured with Hobfoll and colleagues' (2012) four-item measure. These items were presented on a 5-point unipolar scale, with specific response options for each item. Participants were first provided with the following directions: "These questions refer to your health, holistically (i.e., physically and mentally). Answer these questions to the best of your abilities." An example item included: "In general, would you say your health is…" which was paired with the following response options: (1) Poor; (2) Fair; (3) Good; (4) Very good; (5) Excellent. This scale was found to demonstrate acceptable levels of reliability (α = .73).

Disclosure Likelihood. IPV disclosure likelihood was measured with 9 items, adapting from Hansia and Merolla's (2021) 8-item inventory. The items were presented with a 7-point bipolar scale from (1) Extremely unlikely to (7) Extremely likely. Participants were provided with the following directions, "If you were in a romantic

relationship with a person who is [Muslim/non-Muslim] and that person committed intimate partner violence against you (e.g., act(s) that could be considered physically, sexually or psychologically abusive), how likely would you be to seek help from…" An example item included: "Law enforcement". To adapt Hansia and Merolla's (2021) scale, their eight original items were used and in line with their recommendations for future directions, "Healthcare provider" was added as an additional item. Although items were evaluated individually, this scale was found to demonstrate acceptable levels of reliability for items referring to both perpetrators who were Muslim (α = .81) and non-Muslim (α = .84).

Barriers to Help Seeking. Barriers to seeking help was measured with 13 items, including Simmons and colleagues' (2011) original 10-item inventory. The items were presented on a 7-point bipolar scale from (1) Strongly Disagree to (7) Strongly Agree. Participants were provided with the following prompt: "People who are abused do not seek help because…" and then responded to each of the items. An example item included: "They think no one can protect them." Additionally, in line with recommendations from community partners, the following three items were added: "They are afraid they will get hurt;" "They think the abuse is okay;" and "They think getting help goes against Islam." Although items were evaluated individually, this scale demonstrated acceptable levels of reliability (α = .84).

Chapter 4: Results

Table 3 presents descriptive statistics and intercorrelations of all study variables. In this sample, 48% reported a history of IPV. To test *Hypothesis 1*, the impact of IPV on social outcomes was examined by running a between-subjects MANOVA with attitudes towards religion, perceived marginalization, sense of community, and loneliness as dependent variables and IPV as the independent variable (0 = no reported IPV, 1 = reported IPV). The omnibus MANOVA of the main effect of IPV was significant, $F(4, 195) = 28.22$, $p < .001$, $\eta^2 = .37$, Wilk's $\lambda = 0.63$. Additionally, the univariate ANOVAs for attitudes towards religion, $F(1, 198) = 87.32$, $p < .001$, $\eta^2 = .31$, perceived marginalization, $F(1, 198) = 17.26$, $p < .001$, $\eta^2 = .08$, sense of community, $F(1, 198) = 9.63$, $p = .002$, $\eta^2 = .05$, and loneliness, $F(1, 198) = 20.35$, $p < .001$, $\eta^2 = .09$, were each significant, such that those who reported IPV experienced more negative social outcomes in each case compared to those who did not report IPV (see Table 4 and Figure 2). Taken together, these results fully support *Hypothesis 1*.

To test *Hypothesis 2*, the impact of IPV on health outcomes was examined by running a between-subjects MANOVA with perceived stress, PTSD symptoms, and general health perceptions as dependent variables and IPV as the independent variable (0 = no reported IPV, 1 = reported IPV). Again, the omnibus MANOVA of the main effect of IPV was significant, $F(3, 194) = 17.89$, $p < .001$, $\eta^2 = .22$, Wilk's $\lambda = 0.78$. Additionally, the univariate ANOVAs for perceived stress, $F(1, 196) = 14.56$, $p < .001$, $\eta^2 = .07$, PTSD symptoms, $F(1, 196) = 36.25$, $p < .001$, $\eta^2 = .16$, and general health perceptions, $F(1, 196) = 28.28$, $p < .001$, $\eta^2 = .13$, were each significant, such that those who reported IPV experienced more negative health outcomes in each case compared to

those who did not report IPV (see Table 5 and Figure 3). As such, these results fully support *Hypothesis 2*.

To answer *Research Question 1*, disclosure likelihood was explored across nine disclosure sources when perpetrators of IPV were either Muslim or non-Muslim. First, differences in disclosure likelihood when perpetrators were Muslim was descriptively explored. Participants reported that they were most likely to disclose to healthcare providers, $M = 4.72$, $SD = 1.85$, law enforcement, $M = 4.66$, $SD = 1.88$, and a Muslim DV shelter / advocacy group, $M = 4.65$, $SD = 2.00$, and were least likely to disclose to a religious leader, $M = 4.11$, $SD = 2.03$, a non-Muslim friend, $M = 4.04$, $SD = 2.14$, and a mosque, $M = 3.81$, $SD = 2.02$. When perpetrators of IPV were non-Muslim, a similar pattern was found. In particular, participants reported that they were most likely to disclose to law enforcement, $M = 5.12$, $SD = 1.80$, healthcare providers, $M = 4.82$, $SD = 1.94$, and a non-Muslim DV shelter / advocacy group, $M = 4.62$, $SD = 2.00$, and were least likely to disclose to a family member, $M = 4.18$, $SD = 2.18$, a religious leader, $M = 3.56$, $SD = 2.04$, and a mosque, $M = 3.55$, $SD = 2.09$. See Tables 6-7 and Figure 4 for full descriptive findings.

Finally, to answer *Research Question 2*, the perceived barriers to seeking help were explored among the 13 barriers identified as potentially important by community partners. Descriptively, participants reported the following three barriers as the highest barriers to seeking help: they think they will lose their children, $M = 5.69$, $SD = 1.45$; they are afraid their children will get hurt, $M = 5.66$, $SD = 1.48$; and they do not want anyone to know, $M = 5.54$, $SD = 1.52$. Participants reported the following three barriers as the lowest barriers to seeking help: the abuse isn't anyone else's business, $M = 4.43$,

SD = 1.83; they think the abuse is okay, *M* = 4.23, *SD* = 1.78; and they think getting help goes against Islam, *M* = 3.81, *SD* = 1.96. See Table 8 and Figure 5 for full descriptive findings.

Chapter 5: Discussion

Although prior researchers have demonstrated the impact of IPV on social and health outcomes, including among individuals with intersectional identities, relatively little work has been conducted exploring IPV among Muslims. In this study, results demonstrated that individuals who reported a history of IPV had worse social and health outcomes compared to those who did not report a history of IPV. Social outcomes included a more negative attitude towards religion, higher perceived marginalization, a lower sense of community, and higher loneliness. Health outcomes included higher perceived stress, higher perceived PTSD symptoms, and lower general health perceptions.

In addition, exploratory results demonstrated that if IPV perpetrators were Muslim, participants reported they would most likely disclose to healthcare providers, law enforcement, and a Muslim DV shelter/advocacy group. They would least likely disclose to a religious leader, a non-Muslim friend, and a mosque. If perpetrators were non-Muslim, they would most likely disclose to law enforcement, healthcare providers, and a non-Muslim DV shelter / advocacy group. They would least likely disclose to a family member, a religious leader, and a mosque. In either scenario, they would most likely report to healthcare providers, law enforcement, and an advocacy group specific to the perpetrator's religious identity. They would least likely disclose to religious leaders and a mosque in both scenarios.

Finally, participants reported the following three barriers as the highest barriers to seeking help: they think they will lose their children, they are afraid their children will get hurt, and they do not want anyone to know. Participants reported the following three

barriers as the lowest barriers to seeking help: the abuse isn't anyone else's business, they think the abuse is okay, and they think getting help goes against Islam.

Implications

The finding that Muslims who experienced IPV also reported lower attitudes towards their religion, higher marginalization, lower sense of community, and higher loneliness aligns with broader work linking IPV to feelings of isolation and social connectedness to one's community (e.g., Boyda et al., 2015; Carvalho et al., 2011). These findings are all the more problematic as social factors representing belongingness in one's community are important not only for the prevention of IPV but also for healing from trauma including IPV (see Schultz et al., 2016). In fact, the community has been identified as a key place for prevention, target of intervention, and force for intervention regarding IPV (Mancini et al., 2006).

As shown in previous literature, Muslims are unwilling to disclose to religious leaders (Hansia & Merolla, 2021), which directly relates to negative social outcomes. If IPV is addressed by religious leaders and mosques, community members will feel more comfortable having these conversations and speaking up if they need support. This will allow for a higher sense of community, a more positive attitude towards religion, and less isolation from other community members. The negative social outcomes of IPV can be reduced, which could have far-reaching positive preventative and protective outcomes.

In addition, some inconsistencies within disclosure were identified. Within this sample, law enforcement was among the highest likelihood for disclosure, whereas Hansia and Merolla (2021) found that law enforcement was one of the least likely sources of disclosure. One potential difference in findings may have to do with the fact that

participants were also recruited from IPV organizations, which could have resulted in increased knowledge of systems and increased contact with outside supports.

The barriers identified by the Muslim community should be considered by the appropriate groups. Muslims are less likely to reach out to non-Muslim organizations when the perpetrator is Muslim, and considering there are not many Muslim specific resources, this gap can be lessened by listening to the Muslim community and providing culturally appropriate care (see Hansia & Merolla, 2021). This can be done by IPV organizations/advocacy groups, healthcare providers, and law enforcement as they were identified as some of the most likely sources of disclosure. Along with that, religious leaders and organizations need to work together to educate the community on what IPV is, the impacts, and available resources. Specifically, individuals with a history of IPV should be educated on health and social outcomes. Identifying the outcomes, working towards addressing them, and acknowledging the shortcomings within the Muslim community will all lead to better education and support for those who need it.

Limitations

There were several limitations within this study. First, as this sample was gathered from both the general U.S. Muslim population and from domestic violence organizations, it is unclear whether the rates of IPV found in this sample could be generalized to the general population of Muslims in the US. Second, this survey was collected with cross-sectional self-report data, thus limiting the ability to draw causal inferences. Third, barriers to support were assessed by asking participants to provide their beliefs about why people do not seek help. Barriers could be better identified by individuals with a history of IPV as what an individual does versus what they might do can vary. Additionally,

there also appeared to be an assumption that individuals experiencing IPV have children, as two of the top three barriers identified were regarding their well-being.

Future Directions

Future studies should seek to better distinguish differences between general populations and Muslims who have a history of IPV. Along with that, barriers to support should be further examined, and how it can change depending on circumstances. It is especially important to consider those with and without children. Intervention studies should explore religious leaders and mosques taking on a positive role, and its impact on support and IPV outcomes within the community. Lastly, thorough research is needed on the differences and similarities of culture and religion in relation to IPV.

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Tables

Table 1

Sociodemographics

Variable	*M* (*SD*)/%
Age	33.94 (10.09)
Gender	
Female	71%
Male	28%
Transgender	1%
Race	
White/Caucasian	24%
South Asian	22%
Asian	18%
Middle Eastern	12%
Multiracial	12%
Black/African American	9%
Pacific Islander	2%
Native American	1%
Highest Level of Education	
Less than High School	1%
High School Diploma/GED	11%
Some College or Technical School	15%
2 Year Degree (e.g., Associate's)	16%
4 Year Degree (e.g., Bachelor's)	29%
Master's Degree	22%
Doctoral or Professional Degree	7%
Relationship Status	
Married	63%
Single, Never Married	24%
Committed Relationship	5%
Divorced	5%
Separated	2%
Widowed	1%
Number of Marriages	
One	83%
Two	14%
Three	2%
Five or More	1%
Sexual Orientation	
Straight/Heterosexual	91%
Bisexual	4%
Lesbian	1%
Gay	1%
Pansexual	1%
Asexual	1%
Questioning	1%

Table 2

Participant Location by U.S. State

U.S State	%
Oregon	32
Michigan	13
Texas	13
California	6
Washington	5
Indiana	4
Florida	3
Illinois	3
Delaware	2
Georgia	2
Idaho	2
Missouri	2
Utah	2
Virginia	2
Alabama	1
Alaska	1
Arizona	1
Arkansas	1
Colorado	1
Hawaii	1
Iowa	1
Kansas	1
Louisiana	1
Maryland	1
Massachusetts	1
Minnesota	1
Nebraska	1
Nevada	1
New Jersey	1
New York	1
Ohio	1
Oklahoma	1
South Carolina	1
West Virginia	1

Table 3

Means, Standard Deviations, Intercorrelations, and Reliabilities

	M	*SD*	1	2	3	4	5	6	7	8
1. IPV History	0.48	0.50	-							
2. Attitudes Towards Religion	4.20	0.82	-.55***	(.87)						
3. Perceived Marginalization	3.45	1.30	.28***	-.09	(.78)					
4. Sense of Community	4.71	1.24	-.22**	.38***	-.12	(.90)				
5. Loneliness	2.97	0.93	.31***	-.34***	.28***	-.41***	(.75)			
6. Perceived Stress	2.65	0.76	.26***	-.30***	.24***	-.23***	.49***	(.63)		
7. PTSD Symptoms	2.50	0.97	.39***	-.44***	.37***	-.31***	.50***	.60***	(.78)	
8. General Health	3.38	0.74	-.35***	.31***	-.19**	.10	-.27***	-.25***	-.31***	(.73)

Note. Reliabilities presented on the diagonal.

Table 4

MANOVA Results for Social Outcomes with Mean Differences

Multivariate test of significance					
Test	*df*	error *df*	*F*	η^2	Wilks's λ
Wilks' Lambda	4	195	28.22***	.37	0.63

Univariate F-tests				
Dependent Variable	*df*	error df	*F*	η^2
Attitudes Towards Religion	1	198	87.32***	.31
Perceived Marginalization	1	198	17.26***	.08
Sense of Community	1	198	9.63**	.05
Loneliness	1	198	20.35***	.10

Means and Standard Deviations				
	No IPV History		Reported IPV History	
	M	*SD*	*M*	*SD*
Attitudes Towards Religion	4.63	0.56	3.73	0.79
Perceived Marginalization	3.10	1.12	3.83	1.39
Sense of Community	4.97	1.26	4.43	1.17
Loneliness	2.70	0.98	3.26	0.78

Table 5

MANOVA Results for Health Outcomes with Mean Differences

Multivariate test of significance					
Test	*df*	error *df*	*F*	η^2	Wilks's λ
Wilks' Lambda	3	194	17.89***	.22	0.78

Univariate F-tests				
Dependent Variable	*df*	error df	*F*	η^2
Perceived Stress	1	196	14.56***	.07
PTSD Symptoms	1	196	36.25***	.16
General Health Perceptions	1	196	28.28***	.13

Means and Standard Deviations				
	No IPV History		Reported IPV History	
	M	*SD*	*M*	*SD*
Perceived Stress	2.46	0.81	2.86	0.64
PTSD Symptoms	2.13	0.87	2.90	0.92
General Health Perceptions	3.64	0.72	3.11	0.67

Table 6

Disclosure When IPV Perpetrators are Muslim

Variable	*M*	*SD*	Extremely Likely (%)	Moderately Likely (%)	Slightly Likely (%)	Neither Likely nor Unlikely (%)	Slightly Unlikely (%)	Moderately Unlikely (%)	Extremely Unlikely (%)
Healthcare provider	4.72	1.85	21	18	22	12	10	12	6
Law enforcement	4.66	1.88	21	18	19	14	12	10	7
A Muslim domestic violence shelter/advocacy group	4.65	2.00	23	21	14	12	9	13	9
A family member	4.53	2.07	24	17	15	13	8	13	11
A Muslim friend	4.41	2.16	25	16	13	6	14	15	12
A non-Muslim domestic violence shelter/advocacy group	4.22	2.07	18	17	15	12	10	16	13
A religious leader	4.11	2.03	16	13	20	11	15	10	16
A non-Muslim friend	4.04	2.14	19	15	11	9	16	16	15
A Mosque	3.81	2.02	13	10	17	15	14	13	19

Table 7

Disclosure When IPV Perpetrators are Non-Muslim

Variable	*M*	*SD*	Extremely Likely (%)	Moderately Likely (%)	Slightly Likely (%)	Neither Likely nor Unlikely (%)	Slightly Unlikely (%)	Moderately Unlikely (%)	Extremely Unlikely (%)
Law enforcement	5.12	1.80	27	26	18	9	7	8	5
Healthcare provider	4.82	1.94	25	22	13	13	10	9	7
A non-Muslim domestic violence shelter/advocacy group	4.62	2.00	23	18	16	12	10	11	9
A non-Muslim friend	4.54	2.06	21	21	15	10	9	11	12
A Muslim friend	4.23	2.11	21	13	14	12	14	12	14
A Muslim domestic violence shelter/advocacy group	4.2	1.99	14	20	13	14	14	12	13
A family member	4.18	2.18	22	15	9	11	15	11	17
A religious leader	3.56	2.04	13	9	11	14	17	14	22
A Mosque	3.55	2.09	13	8	13	16	13	10	26

Table 8

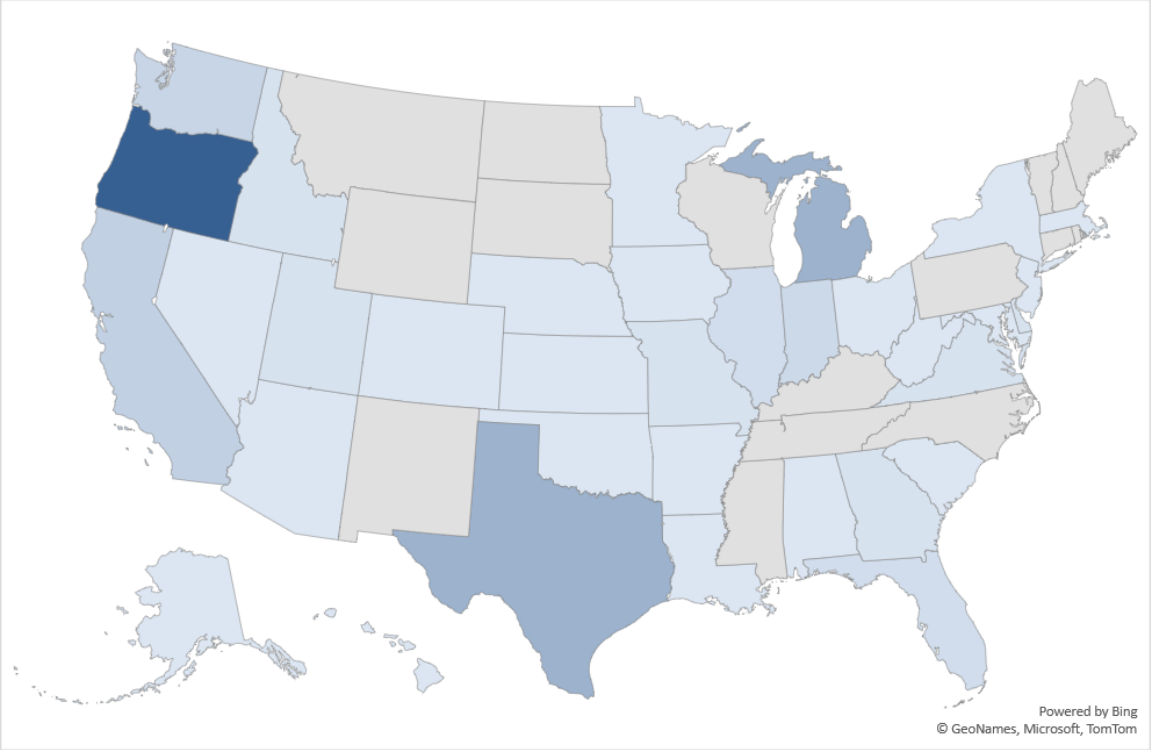
Barriers to Help Seeking

Variable	*M*	*SD*	Strongly Agree (%)	Agree (%)	Somewhat Agree (%)	Neither Agree nor Disagree (%)	Somewhat Disagree (%)	Disagree (%)	Strongly Disagree (%)
They think they will lose their children.	5.69	1.45	36	32	15	6	5	6	0
They are afraid their children will get hurt.	5.66	1.48	34	36	11	8	5	6	1
They do not want anyone to know.	5.54	1.52	35	25	18	10	5	7	1
They think they will lose their home.	5.49	1.54	32	28	21	5	10	4	2
They are afraid they will get hurt.	5.48	1.49	30	30	20	7	7	6	1
They are embarrassed.	5.38	1.61	31	26	18	6	11	7	1
They do not want to lose their partner.	5.15	1.57	20	32	19	12	7	9	1
They think no one can protect them.	5.13	1.66	22	29	20	9	7	10	2
They do not know what services are available.	4.94	1.57	16	26	25	12	11	8	2
The abuse isn't serious enough.	4.49	1.84	13	23	21	14	7	14	8
The abuse isn't anyone else's business.	4.43	1.83	15	18	20	14	14	11	8
They think the abuse is okay.	4.23	1.78	9	20	20	17	12	14	8
They think getting help goes against Islam.	3.81	1.96	13	12	13	17	11	23	11

Figures

Figure 1

Heat Map of Participant Response Location by U.S. State



Note. No participant responses from states in grey.

Figure 2

Mean Differences of Social Outcomes Based on IPV History

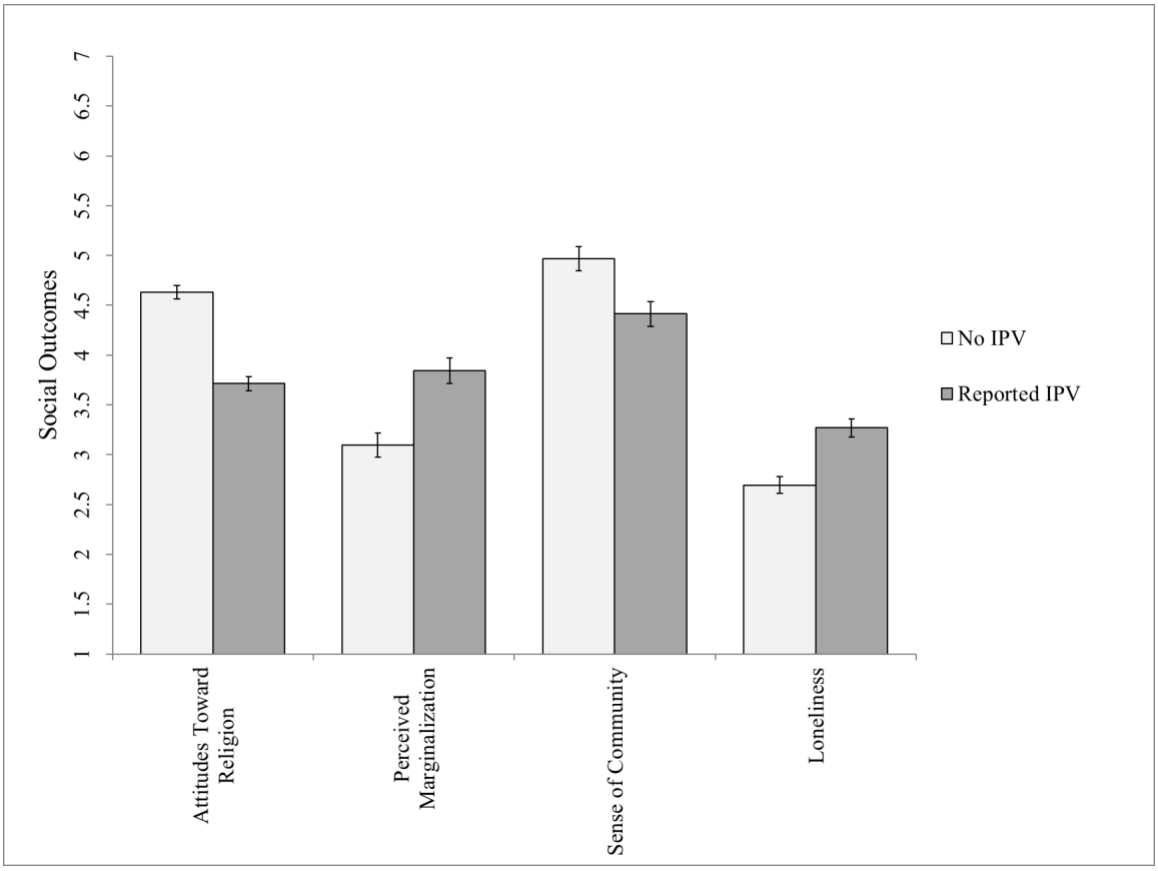


Figure 3

Mean Differences of Health Outcomes Based on IPV History

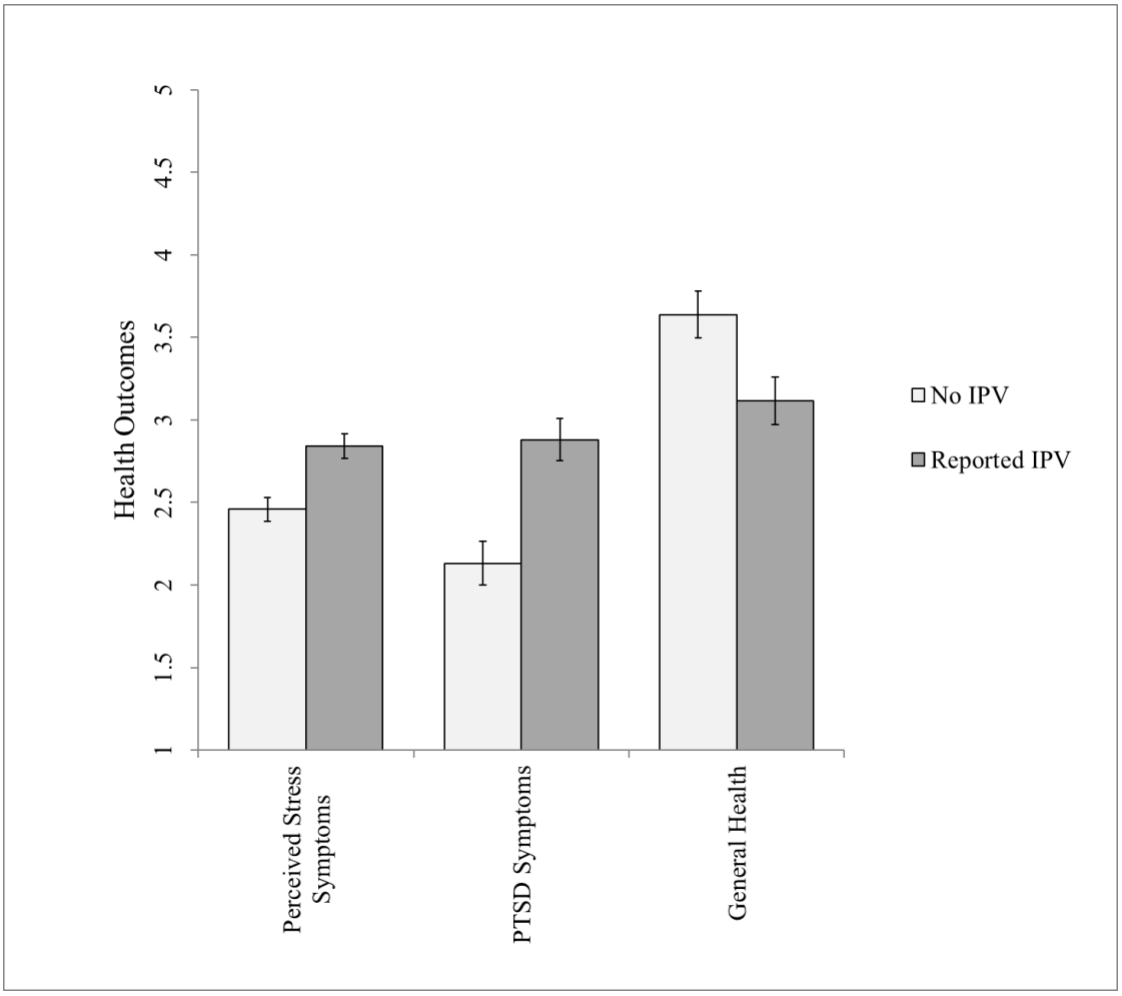


Figure 4

Disclosure Likelihood by Source Based on Religious Identity of IPV Perpetrator

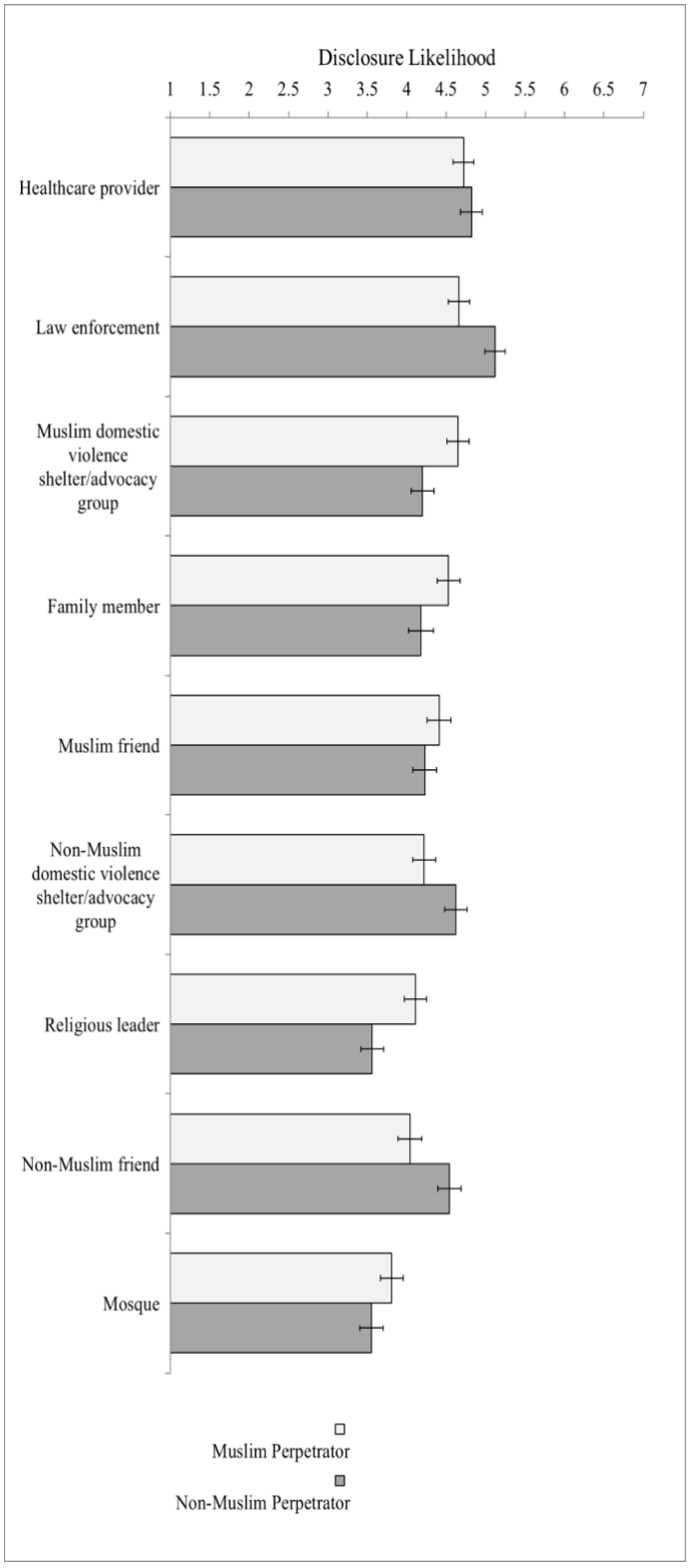
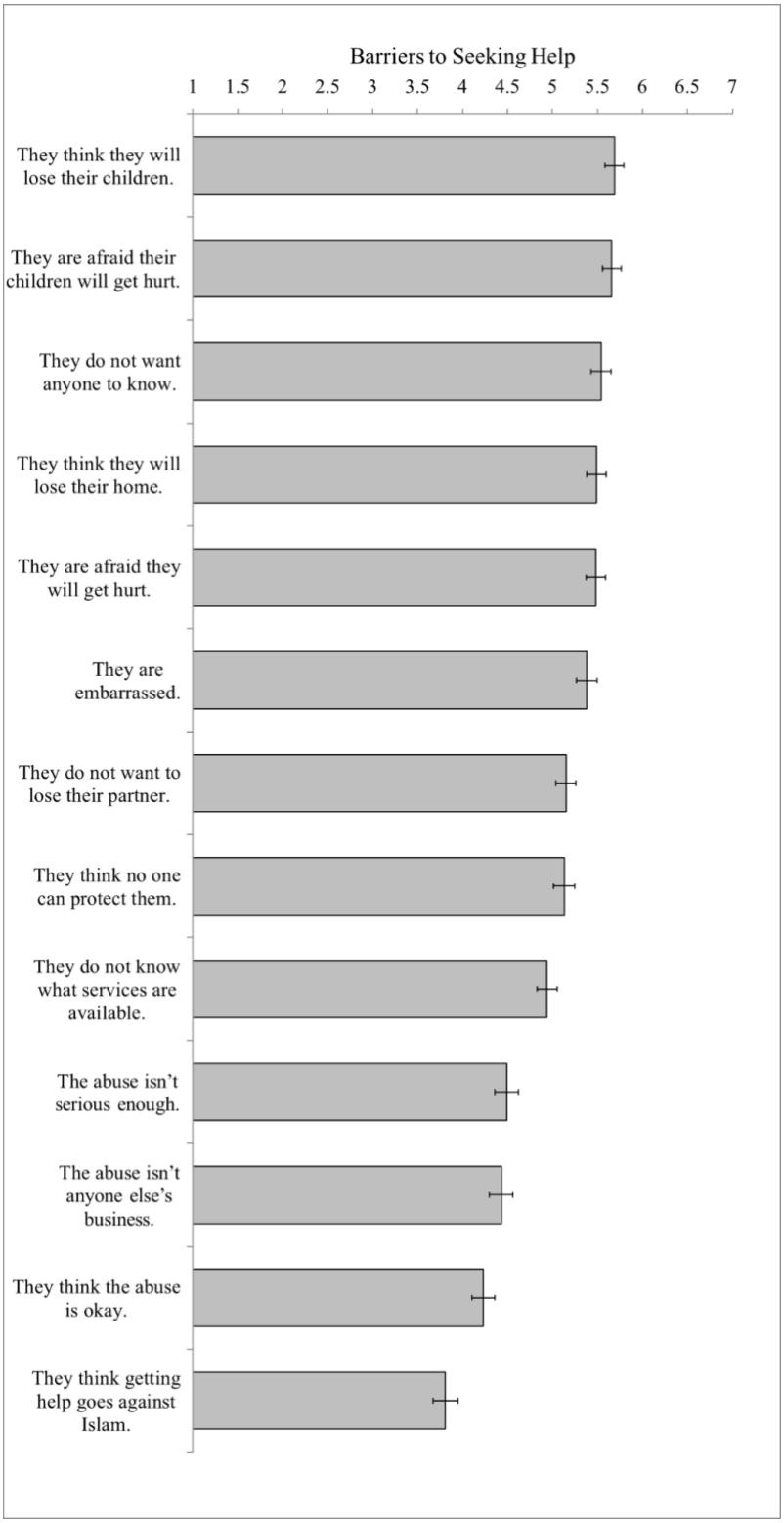


Figure 5

Barriers to Seeking Help



Appendix A: Scale Items

IPV History

Instructions: Please rate the following items to the best of your abilities.

This scale included the following response options: (0) No; (1) Yes.

1. Has an intimate partner ever threatened you with physical violence?
2. Has an intimate partner ever hit, slapped, pushed, kicked, or physically hurt you in any way?
3. Have you ever experienced any unwanted sex by a current or former intimate partner?

Barrett, K. A., O'Day, B., Roche, A., & Carlson, B. L. (2009). Intimate partner violence, health status, and health care access among women with disabilities. *Women's Health Issues*, *19*(2), 94–100. https://doi.org/10.1016/j.whi.2008.10.005

Attitudes Towards Religion

Instructions: Please rate the extent to which you agree with the following items.

This scale included the options to respond from 1 to 5: (1) Not at all; (2) A little bit; (3) Somewhat; (4) Quite a bit; (5) Very much.

1. Allah helps me.
2. My prayers help me a lot.
3. Islam helps me lead a better life.
4. I believe that Allah helps people.
5. Mohammed (peace be upon him) provides a good lifestyle model.
6. I pray five times a day.
7. I fast the whole month of Ramadan.

Adapted from Wilde, A. & Joseph, S. (1997). Religiosity and personality in a Moslem context. *Personality and Individual Differences*, *23*(5), 899–900. https://doi.org/10.1016/S0191-8869(97)00098-6

Perceived Marginalization

Instructions: Please rate the extent to which you agree with the following items.

This scale included the options to respond from 1 to 7: (1) Strongly disagree; (2) Disagree; (3) Somewhat disagree; (4) Neither agree nor disagree; (5) Somewhat agree; (6) Agree; (7) Strongly agree.

1. Muslims like me are worth less than others in American society.
2. With my background as a Muslim I will have problems when looking for work.
3. For Muslims like me, leading a normal life is made difficult.
4. In our society, Muslims like me are not offered any chances.
5. As a Muslim, I will never fit in American society.

Adapted from Hansia, A., & Merolla, A. J. (2021). Intimate partner violence disclosure among Muslim-Americans: A survey study of disclosure likelihood to varying networks and the roles of relational context, religiosity, and marginalization. *Journal of Applied Communication Research*, *49*(6), 609–631. https://doi.org/10.1080/00909882.2021.1970793

Sense of Community

Directions: Please think about these questions within the context of your Muslim community.

This scale included the options to respond from 1 to 7: (1) Strongly disagree; (2) Disagree; (3) Somewhat disagree; (4) Neither agree nor disagree; (5) Somewhat agree; (6) Agree; (7) Strongly agree.

1. I can get what I need in this community.
2. This community helps me fulfill my needs.
3. I feel like a member of this community.
4. I belong in this community.
5. I have a say about what goes on in my community.
6. People in this community are good at influencing each other.
7. I feel connected to this community.
8. I have a good bond with others in this community.

Adapted from Peterson, N. A., Speer, P. W., & McMillan, D. W. (2008). Validation of a brief sense of community scale: Confirmation of the principal theory of sense of community. *Journal of Community Psychology*, *36*(1), 61–73. https://doi.org/10.1002/jcop.20217

Loneliness

Directions: Please think about these questions generally.

This scale included the options to respond from 1 to 5: (1) Never; (2) Rarely; (3) Sometimes; (4) Often; (5) Always.

1. How often do you feel that you lack companionship?
2. How often do you feel left out?
3. How often do you feel isolated from others?

Hughes, M. E., Waite, L. J., Hawkley, L. C., & Cacioppo, J. T. (2004). A short scale for measuring loneliness in large surveys: Results from two population-based studies. *Research on Aging, 26*(6), 655–672. https://doi.org/10.1177/0164027504268574

Perceived Stress Scale

Directions: Please rate the following items to the best of your abilities.

This scale included the options to respond from 1 to 5: (1) Never; (2) Sometimes; (3) About half the time; (4) Most of the time; (5) Always.

1. In the last month, how often have you felt that you were unable to control the important things in your life?
2. In the last month, how often have you felt confident about your ability to handle your personal problems? (Reverse-scored)
3. In the last month, how often have you felt that things were going your way? (Reverse-scored)
4. In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?

Cohen, S. (1988). Perceived stress in a probability sample of the United States. In S. Spacapan & S. Oskamp (Eds.), *The social psychology of health* (pp. 31–67). Sage Publications, Inc.

PTSD Symptoms

Directions: Indicate how much you have been bothered by each problem in the past month. The list of problems and complaints are sometimes responses to stressful life experiences.

This scale included the options to respond from 1 to 5: (1) Never; (2) Sometimes; (3) About half the time; (4) Most of the time; (5) Always.

1. Repeated, disturbing, and unwanted memories of the stressful experience.
2. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations).
3. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous).
4. Feeling jumpy or easily startled.

Price, M., Szafranski, D. D., van Stolk-Cooke, K., & Gros, D. F. (2016). Investigation of abbreviated 4 and 8 item versions of the PTSD Checklist 5. *Psychiatry Research, 239*, 124–130. https://doi.org/10.1016/j.psychres.2016.03.014

General Health

Directions: These questions refer to your health, holistically (i.e., physically and mentally). Answer these questions to the best of your abilities.

1. In general, would you say your health is…"

   (1) Poor; (2) Fair; (3) Good; (4) Very good; (5) Excellent

2. To what extent do you have any particular health problems?

   (1) A very great extent; (2) A great extent; (3) A moderate extent; (4) Almost never; (5) Never/no extent

3. How much of the time has your health kept you from doing the kind of things other people your age do?

   (1) All of the time; (2) Most of the time; (3) Sometimes; (4) Rarely; (5) None of the time

4. To what extent do you feel healthy enough to carry out things that you would like to do?

   (1) Never/no extent; (2) Almost never; (3) A moderate extent; (4) A great extent; (5) A very great extent

Hobfoll, S. E., Vinokur, A. D., Pierce, P. F., & Lewandowski-Romps, L. (2012). The combined stress of family life, work, and war in Air Force men and women: A test of conservation of resources theory. *International Journal of Stress Management, 19*(3), 217–237. https://doi.org/10.1037/a0029247

Disclosure Likelihood

Directions: If you were in a romantic relationship with a person who is [Muslim/non-Muslin] and that person committed intimate partner violence against you (e.g. act(s) that could be considered physically, sexually or psychologically abusive), how likely would you be to seek help from…

This scale included the options to respond from 1 to 7: (1) Extremely unlikely; (2) Moderately unlikely; (3) Slightly unlikely; (4) Neither likely nor unlikely; (5) Slightly likely; (6) Moderately likely; (7) Extremely likely.

1. A Muslim friend.
2. A non-Muslim friend.
3. A family member.
4. A non-Muslim domestic violence shelter/advocacy group.
5. A Muslim domestic violence shelter/advocacy group.
6. A religious leader.
7. A Mosque.
8. Law enforcement.
9. Healthcare provider.

Adapted from Hansia, A., & Merolla, A. J. (2021). Intimate partner violence disclosure among Muslim-Americans: A survey study of disclosure likelihood to varying networks and the roles of relational context, religiosity, and marginalization. *Journal of Applied Communication Research*, *49*(6), 609–631. https://doi.org/10.1080/00909882.2021.1970793

Barriers to Help Seeking

Directions: People who are abused do not seek help because…

This scale included the options to respond from 1 to 7: This scale included the options to respond from 1 to 7: (1) Strongly disagree; (2) Disagree; (3) Somewhat disagree; (4) Neither agree nor disagree; (5) Somewhat agree; (6) Agree; (7) Strongly agree.

1. They do not want anyone to know.
2. They are embarrassed.
3. They do not know what services are available.
4. They think no one can protect them.
5. They are afraid their children will get hurt.
6. They do not want to lose their partner.
7. They think they will lose their children.
8. They think they will lose their home.
9. The abuse isn't anyone else's business.
10. The abuse isn't serious enough.
11. They are afraid they will get hurt.
12. They think the abuse is okay.
13. They think getting help goes against Islam.

Adapted from Simmons, C. A., Farrar, M., Frazer, K., & Thompson, M. J. (2011). From the voices of women: Facilitating survivor access to IPV services. *Violence against women*, *17*(10), 1226–1243. https://doi.org/10.1177/1077801211424476