Ab bas: Resiliency and Cultural Factors in South Asian Women Survivors of Sexual Assault

Ashley Jacob

A Dissertation Submitted to the Faculty of

The Chicago School of Professional Psychology

In Partial Fulfillment of the Requirements

For the Degree of Doctor of Clinical Psychology

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Dedication

I would like to dedicate this project to all the women who fight for justice, equality, and change through their stories and bravery. And to all the women who shared their story with me, I am inspired and in awe of your courage and perseverance.

I would also like to dedicate this project to my big brother, Sumith. When I first told you the topic for my dissertation, you smiled. When I told you a year later, that this project just felt too challenging and I wanted to quit, you reminded me that if anyone could do it, it was me. And when I told you that, after three years, I was finally finished, you just hugged me and said, “I’m so proud of you.” Never in my life had I met anyone who was as brave, kind, or loving as you. You constantly inspired people to spread goodness through your testimony, including me. I was lucky to have experienced that love for over 20 years, and I continue to be inspired by the strength of those you cared for. Thank you for always believing in me. For supporting and encouraging me. And for reminding me every day, what it means to love someone unconditionally. I miss you and I love you.

Abstract

Women within South Asian communities experience high rates of sexual violence. According to the National Crime Bureau, there were 36,735 reported occurrences of rape in India in 2014. Approximately 41.7% of women in India will experience physical and psychological abuse from their families, (e.g. kidnapping, sexual and physical assault, and acid throwing), in addition to abuse as a result of her family's inability to make dowry payments. According to the previous research, these statistics are impacted by several cultural factors including: patriarchal society, perception of women, stigma associated with violence, and limited access to mental health resources.

A total of 38 individuals participated in the online, confidential survey, and were screened for eligibility by completing the demographic questions. Of these participants, 19 women (50%) met the inclusion criteria and consented to participate in the study, and 16 women (42.1%) completed the remaining 10 questions. On average, participants reported a strong association to their cultural identity, and considered it to be an important factor in their recovery process. Additionally, responses indicated that family and community is a culturally-bound resiliency factor, as many women emphasized the importance of their family as a key factor in their process of healing. Consistent with the literature, responses suggested that occurrences of victim blaming, fear of damaging reputation and image, stigma associated with sexual violence, and discomfort with disclosure contributed to culturally-bound barriers to healing.

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Chapter 1: Nature of the Study

Background

In December of 2012, a 23-year old student, Jyoti Singh, and her friend, Awindra Pratap Pandey, were traveling via bus in Delhi, India. Awindra was beaten and thrown off the bus, while Jytoti was brutally beaten and raped by six perpetrators, including the driver. Awindra suffered several injuries, including broken limbs, but survived the attack. Jyoti sustained severe injuries and was transferred to a medical facility in Singapore to receive further care; however, approximately 12 days following the attack, she succumbed to her injuries and died. This case received widespread media coverage, both nationally and globally, and many citizens of India began to demand that the government create and enforce legal policies that would effectively protect victims of sexual assault and prosecute perpetrators without delay. Although the perpetrators were convicted of murder and sexual assault, this is rarely the case. According to the National Crime Bureau (2014), there were 36,735 reported occurrences of rape in India in 2014. Approximately 16,575 individuals were acquitted, 487 were discharged, 6,637 were convicted. The remaining 13,036 are awaiting trial.

Most Indian communities are patriarchal, attributing success and financial responsibility to the men, while women are considered to be "burdens" or "born to be fed throughout their lives," causing more financial strain on families. (Chaudhuri, Morash, & Yingling, 2014; Niaz & Hassan, 2006; Singh, Hays, Chung, & Watson, 2010). Due to this, they experience discrimination, lack of empowerment and independence, and family and societal pressure, and limited opportunities in education and employment (Singh et. al, 2010). Additionally, they are often victims to exchange or child marriages, dowry, and confinement to their homes. Approximately 41.7% of women in India will experience physical and psychological abuse from

their families, (e.g. kidnapping, sexual and physical assault, and acid throwing), in addition to abuse as a result of her family's inability to make dowry payments (NCRB, 2012, p 385; Niaz & Hassan, 2006). This contributes to female infanticide and human trafficking amongst many rural communities. For example, there was a case in which a woman brought her newborn daughter home, and the mother-in-law mixed a poisonous herb into the baby's formula and fed it to her. She believed that sacrificing the baby girl would "guarantee a boy in the next pregnancy" (Niaz & Hassan, 2006, p 118). Furthermore, rural families will either voluntarily or involuntarily sell their daughters into human trafficking or prostitution to make ends meet or pay a debt. Women sold into this business experience violence, sexual assault, and torture from clients, brothel owners, and even members of law enforcement. A study conducted in Bangladesh, found that women have a greater chance (i.e. 2:1) of being diagnosed with a mental disorder than men, and a 3:1 ratio of committing suicide (as cited in, Niaz & Hassan, 2006).

According to Raj & McDougal (2014), approximately 27.5 million Indian women experienced sexual assault and 1% of those were reported to officials. Additionally, approximately 10% of sexual assault cases were crimes of marital rape; however, because marital rape is not illegal in India, no legal action was taken.

Problem Statement

Research indicates that there are several contributors to how women may experience their recovery process following sexual assault, including the impact of disclosure, impact of negative responses from others, and rape myth acceptance. According to Ullman (2012), the ability to disclose an experience of sexual assault contributes to overall effectiveness of the recovery process. Additionally, fear of negative reactions from others (i.e. various levels of one's support system) contributes to difficulty disclosing rape. Acceptance of rape myths (i.e. "any healthy

woman can resist a rapist if she really wants to," "women ask for it," etc.), can impact one's comfort accessing mental health services following an assault. However, these factors are primarily based on Western research and there is little information on culturally bound effects of disclosure for women in Indian communities.

Purpose of the Study

The purpose of this study is to increase the understanding of the culturally-bound traditions and perceptions of sexual assault within South Asian communities, which may increase the provision of effective, culturally competent care. As stated, previous research in this area focused on other populations (e.g. Hispanic, East Asian, etc.), or on cultural competency when working with clients who have a history of trauma and are of a different cultural background. There is little research on the intersection of culture and recovery within this population, especially resiliency factors that contribute to healing. Therefore, the goal of this study is to utilize the previous literature and provide additional information about culturally bound factors that will be useful for professionals.

The proposed study will utilize a qualitative approach, specifically an online, anonymous, confidential survey on SurveyMonkey. The proposed participations will include individuals who identify as heterosexual, cisgender women, over the age of 18, are survivors of unwanted sexual experiences (by a partner or stranger) and identify as first-generation United States immigrants of Indian descent, with proficiency in English. The participants will also include survivors of one or more incidents of unwanted sexual experiences, and the experience must have occurred when the participant was an adult.

Research Questions and Hypotheses

The overall question guiding this study was: How does culture impact the overall experience of survivors of unwanted sexual experiences for women in South Asian communities. The study was further grounded by two subquestions:

1. How does culture contribute to potential barriers and resiliency factors in healing?
2. What are some potential recommendations for clinicians working with this population?

Theoretical Framework

According to Briere and Scott (2015), there are several practices that are effective for treatment of complex trauma in children or adults. The authors outlined several interventions including, cognitive-behavioral (most commonly utilized, especially exposure therapy), affect regulation training (helping clients tolerate and regulate the emotional responses to trauma), psychodynamic (focusing on interpersonal difficulties, attachment concerns, and identity issues), and multi-target therapies (integrating several modalities of treatment). Additionally, the authors discussed pharmacotherapeutic and pharmacotherapy interventions to help regulate physical symptoms of PTSD, in addition to management of potential comorbid disorders, such as "…substance use, suicidal ideation, and dissociation" (p 519). Furthermore, Briere and Jordan (2004) outlined various assessment and treatment challenges when working with female survivors of violence, including (1) potential previous traumatic experiences that have occurred and (2) assessing symptoms of trauma. Clinicians should also be mindful of safety concerns and symptom severity when treatment planning, as most standardized therapy interventions may need to be adapted and lengthened to accommodate for individual experiences.

One of the phenomena being explored in this study is the impact of cultural traditions and values on the process of healing from unwanted sexual experiences for women in South Asian communities; in addition to utilizing this information to guide treatment planning for individuals within this population. Although, there is significant literature on assessment and treatment for women survivors of sexual assault, much of the literature detailing best practices is based in Western culture and traditions. Therefore, it may not be efficient or culturally mindful for other cultures. This study hopes to explore and identify culturally bound practices that will assist clinicians in providing effective care.

Scope of the Study

There are several characteristics that limit the scope of this study, including participation selection, difficulty accessing participants, and limited information. This study was completed for partial fulfillment for a degree requirement; therefore, eligibility criteria and access to participants was challenging. The preferred research method was in-person, qualitative interviews with participations; however, throughout the development of the proposal it became evident that this would be difficult. Therefore, the method was changed to online, anonymous, and confidential surveys. Although this methodology increased participation, it limited the amount of information provided, impacting the ambiguity of the responses and ability to obtain richer information.

Significance of Study

This study will potentially offer information to assist with training professionals on the important factors to be considered when working with this population, and the impact of acculturation. For example, professionals should utilize clinical skills such as warmth, normalizing, validation, and psychoeducation to increase rapport and comfort within the

therapeutic process, in addition to avoidance of the use of psychological jargon to make language more accessible. Additionally, professionals should consider the potential intersection of family dynamics, religious/spiritual beliefs, community involvement, and individual experiences when allowing clients space to explore their experiences. Furthermore, the impact of acculturation may contribute to barriers within the therapeutic process, as many individuals who identify with this population may not find Western practices beneficial. Overall, this study hopes to provide a broader and more detailed understanding of culturally bound factors of resiliency and challenges South Asian women may encounter, following unwanted sexual experiences.

Summary

In addition to the data gathered, this study will utilize the previous research and literature to increase cultural humility and understanding regarding the impact culture has on South Asian women survivors of sexual assault. The next several chapters will expand upon literature, explain the process of data collection and results, and discuss clinical implications and future research. Chapter 2 will present literature related to women in India, occurrences of assault in India, mental health within South Asian communities, resilience and protective factors, and previous research. Chapter 3 will present a more detailed look at methodology of this study, ethical considerations, and limitations. Chapter 4 will present the results of the study, including demographics, participation responses, and charts with additional information. Lastly, Chapter 5 will discuss clinical implications for professionals working with this community and recommendations for future research.

Chapter 2: Literature Review

Women in India

The historical perception of women in India is quite paradoxical, as mythology often depicts women in a strong and powerful manner, while society practices discrimination and violence against them. For instance, there are stories within several religious texts, such as the Goddesses in Hinduism and women in the Bible that exemplify these contradictory messages.

In the Hindu religion, there are several Devis (goddesses), including: Shakti-Goddess of strength, Parvati- Goddess of love and fertility, Lakshmi- Goddess of wealth, Saraswati-Goddess of wisdom, Sita- Goddess of beauty and earth, and others (Kinsley, 1988). These females were revered, feared, and adored amongst believers, so long as they remained pure and protected their virtue. For example, the Goddess Sita, was married to Ram, but was admired by Ravan. Ravan became obsessed with her beauty and kidnaped her, taking her to his kingdom for over a year. He often expressed his sexual desires, but she remained faithful to Ram. Ram waged a war against Ravan's kingdom to rescue Sita, and they returned back to their kingdom (Ayodhya), where they were crowned King and Queen. However, the people of Ayodhya did not believe she remained pure after her capture, and Ram, despite knowing of her faithfulness, did not want rumors to undermine his authority in the kingdom. Therefore, he exiled Sita from his kingdom and she returned to 'Earth' (her mother).

These stories are also found in other religious texts such as the Bible. Christianity is the third largest religion in India (Census of India, 2011) and the Bible tells similar stories, such as Jezebel (a presumed sexually immoral and promiscuous woman), and the woman who was a sinner that washed Jesus Christ's feet, despite the protests from Pharisees and the disciples (NIV Bible, n.d.). Additionally, there are several Biblical versus that stress the importance of purity,

such as 1 Corinthians 6:18 (NIV): “Flee from sexual immorality. All other sins a person commits are outside the body, but whoever sins sexually, sins against their own body” or 1 Thessalonians 4:3-5, 7 (NIV): “**3** It is God’s will that you should be sanctified: that you should avoid sexual immorality; **4** that each of you should learn to control your own body in a way that is holy and honorable, **5** not in passionate lust like the pagans, who do not know God; **7** For God did not call us to be impure, but to live a holy life.”

It is important to note that religious texts are not a casual factor to the prevalence of sexual assault within South Asian communities. However, it may contribute to internalized messages passed down from generation to generation. According to Elster (2003), many communities interpret and give meaning to religious texts based on cultural and historical values that are unique to that community. The examples written above have similar themes regarding purity, and they exemplify the importance of remaining pure to avoid the potential consequences that follow if one is presumed to have not protected their virtue (e.g. rejection, ostracization, etc.). These are some of the messages that contribute to the overall perception of women in India. Women are to remain virtuous to preserve the respect, acceptance, and reputation of not only themselves, but their families as well. Those who do not do so may be ridiculed, rejected, devalued, or ostracized from the community (Niaz & Hassan, 2006).

A woman’s sexuality is viewed as her “source of power,” which is often contradictory to her role of submission in the community (Hunjan & Towson, 2007, p 59). Despite this, sexuality is often controlled by strict messages regarding her responsibility to protect her family’s honor by remaining a virgin until marriage. It also ensures her value with potential suitors and family alliances and future legitimacy of heirs. This limited sexual experience and type of controlled sexuality may increase a woman’s vulnerability in relationships. For instance, it may contribute

to the perception of what a romantic relationship entails (e.g. her duty to perform sexual acts for her husband after marriage), difficulty with exercising her sexual rights (e.g. consent), and tendency to remain silent to abuse. It may also contribute to the fear and insecurity about engaging in a sexual relationship, especially on her wedding night. One woman described this experience stating, "…what am I supposed to say? Can I say no, that's what I was really scared of, because I had never had a relationship, and…you're expected to share yourself physically with someone you don't even know" (p 61).

Regarding sexual practices, India tends to favor conservatism, despite creating the sexual literature Kama Sutra. Therefore, the topic of sex is considered taboo. In fact, as previously stated, sexually active women are stigmatized within most Indian communities. For example, Indian films often illustrate negative social and personal consequences for women who are sexually active, including ostracization and validation of sexual assault (Hunjan & Towson, 2007). Despite this stigma, there is an increase in access to violent and sexualized images (i.e. pornography and criminal principles), due to advances in technology and research indicates that prolonged and increased exposure to violent images may increase the likelihood of violent behavior (Sharma, Pardasani, & Nandram, 2014).

In additional to sexual stigma and the perception of women, India is primarily a patriarchal society (or "masculine society" as discussed later), in which women are often seen as property, and exploited by the community (Sharma, et. al, 2014). There is also a transfer of property that occurs between a woman's biological family and her marital family, as she is expected to move out of her home and live with her in-laws. This is impacted by the belief that a woman's primary duty is to her husband, contributing to the occurrences of marital violence, as women are expected to successfully complete their duties as a wife and can be "punished" if they

do not (Hunjan & Towson, 2007). This transfer of property also contributes to the definition of the transition from childhood to adulthood and the cultural belief that a woman's destiny is to be married, which is how she obtains value within the family and community (Hunjan & Towson, 2007). It "formalizes her status as property and entitles the groom and his family to every right over her" (p 61). Once married, it is a woman's duty to satisfy her husband's sexual needs, without any consideration for her own comfort. In fact, any reluctance is assumed to be indicative of her shyness, which translates to her virtue and chastity.

However, there have also been important and significant changes made to gender roles, specifically regarding women's movement towards empowerment and equality (Kabeer, 2015). For example, there has been an increase in women's literacy rates, employment opportunities, and even seats on local and national government. For instance, approximately 33% of seats in local and national government are reserved for women. This encourages female participation and motivation in political and local movements (Kabeer, 2015). Additionally, Indira Gandhi was India's first female Prime Minister, serving from 1966-1977, and again from 1980 until she was assassinated in 1984 for political reasons. Despite this, many Indian communities (especially low-income communities) tend to consider women as burdens, as they are viewed as another mouth to feed, in comparison to men who are thought to be the breadwinners in the home. This mentality often contributes to the increased occurrences of sex selection (families may choose or encourage abortions if the fetus is female), dowry (a woman's worth is depended on many things, including her purity), discrimination (amongst work and responsibilities inside and outside the home), and violence against women (Niaz & Hassan, 2006).

Men are considered to have higher worth (both economically and within families) than women, and women are often subjected to "maltreatment, neglect, and abandonment" especially

as infants (Sharma, et. al, 2014, p 366). Women are also expected to provide "service, sacrifice, and devotion," (Hunjan & Towson, 2007, p 53). Sharma et. al, (2014) defines power distance as the "degree of tolerance of social inequality by members in a social system" and India values a hierarchy society, in which gender inequality is considered a source of power (p 66). Therefore, women have considerably less power than men, contributing to higher levels of discrimination and dissonance within communities. As previously stated, India is also a "masculine society" as it endorses a patriarchal belief system. This often contributes to the endorsement of stereotypical gender roles, specifically the belief that men are supposed to be dominant and in control, while women are submissive.

Messages of male superiority also translate to marriage dynamics, as women often look up to their husbands and are often taught to be dependent on them (Hunjan & Towson, 2007). One woman stated, "your husband is your God, without him you're nothing" (p 57). Many women are expected to portray a visible representation of their marital status (e.g. *bindi* [dot worn on forehead], or *sindoor* [traditional vermilion red colored powder, worn along the parting of their hair]). These beliefs regarding male superiority often contribute to a woman's tendency to return to an abusive environment, in addition to maintaining her family's honor and reputation in the community.

Male dominance is a common theme among many communities and contributes to abusive behaviors that are enacted to appropriate power and control (Hunjan & Towson, 2007). Many women reported that in addition to experiencing physical abuse (ranging between battery to attempted murder), they also experienced various forms of sexual abuse including "rape, attempts at reproductive control, and using the threat of another woman to demean and humiliate them" (e.g. marital affairs) (p 63). One woman described her experience with marital rape

stating, "…of course he want the sex with me, he want the sex only, then in the morning he is the strange person to me. I'm like a stranger in their house…like a servant, working in the home and then they beat me daily. Then when I was feeling hurt, I have a pain, and then he want with me sex, but I, I never say no. I never refused. He raped me always" (p 63). Another woman described her husband's tendency to control her reproductive rights, stating that he refused to utilize birth control and contraceptives, instead choosing to "…beat me every day in my stomach, he kicked me that he don't want me to become pregnant. Every day he, he did the sex with me, and every next day he'd kick me" (p 63). Other women discussed their experiences with husband's refusing to claim the legitimacy of their child (i.e. believing the baby was not his) and forcing them to have abortions.

Gender roles also set the precedent for the expectation of a woman's responsibility within her marriage. According to Hunjan & Towson (2007), there is a theme of "self-sacrifice" or putting the needs of one's husband above her own (p 58). This contributes to the tolerance of abusive behavior including, verbal, emotional, physical, and sexual abuse. This is often perpetuated by a belief that sacrifice and struggles are rewarded later. Additionally, elders within the community may also perpetuate this message, passing down these beliefs to their own daughters or daughter-in-laws. For example, a woman recalled an experience of confiding in her mother regarding her husband's "temper tantrums" and her mother responded, "Oh Indian men they're like that. You have to, you have to give them, their way, so that their ego is satisfied, this is just the way it is…just don't talk back to him, because they're not used to that, so try to, try to please him…" (Hunjan & Towson, 2007, p 58). This illustrates the teachings of many families regarding a woman's duty to be submissive and self-sacrificing to her husband, in addition to the underlying messages regarding her responsibility to endure abusive environments.

Assault in India

Women in India endure physical, sexual, and psychological violence at many different levels, including at the hands of family members, spouses, strangers, lawmen, and people within the community. They experience "wife-beating, murder of wives, kidnapping, rape, physical assault, and acid throwing" in addition to being sold into prostitution and human trafficking (Niaz & Hassan, 2006, p 118). There are also cases involving honor killings and ritualized suicide (or murder) known as *sati*, in more traditional communities. Honor killings, also known as *Karo Kari* in some areas (which refers to women who have 'blackened themselves,' or disgraced themselves in some way, dishonoring the family), are typically executed by men who perceive their wives, daughters, or sisters have committed an act that dishonors the man. This occurs in villages and communities across India. *Sati* is the ritual where a widow will either voluntary or involuntarily (by use of force or coercion) throw herself on to her husband's funeral pyre, as a representation of her devotion and sacrifice. Furthermore if the ritual does not occur, women are expected to live a simple life- wearing only white, refraining from wearing jewelry or makeup, living in a separate quarters of the house, eating separate meals from the family, and are unable to participate in family functions, especially weddings as she is considered to be unlucky (Niaz & Hassan, 2006).

Additionally, there are cases that involve women who are murdered as a result of familial disputes, or commit suicide as a means of escaping from the pressures and brutality of their environment, occurrence of dowry violence (violence executed by husbands as a result of insufficient dowry payments), and violence by lawmen (specifically rape) while detained (Niaz, 2003).

India has several laws to protect against rape, such as section 375 and 376 of the Indian Penal Code (IPC). Section 375 provides the legal definition of rape, while Section 376 provides the punishment. Section 375 of the IPC states that, "a man is said to have committed rape who, except in the case hereinafter excepted, has sexual intercourse with a woman under circumstances falling under any of the five following descriptions: (1) Against her will, (2) Without her consent, (3) With her consent, when her consent has been obtained by putting her in fear of death or hurt, (4) With her consent when the man knows that he is not her husband, and her consent is given because she believes that he is another man to whom she is or believes herself to be lawfully married, and (5) With or without her consent when she is under 16 years of age" (Jiloha, 2013, p 2). This definition clarifies that penetration is satisfactory to constitute the sexual intercourse as rape, and distinctively states the exceptions (i.e. intercourse by a man with his own wife without her consent and the legal age). This definition was amended following the Delhi rape case in 2012, to include "both penile and nonpenile insertion into bodily orifices of a woman by a man," in addition to increasing the legal age to 18 years old (p 4). Section 376 states that the punishment for rape is life in prison, or 10 years plus a fine. However, it exempts a woman who was raped by her husband or is over the legal age, in which case the punishment may be 2 years with or without a fine. Additionally, as previously stated, marital rape is not illegal in the country of India. Therefore, victims are forced to attempt to utilize Section 498-A of the IPC ("perverse sexual conduct by the husband"), or the Protection of Women from Domestic Violence Act of 2005 (PWDVA) (p. 4). Although these laws can provide some protection against marital rape or other practices of sexual and domestic abuse, it can only provide civil remedies for the offences, such as 2-10 years in jail and/or a fine (Jiloha, 2013).

Despite the presence of these laws, there are several loopholes that contribute to the propensity of violence. For example, Section 375 of the IPC criminalizes "sexual intercourse with a woman" without the presence of consent, while Section 354 states that any "criminal assault on a woman with intent or outrage to her modesty" (such as sodomy, oral sex, or penetration of a foreign object) are also illegal (Sharma et. al, 2014, p. 366). These laws specifically relate to a woman's virtue rather than deter the act of rape, as it explicitly states that the intent of the crime must be to dishonor her modesty. For example, marital rape is not considered illegal, as once a woman is married it is considered part of her duty to engage in sexual intercourse, which is also impacted by the belief that a woman is considered to be property (Jiloha, 2013; Sharma et. al 2014). Furthermore, according to the National Crime Bureau (2014), there were 36,735 reported occurrences of rape in 2014. Of the approximate 37,000 cases, roughly 16,575 individuals were acquitted, 487 were discharged, 6,637 were convicted and the remaining 13,036 are awaiting trial. The low conviction rate and difficulty enforcing laws, contributes to high number of cases that go unreported daily (Jiloha, 2013; Sharma, et. al, 2014).

In addition to lack of protection in laws, the level of corruption within the legal system also contributes to the decrease in disclosure of violence. Many times, lawmen are aware of the occurrence of violence against women and either does nothing to stop it or is the cause of it. According to Niaz (2003), approximately 41 women experienced violence from lawmen between January and November 1999, which included 21 cases of gang rape and 14 cases of physical abuse. Furthermore, in 2000, approximately three incidents of death by "maltreatment or grave abuse at the hands of law enforcers" occurred (p 180). Additionally, according to Sharma et. al, (2014), there has been an increased shift in rural population to urban migration, due to a decrease

in access to resources and opportunities. This contributes to the widening gap between the privileged and underprivileged communities and lack of police protection in low-income areas, as security is not a primary concern for urban and government management. The lack of authority in these areas contributes to the increase occurrences of crime, especially violence against women, as crimes are underreported and unacknowledged by officials.

Sexual violence

Several factors contribute to the propensity of sexual violence, including: societal responses, difficulty with disclosing sexual violence, secondary victimization, and rape myth acceptance.

In Western culture disclosure of sexual violence may contribute to the recovery process of survivors on many different levels (Ullman, 2010). For example, on a societal level it can contribute to the resistance of rape, because of increased awareness through labeling the experience. On an individual level, it may assist survivors in understanding their experience of victimization and recovery, in addition to providing them a sense of control and empowerment that may have been taken away because of the rape. Furthermore, it provides them the opportunity to access resources including medical, legal, and mental health services.

There are several factors related to the disclosure of rape, including age, ethnicity, culture, acculturation, gender, and social and familial expectations. Data collected from the National Violence Against Women Survey (NVAWS), indicated that older survivors are more likely to report their rapes to the police, immediately following the incident, than younger survivors (as cited in, Ullman, 2010). Asian Americans are less likely to disclose rape, due to cultural stigma around seeking mental health services, potential negative responses from others, and perceptions regarding sexuality and virtue (Ullman, 2010). Furthermore, there are higher

negative judgments towards survivors of assault within these communities. Acculturation is also an important factor, as those who are more acculturated into Western culture are more likely to disclose (Ullman, 2010). The current study hopes to understand the impact of disclosure in the Indian culture, as there is limited research on this topic.

In addition to difficulty with disclosure, the anticipated negative reactions from formal (e.g. clinicians, police, medical professionals, etc.) and informal support systems (e.g. family, friends, partners, etc.) may also contribute to the impact on healing (Ahrens, 2006; Chaudhuri, et. al, 2014; Ullman, 2010). These reactions include covert and overt statements of victim blaming and overall lack of support. Examples of this include statements such as, "What were you wearing?" or "You were asking for it." Additionally, it includes questions regarding their behaviors at the time of the incident, such as possible substance use. These experiences are often referred to as secondary victimization, as it adds to the powerlessness of the act and "minimizes the seriousness of the crime" (Ahrens, 2006, p 264). Feminist sociologist Shulamit Reinharz characterizes the use of one's voice as the "ability, the means, and the right to express oneself, one's mind, and one's will" (as cited in Ahrens 2006, p 263). Reinharz goes on to state that the lack of expression is a representation of silence. This philosophy is a metaphor that underlines the power/privilege and oppressive dynamic within various communities. To speak represents power, while silence is a representation of defenselessness and disempowerment, which is consistent with the experience of rape.

As previously stated, there is also a fear that disclosing one's sexual assault will result in losing family and community support within South Asian communities (Hunjan & Towson, 2007). For example, one woman stated that following the separation of her physically, emotionally, and sexually abusive husband, her parents refused to allow her back into the home

and she was forced to find refuge in a woman's shelter, which contributed to the perpetuation of her abuse and her difficulty with healing. The fear to lose family support may often be intensified for women who immigrate to other countries, as they are isolated from their families and communities and face acculturation difficulties.

The occurrences of victim blaming and negative responses from others are often impacted by the rate of acceptance of rape myths within the community. According to Ullman (2010) there is a "Real Rape" Stereotype, which is the stereotypical rape illustration or mental images that are perpetuated by society and media (p 15). This assumption leads to the conclusion that "real victims" are those who are without blame and had a "legitimate" experience of rape (i.e. perpetrator is a non-white male, victim is a White female, the man is a stranger, the woman physically fights him off after verbally telling him 'no,' dressed modestly, and acting within acceptable behavior for a female). Therefore, victims of a lower SES, or victims who belong to an ethnic minority, are not considered to be "real victims." Additionally, stranger rape is also considered to impact the legitimacy of the assault, despite the research that indicates perpetrators of rape are more likely to be partners, friends, or acquaintances. For example, the Rape, Abuse, & Incest National Network (2015) reports that three out of four perpetrators are known by the victims.

Despite the statistics on the sexual assault, there is a high rate of rape myth acceptance within all communities and cultures. Burt (1980) defined rape myths as the "prejudicial, stereotyped beliefs about rape, rape victims, and rapists" (p 217). In the study, Burt found that not only do many people in America believe these myths, but also their attitudes are dependent upon their acceptance in rape myths and interpersonal violence, sex role stereotypes, and wariness of the opposite sex. The results of the study also indicated that a shift in adherence to

these beliefs would be difficult, if not impossible, due to the pervasiveness of these attitudes amongst race, gender, and nationality. Burt & Albin (1981) categorized these rape myths into four groups: (1) “Nothing happened”- Victims make false allegations; (2) “No harm was done”- sexual assault is “just sex;” (3) “She wanted it”- females say ‘no’ when they actually mean ‘yes;’ (4) “She deserved it”- women ask for rape (as cited in, Ullman 2010 p 16).

Devdas and Rubin (2007) conducted a study in which they explored the differences of rape myth acceptance between first and second generation born South Asian American women. They utilized Burt’s definition of rape, in addition to several scales (i.e. The Rape Myth Acceptance Scale and the Suinn-Lew Asian Self-Identity Acculturation Scale) and a demographic questionnaire to determine the level of adherence to South Asian culture and rape myths. They found that “first-generation South Asian American women had higher rape myth acceptance than second-generation South Asian American women” (p 703-704). Additionally, they found a direct connection between the beliefs regarding how a woman should behave and their views on sexual assault. For example, they theorized that first-generation South Asian American women were likely to have been raised under the assumption that a woman is responsible to maintain her virtue and prevent pre-marital sexual relations, which may have contributed to their adherence to rape myths. Interestingly first-generation women were able to demonstrate sympathy for the victims and believed a crime was committed; however, they did not accept that the victims were blameless, assuming that the victims should have been able to prevent the assault or were behaving in a manner that indicated willingness to have sexual intercourse. On the other hand, second-generation participants were more likely to have Westernized values and beliefs, such as an understanding of gender roles, which may have

contributed to the lower rates of rape myth acceptance. The authors believed that these results were indicative of the relational ties between acculturation and rape myth acceptance.

As previously stated, there is research that suggests that those who are more acculturated to Westernized culture are more likely to reach out for support, disclose rape, in addition to a decreased likelihood of accepting rape myths (Devdas & Rubin, 2007; Ullman, 2010). Research indicates that the increased growth in economy, technology, and lifestyle, are parallel to the concepts found in more Westernized communities. These adopted ideologies often impact traditional values, such as the importance of family (e.g. increase in divorce and separation of family). Additionally, the increase in technology provides unlimited access to violent or pornographic content to individuals, including children and young adults. This impacts the development of beliefs and perceptions on the appropriate treatment of women, in addition to acceptable sexual practices (e.g. physical violence and rape) (Sharma et. al, 2014).

A study conducted by Koo, Stephens, Lindgren, & George (2012) incorporated misogynistic beliefs, acculturation factors, and ethnic identity in Asian American and White college aged men, to determine the culturally bound differences in rape-supportive beliefs. Approximately 48% of the Asian-American men identified as first generation, 27% identified as second-generation, and about 88% identified as third generation. They provided a case vignette of an occurrence of acquaintance rape and assessed it based on four areas: (1) level of blame placed on the perpetrator and (2) victim, (3) credibility of victim's refusal of sexual advances, and (4) to what degree they would classify it as rape. The study found, that Asian-American men tend to support more rape-affirmative judgments than White men, which was impacted by misogynistic attitudes (especially towards blaming the perpetrator, victim, and determining credibility). Acculturation was correlated with less rape-supportive judgments, and ethnic

identity was correlated with perpetrator and victim blame, regardless of level of acculturation. These findings indicate that culturally bound beliefs regarding rape have a significant impact on the degree to which rape-supportive judgments are made among this population (i.e. Asian-American college aged men), despite the level of acculturation.

According to Fong (1997), the degree of acculturation in Asian-American women has an impact on "self-concept, behavior, and status attainment" within in this population (p. 93). The intersection of Asian and American values may also impact development of personality, based on four types of ethnic identities: "(1) traditionalist, who are low on American values, high on Asian values (i.e. retain traditional values and negatively dispose American culture; self-worth is defined by obedience to parents and bringing honor to the family); (2) assimilationist, who are high on American values and low on Asian values (i.e. tend to defy parental authority and reject ethnic culture; defines self-worth in terms of acceptance by Americans and considers herself more American than Asian); (3) pluralist, who are high on both American and Asian values (i.e. incorporates useful aspects of both minority cultures and attempts to balance responsibilities at home, work, and in the community; self-worth is defined by ethnic pride- frequent association with her own people and ability to retain many aspects of traditional culture while fully participating in mainstream American society); and (4) ambivalent, who are low on both American and Asian values (i.e. reject both traditional and American cultures and exhibits a great degree of social and cultural alienation; self-worth is defined individualistically, as it fits each situation)" (as cited in Fong, 1997, p. 93-94). This process is fluid and complex, contributing to identity development and understand of oneself within their own ethnic culture and the Westernized culture. This may also contribute to acceptance of rape myths and comfortability with disclosing rape. For example, a traditionalist may be less inclined to disclose

rape, as they may believe it brings dishonor to themselves and their family's reputation (Fong, 1997).

Mental Health Within South Asian Communities

The impact of sexual assault on women's mental health is positively correlated with symptoms of posttraumatic stress (occurring 17-65% of cases), including flashbacks, nightmares, interpersonal distress, depression, and anxiety (Campbell, Dworkin, & Cabral, 2009). Approximately 12-40% of survivors experience generalized anxiety, 13-49% experience dependency on alcohol, and 28-61% utilize other illicit substances. Additionally, approximately 23-44% of survivors acknowledge suicidal ideations, and 2-19% report suicidal attempts. Many factors contribute to the negative impact on mental health including, "the assault itself, post-assault disclosures and help-seeking, and sociocultural norms" (p 226). Additionally, there are neurological and biological factors as well. For example, the hypothalamic-pituitary-adrenal (HPA) axis may "contribute to structural and functional abnormalities" contributing to posttraumatic symptoms (Chivers-Wilson, 2006, p 111). These factors are important areas of consideration when working with survivors of trauma. Several recovery procedures have been reported as successful, such as perceived positive regard and early social support, in addition to a supportive environment and education on providing trauma sensitive care (Chivers-Wilson, 2006). There is limited research on culturally-specific norms and the provision of care for the South Asian population.

According to a report by Riecher-Rössler (2016), differences in gender also contribute to the overall experience, onset, risk factors, and clinical features of many disorders including depression, schizophrenia, trauma, and anxiety. There are also gender specific differences that impact the "onset, clinical features, frequency of psychotic symptoms, course, social

adjustments, and long-term outcome of severe mental disorders" (Malhotra & Shah, 2015, p 205). For example, women in India are two to three times more likely to experience a common mental disorder (e.g. depression and anxiety) than men. There are several factors that contribute to this, including hormonal changes (related to the reproductive cycle, such as experience of menopause) and gender disadvantages (e.g. sexual/physical violence by husbands, low autonomy in decision making, decrease support from family members) (Malhotra & Shah, 2015). There are also life stressors to consider, such as the expectation of bearing children, nurturing the elders in the family, and decrease in opportunities for education or employment. Obtaining mental health assistance is difficult for women, as there is an overall lack of availability in resources for them. Furthermore, one must consider the social consequences as well, such as abandonment by families, homelessness, and increased vulnerabilities to abuse.

The perception of mental health in South Asian communities impacts the comfortability and availability of accessing resources for an individual's suffering. Historically, mental illness was viewed as a curse placed on a family, or a "lifelong affliction with near-supernatural origins" (Kumar, 2002, p 257). This contributed to the difficulties in developing and treating mental health, as one cannot treat a curse using science or research. This also impacted the development of the definition of mental health disorders (beginning with the term mental *illness*) and its facilities. Individuals suffering from disorders were first placed in "mad houses" to lock them away from the community. Later, "mental asylums" were created to prevent harassment from others, and finally "mental health institutes" were developed, which is used today (p 257). Currently, mental health is viewed from a biomedical model versus a bio-psychosocial model. This means that knowledge regarding mental health is based on biomedical research, to explain the causality of mental disorders (chemical, electrical, and physical), which contributes to the use

of medicine as treatment. Although the biomedical model can be useful in determining the development and maintenance of symptomology, research indicates that a holistic perspective offers a more comprehensive and balanced explanation (Kumar, 2002). The biomedical model also limits availability to obtaining resources, as an individual must meet all criteria for that *illness* to receive appropriate support. Seeking out more traditional therapeutic services (e.g. individual or group therapy, support groups, etc.) is considered taboo in India and has an associated stigma of being "crazy." Therefore, many individuals do not receive proper and beneficial mental health care, in fear of public judgment or discrimination. Additionally, there is an added fear of damaging personal and familial reputations. Despite this, there has been an increase in advocacy for mental health awareness in India (World Health Organization, 2015). According to WHO (2015), organizations in India such as the Quality Rights Project (established in 2014) encourages mental health staff to view the individual as a whole person, with different life experiences, family history, socio-cultural factors, and medical factors that contribute to their disorder. The Quality Rights Project also advocates for improvement in access and conditions of mental health institutions. Currently, there are approximately 43 government-funded mental health institutions, providing services for about 70 million individuals (for every 1 million people, there are about 3 professionals) (World Health Organization, 2015).

Tavkar, Iyer, & Hansen (2008), proposed several cultural values and presentation of mental health concerns, that reportedly impact the barriers to accessing mental health services within Indian communities. Primary cultural values include: a group-oriented community, an Eastern medicine perspective (i.e. holistic approaches), religion, importance of family, gender roles, parenting practices (i.e. high standards that emphasize morality and familial obligations), preference to keep concerns within the home, and disregard for romantic relationships before

marriage. Regarding the presentation of mental health concerns, many disorders manifest in psychosomatic symptoms, such as body pains and weakness (as cited in, Tavkar et. al, 2008). Additionally, most members within Indian communities attribute psychological distress to increased stress or deny the presence of such distress. This denial and detachment contributes to an increased vulnerability to suicidal behaviors within the population and increase levels of alcoholism and violence (Das & Kemp 1997; Karasz, et al., 2016; Roberts, Mann, & Montgomery, 2016).

Barriers to accessing mental health services include: (1) cultural, (2) socioeconomic, and (3) psychotherapeutic factors. Regarding cultural variables, there is a strong belief that seeking help from mental health professionals is disgraceful and brings shame to the individual and family (as cited in, Tavkar et. al, 2008). Additionally, many individuals consider family members and religious institutions as the primary sources of support, which decreases the likelihood of obtaining help from mental health professionals (Tavkar, et. al, 2008). The emphasis on religion also contributes to a belief that suffering was placed upon the individual as a curse for a moral indiscretion or as a test of strength; and the suffering should be endured in order to obtain future rewards or atonement for sins (for both the individual and family). The tendency for individuals to experience psychological distress as physical symptoms, contributes to an increase in seeking health care professionals instead of mental health services, which can lead to misdiagnoses and difficulty with effective symptom management (as cited in, Tavkar, et. al, 2008).

Despite an increase in education and employment opportunities, many individuals still live in lower socioeconomic conditions and consequently have difficulty accessing affordable care (Tavkar, et. al, 2008). This contributes to a tendency to prioritize other needs before mental health concerns, and continued endurance of psychological distress and traumatic experiences.

Regarding Indian immigrants in the United States, the "unemployment rate…is more than double that of immigrants who entered the U.S. before 1980" and many of these individuals are unaware of organizations that provide emergency assistance and supportive services for low-income communities (p 5).

Some psychotherapeutic barriers to Indians accessing mental health care services include therapy practices, therapist-client relationship, and boundaries in the therapeutic relationship (Tavkar, et. al, 2008). Most Western therapy practices place an emphasis on facilitating client growth and understanding of their role in their presenting concerns. However, many South Asian individuals view clinicians as a "guru" or doctor who will provide them with a more direct approach to solving their problems, similar to most health care practices. Regarding boundaries, it is not unusual for Indians to invite their clinicians to social gatherings or dinners at their homes, as this is a cultural norm and considered to be a form of respect. Therefore, the professional and ethical boundaries within the therapeutic relationship can often feel like a rejection and contribute to client's perceiving their therapist to be cold or detached (as cited in, Tavkar 2008).

According to Kallivayalil (2007), South Asian women are more likely to intellectualize their traumatic experiences than discuss their mental and emotional responses. This reportedly increases the likelihood of "acceptability" around interpersonal violence and mental health (p 81). The study conducted by Kallivayalil (2007) explored the various components that contribute to the negative responses to mental illness and accessing mental health services. According to the results, the primary component of negative response is silence and stigmatization around discussing mental health. Das and Kemp (1997) identify three possible explanations for this phenomenon (as cited in Kallivayalil, 2007). The first explanation provided is the idea of "model

minority myth," which describes the belief that financial and social success is directly related to one's ability to successfully maintain cultural integrity and cohesion (p 82). This essentially means that disrupting the cultural norm (e.g. disclosing interpersonal violence and acknowledging mental health concerns) will decrease one's ability to find success in areas of work, education, family, etc. The second explanation provided is the belief that one's family is the only appropriate support system for potential mental health concerns, which highlights the belief that discussing personal matters with outside resources is traditionally unacceptable and does not consider the complexities of mental health concerns. Instead there is a belief that an individual who accesses mental health services is "insane," which has a negative impact, especially for women (p 82). For example, women who are deemed insane may lose their creditability within the community, undermining their ability to be a caretaker, which may impact custody of children. Finally, the research indicates that Westernized therapy practices typically place an emphasis on the individual experience and encouraging autonomy, which is incongruent with the traditional South Asian collectivist culture (i.e. individualized experiences are not as important as the family or community experiences). Additionally, the literature indicates that although acculturation decreases stigmatization of utilizing outside resources, it still does not include mental health services. Rather, non-psychological resources such as primary care physicians and religious leaders are considered more acceptable (as cited in Kallivayalil, 2007). These components of the perception of mental health within the South Asian community are important to consider when providing services to members who identify as South Asian.

Tavkar et. al (2008), offered several recommendations when working with South Asians. Most Western practices and expectations for behaviors will not be conducive in providing

effective care, such as family or group therapy, due to the cultural values and traditions. Due to high regard for family reputation, it may not be helpful to discuss the familial stressors as contributors to mental health concerns, especially in the early stages of the therapeutic relationship (as cited in Tavkar, et. al, 2008). Additionally, the authors recommended clinicians take more of an active role in the therapeutic dynamic, exhibiting therapeutic control and engagement, as this can help reduce client's anxiety. Furthermore, clients may demonstrate limited initiative for independent growth. Most South Asians view clinicians as authority figures, therefore they may not convey disagreement with a clinician as overtly as most Western communities. For example, clients often demonstrate disagreement by terminating services prematurely, noncompliance, and passive aggressive behaviors (as cited in, Tavkar, et. al, 2008). Furthermore, clients may not demonstrate obvious emotional expression, as this is not typically a cultural norm. Instead, they may make inconsistent eye contact, demonstrate inappropriate affect (e.g. smiling or laughing when discussing uncomfortable topics), and appear guarded or distant in the therapeutic relationship. Due to tendency to terminate services prematurely, it may be most beneficial to work from a short-term therapy model, with a focus on crisis management and skill building (Tavkar et. al, 2008). Regarding maintaining cultural competence, clinicians should utilize caution with DSM diagnoses, as it often fails to capture non-Westernized cultural norms. Furthermore, it is important for clinicians to be culturally aware without this knowledge interfering or limiting space for individuality. Clinicians should also explore a client's acculturation status, perspectives on traditional and cultural norms, and individual experiences (as cited in, Tavkar, et. al, 2008). Lastly, the authors recommended that professionals pay attention to how sociopolitical climates can impact members of this community (e.g. the events of September 11th, changes in government, etc.).

Kallivayalil (2007) found that women who experienced interpersonal violence were more likely to discuss their experiences when interview questions were generalized, open-ended, and naturally progressed to the topic. For instance, allowing survivors to first discuss their background, cultural identity, marital status, and family dynamics, increased comfortability, and rapport, which contributed to an ability to discuss their traumatic experiences. The study also recommended that mental health providers utilize empathy, genuine concern, and psychoeducation regarding the benefits of therapeutic assistance without pressuring survivors to access outside resources, which will reportedly decrease the likelihood of secondary victimization.

There was limited research on other culturally-specific treatment recommendations and barriers to treatment.

Resilience and protective factors

According to Sabina & Banyard (2015), resiliency has been defined in various ways across different research. Some describe it as a form of "thriving" and others as a process "in which psychological, social environmental, and biological factors interact to enable an individual at any stage of life to develop, maintain, or regain their mental health despite exposure to adversity" (as cited in, Sabina & Banyard, 2015, p. 337). Another definition of resiliency is "broadly defined as the capacity of a dynamic system to adapt successfully to disturbances that threaten system function, viability, or development" (as cited in, Sabina & Banyard, 2015, p. 337). There are also protective factors, such as individual factors (e.g. optimism, education, emotional intelligence, affect regulation, social attachment, self-esteem, etc.), family factors (e.g. family support, stability in family structures, and satisfaction), and distal factors (e.g. community support, social and/or political involvement, etc.). The authors argue that these factors contribute

to one's resiliency in face of an adversity, traumatic experience, and violence. This may also increase the likelihood of an individual's ability to process, manage, and heal from their trauma. Clinicians are better able to use inherent resiliency and protective factors to implement more effective interventions to promote awareness and skill building and decrease relational aggression and long-lasting posttraumatic symptoms.

According to Hunjan & Towson (2007), one of the primary resiliency factors for Indian women who experience and endure various abusive environments and cultural factors described above is their motivation to change the oppression for future generations. Many women adamantly vocalized their desire to change the narrative of gender roles and norms by parenting their children differently. One woman acknowledged a desire to teach her future daughter values of "strength and independence…so that she understands that no one should be able to take advantage of her" (p 62). Other women discussed their desire to teach their future children about equality, providing their sons and daughters with the autonomy in decision-making they were prevented from having. The authors argued that this is significantly impactful on the attitudes, beliefs, and messages that perpetuate violence against women, which will hopefully contribute to positive changes.

There is limited research on culturally bound resiliency and protective factors, which may contribute to the recovery process of an individual who has experienced a trauma. Therefore, the current study will attempt to gather this information.

Previous Research

A study conducted in 2000-2001 by Hunjan & Towson (2007), provided valuable information regarding the definition and representation of sexuality and gender norms within intimate partner violence in South Asian communities. The study utilized a qualitative approach,

conducting semi-structured interviews among 13 participants with varying demographical information (e.g. age, education status, marital status, place of birth, and religion). The violence experienced also ranged from emotional, physical, and sexual abuse, and attempted murder (Hunjan & Towson, 2007). Regarding gender norms, the study found that participants described "pervasive gender-related messages that reinforced their dependence on men and their domestic, subservient, and passive role in the family" (p 56). Additionally, many participants acknowledged that there was an expected role for females in terms of family and cultural expectations in the home, which typically contribute to the perception of women as subordinate to their male counterparts. The authors argued that these factors contribute to the prevalence of abuse within South Asian communities.

Kallivayalil (2007) conducted a study interviewing, "battered South Asian women as part of an ongoing project on the mental health consequences of domestic violence among women of South Asian origin in the United States" (p. 84). This study found several components that may assist clinicians in providing culturally competent care, including validating and empowering survivors by providing them the freedom to share their narrative. Additionally, the author argued that it is significantly important to address the emotional needs of the individual to counteract the messages of disclosure and accessing mental health services (i.e. idea that attending therapy means one has "severe mental health problems") (p. 93).

According to Briere & Scott (2015), there are several practices that are effective for treatment complex trauma in children or adults. The authors outlined several interventions including, cognitive-behavioral (most commonly utilized, especially exposure therapy), affect regulation training (helping clients tolerate and regulate the emotional responses to trauma), psychodynamic (focusing on interpersonal difficulties, attachment concerns, and identity issues),

and multi-target therapies (integrating several modalities of treatment). Additionally, the authors discussed pharmacotherapetuic and pharmacoptherapy interventions to help regulate physical symptoms of PTSD, in addition to management of potential comorbid disorders, such as "…substance use, suicidal ideation, and dissociation" (p 519). There are other empirically based, interventions that are helpful for the treatment of symptoms of complex trauma, such as DBT (dialectical-behavior therapy) and STAIR (skill training in affect regulation) (Briere & Scott, 2015). The aforementioned interventions have different strengths and limitations that may need to be adapted in order to fit the client's needs. For example, CBT interventions are typically focused on objective problems and tend to be more structured and hands-on, whereas psychodynamic interventions are typically process-heavy, and can be useful when needing to process interpersonal difficulties. Due to this, it may be most beneficial for the client if clinicians utilize a multimodal approach, drawing interventions from different theories to customize a treatment plan that will best support the client's individual experience. Most combined interventions have common characteristics that are effective when working with clients with complex trauma including: (1) a strong therapeutic relationship, (2) use of affect regulation prior to processing emotions related to the traumatic event, (3) scaffolding exposure to traumatic memories or events, (4) "cognitive and relational processing of negative attachment and relational schema," (5) game plan for symptom management and coping (p. 519).

Prior to treatment, clinicians should be mindful of several assessment and treatment challenges when working with female survivors of violence (Briere & Jordan, 2004). Regarding assessment, there are two major areas of concern: (1) potential of previous traumatic experiences and (2) assessing symptoms of trauma. When assessing for trauma, it is important to ask clients about previous trauma, including experiences that may be overlooked, such as child neglect or

stalking. Additionally, clinicians should assess for the symptoms that may likely be associated with specific traumatic experiences. Briere & Jordan (2004) provided suggestions to assist clinicians with this, including utilizing "structured trauma-exposure questionnaires and assessing for general areas of dysfunction and distress" (p. 1262). As previously stated, it is recommended that clinicians use a multimodal treatment, as it will be the most effective with treating the various levels of distress (e.g. biopsychosocial, safety concerns, interpersonal skills, coping, etc.). It is also important to tailor treatment to the client's unique experience. For example, a woman who experienced abuse from a stranger may endorse different presenting concerns than a woman who was abused by a partner or caregiver; therefore, treatment will look different. Additionally, clinicians should be mindful about safety concerns and symptom severity when treatment planning, as most standardized therapy interventions may need to be adapted and lengthened to accommodate for this individual experience (e.g. CBT practices). The authors argue that one of the most important qualities that will be consistent regardless of the client's individual experience, is the clinician's need to assess all levels of trauma and associated symptoms to avoid making generalizations and assumptions.

There is limited research on culturally specific practices or treatments for women survivors of sexual violence in South Asian communities.

Summary

Utilizing the literature on perceptions of women and gender roles in India, factors that contribute to assault, sexual violence, and mental health in India, this study will develop a further understanding of culturally bound resiliency factors and barriers to healing for South Asian women who have experience sexual assault.

Chapter 3: Method

Chapter Overview

As previously stated, this study aims to increase overall understanding of the culturally bound traditions and perceptions of sexual assault within South Asian communities, which may increase the effectiveness of provision of care. This chapter will present information regarding methodology, data collection and ethical considerations.

Research Questions

The overall question guiding this study was: How does culture impact the overall experience of survivors of unwanted sexual experiences for women in South Asian communities. The study was further grounded by two subquestions:

1. How does culture contribute to potential barriers and resiliency factors in healing?
2. What are some potential recommendations for clinicians working with this population?

Research Design

This study utilized an online, anonymous, and confidential survey. The survey was created using Survey Monkey (see Appendix A) and consisted of 13 questions (including demographic information), lasting approximately 10-25 minutes. The researcher recruited participants via several open platforms and online groups (such as Facebook) that work with South Asian women who have experienced sexual assault (see Appendix B). The researcher also contacted several organizations via email, to offer the opportunity for individuals to participate. Participants were first asked to answer demographic questions to determine eligibility (see Appendix C), and those who met criteria were provided the consent form (see Appendix D). Individuals who did not meet criteria were directed to the end of the survey, which thanked them

for their participation and provided culturally competent agencies that provide mental health services to South Asian women who have experienced sexual assault (see Appendix E). The survey was open for about three weeks once posted to provide individuals adequate time to participate. Approximately 38 individuals participated in the survey, and about 16 individuals met the eligibility criteria and consented to participate it the study. Additionally, for the purposes of the study the term "unwanted sexual experience" was used throughout the survey, allowing participants to self-define their experience.

Results from the survey were analyzed using SurveyMonkey's Analyze Results program. The program separated the responses into different demographic and response categories, providing the data for percentages for each response (as indicated in the next chapter). The data remained anonymous through the analysis process. Through the program, the researcher was able to identify and analyze the result summaries, data trends, and individual responses to questions.

Population and Sample

A total of 38 individuals participated in the online, confidential survey, on SurveyMonkey and were screened for eligibility by completing the demographic questions. Of these participants, 19 women (50%) met the inclusion criteria and consented to participate in the study, and only 16 women of the 19 (42.1%) completed the remaining 10 questions (see Table 1 for demographic data). It is unknown why only 16 out of the 19 women completed the remaining questions.

Of the total 38 participants, approximately 25 participants (~66%) identified as a cisgender, South Asian, female (see Table 1 for demographic data). About 19 individuals were between the ages of 26 and 33 (50%); there were six individuals between the ages of 18 and 25 (15%) and six between the ages 42-50 (15%); three participants aged 34-41 (8%) and three aged

51-29 (8%), and one participant was aged 60 and above (3%). Additionally, 28 participants (74%) indicated the perpetrator of their unwanted sexual experience was someone outside the home (other than a spouse or partner). Six women (37.5%) reported that their unwanted sexual experience occurred in the United States of America and eight women (50%) reported it occurred in India. One participant indicated the experience occurred in Europe and one participant did not provide a response (see Table 2).

Ethical Considerations

Due to the trauma history, there is a strong possibility that many participants would have difficulty disclosing information and providing detailed responses. Additionally, many individuals may be guarded due to cultural expectations and roles (Roberts, Watlington, Nett, & Batten, 2010).

Barrett (n.d.) outlined several concerns when working with survivors of trauma. There is a possibility of re-traumatization for potential clients when discussing the assault. To account for that, SAMHSA (2014) suggests allowing as much time as possible between the traumatic event and the trauma narrative, which is recommended for professionals working with this population.

Due to the topic of sexual trauma and the rapport built with the clients, clinicians may be at risk for vicarious trauma or compassion fatigue. According to the American Counseling Association (2011), mental health professionals are at risk for compassion fatigue due to the emotional strain and exposure from working with individuals who have experienced trauma as a result of listening to their stories. Figley (2013) discusses risk of compassion fatigue and burnout in professionals as a result of their work with clients who have experienced trauma. The author describes burnout as a gradual progression towards emotional exhaustion that can result in: fatigue, sleep disturbances, irritability, depression, feelings of helplessness, aggressive, substance

use, poor work performance, withdrawal, dehumanizing, and discouragement as a professional (among other symptoms). While burnout is a gradual progression, compassion fatigue typically has a more rapid onset, with similar symptoms, however more emphasis on feelings of helplessness and confusion, isolation, and disconnection (Figley, 2013). The author also discusses potential tools to help combat compassion fatigue and burnout, including consultation with fellow colleagues, engagement in self-care practices, and preventative care (e.g. psychoeducation and training).

Chapter 4: Findings

Results

Regarding how strongly participants identify with the Indian culture and traditions, the average response was seven and the most frequent response was eight (on a scale from 0-10, where 0 is not at all and 10 is extremely). Furthermore, participants reported an average of six on a similar scale of how much the Indian culture was a factor in the recovery process from their unwanted experience. Approximately half of the responses suggested that family and religion were the primary components within the Indian culture that assisted with healing; while themes of victim blaming, fear of damaging reputation/images, stigma, and discomfort discussing intimate feelings and experiences were identified as the primary barriers to healing. Furthermore, participants reported an average number of four (on a scale from 0 to10), in regards to their comfort disclosing their unwanted sexual experience to members within the Indian community, with about 63% of the responses ranging from 0 to 5.

Results demonstrated that on average participants believed their experience was different from those who may have been raised outside the Indian community (average response was seven, on a scale from 0 to 10), and that this belief was mostly impacted by family and community dynamics, the existence of the cast system, and misogynistic beliefs. Additionally, beliefs that women "should be strong" and demonstrate "courage" to overcome any adversity was a reoccurring theme. Lastly, many participants reported wanted helping professionals to understand the importance of family, the resiliency of the individual, and the perceived risks of seeking support when working with Indian women survivors of sexual assault.

**For participant responses, see Table 3.1-3.6.*

Table 1

Demographics

Table 1.1- Age

Age	# of Responses	Percent of Total Responses
18-25	6	15.79 %
26-33	19	50.00 %
34-41	3	7.89 %
42-50	6	15.79 %
51-59	3	7.89 %
60+	1	2.63 %
Total	**38**	

Table 1.2- Identity

"Do you identify as a cisgender (gender matches sex assigned at birth), South Asian, female?"

Response	# of Responses	Percent of Total Responses
Yes	25	65.79 %
No	12	31.58%
Prefer not to answer	1	2.63 %
Total	**38**	

Table 1.3- Sexual assault perpetrator

"Was the perpetrator of this experience someone outside your home (i.e. other than a spouse/partner)?"

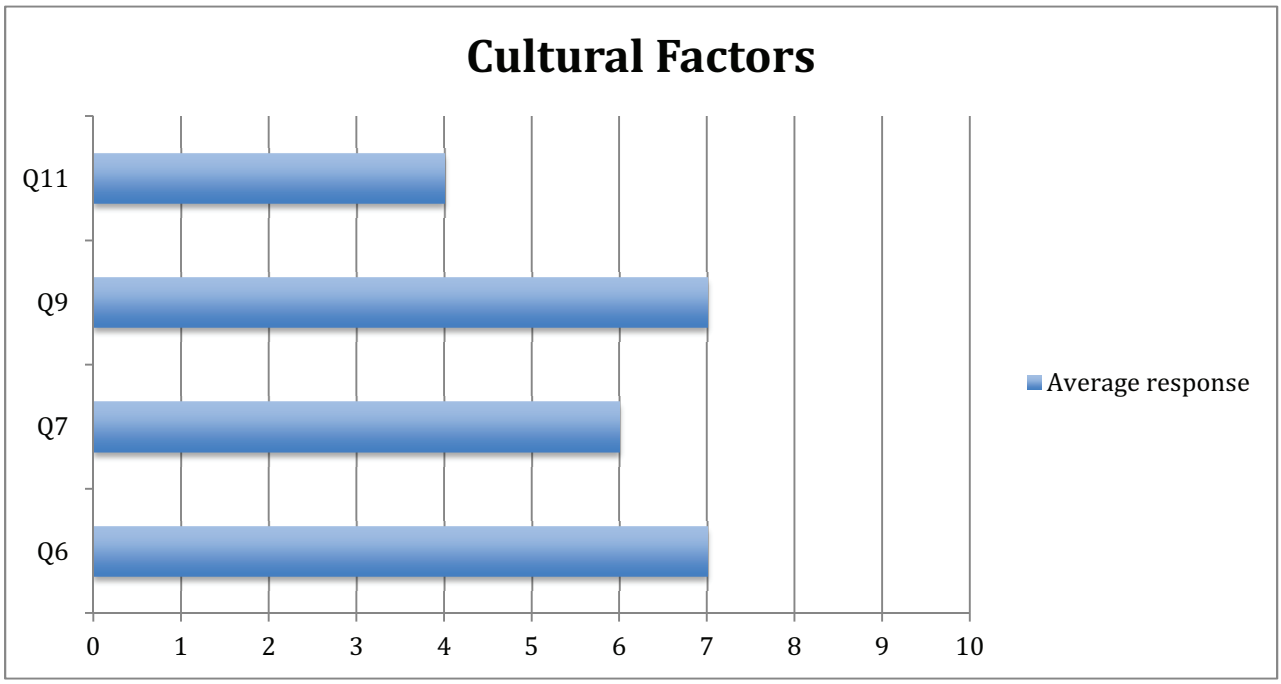
Response	# of Responses	Percent of Total Responses
Yes	28	73.68 %
No	9	23.68 %
Prefer not to answer	1	2.63 %
Total	**38**	

Table 2

Location of Sexual Assault

Location	# of Responses	Percent of Total Responses
United States	6	37.5 %
India	8	50 %
Europe	1	6.25 %
Other	1	6.25%

Figure 1. Cultural factors – average responses.



Q11: How comfortable did you feel disclosing your unwanted sexual experience to members of the Indian community?
Q9: How different do you believe your experience of healing was from women who may have been raised outside the Indian community?
Q7: How much was the Indian culture a factor in the recovery process for your unwanted sexual experience?
Q6: On a scale of 1-10, how strongly do you identify with the Indian culture and traditions?

Table 3

Survey Responses

Table 3.1: Likert scale responses (Questions: 6, 7, 9, 11)

Participant #	Q6	Q7	Q9	Q11
1	8	6	8	6
2	8	5	5	5
3	3	1	2	1
4	10	10	10	10
5	6	3	2	1
6	7	6	6	2
7	7	8	8	3
8	9	8	7	2
9	3	4	6	4
10	10	9	8	1
11	9	8	6	8
12	8	7	8	8
13	8	7	8	8
14	9	8	8	0
15	1	0	8	6
16	6	7	7	No response

Q6: On a scale of 1-10, how strongly do you identify with the Indian culture and traditions?
Q7: How much was the Indian culture a factor in the recovery process for your unwanted sexual experience?
Q9: How different do you believe your experience of healing was from women who may have been raised outside the Indian community?
Q11: How comfortable did you feel disclosing your unwanted sexual experience to members of the Indian community?

Table 3.2: What were the cultural beliefs or traditions that helped with healing process?

Participant #	Responses
1	I don't really remember
2	I was able to speak to my sister and ensure that I wouldn't have to be around the person who assaulted me in the future.
3	My family being around. We didn't really talk about it, but in our culture it's pretty common for families to be really close, and having their presence helped me not feel alone.
4	Rely on Buddha to get me through it
5	Being close to my family and having their support
6	Religion
7	Indian culture is give a respect to female
8	*No response*
9	*No response*
10	Knowing that our family were there in this life and beyond to guide me through heartache
11	Women should be the strength that overcome all the fats.
12	Siddha, Ayurveda
13	Women should be the strength
14	Siddha, Ayurveda
15	My personal beliefs
16	NO

Table 3.3: if possible, please describe [how different you believe your experience of healing was from women who may have been raised outside the Indian community].

Participant #	Responses
1	Its something that happened years ago and is still something that I'm not comfortable for me
2	I think there is a lot of "don't talk about private issues" stigma in my culture but not as much in American culture
3	I had the support of my family after I told them, or at least I did with my parents and one of my siblings that I'm closest to. They were very supportive and I think us being closeknit in our culture helps.
4	I cant really describe it
5	I'm a bit "white-washed," as they say. I think though because our families tend to be very close-knit, the amount of support is to be much more expected
6	No thank you
7	It's difficult
8	It's difficult for outside of Indian community
9	*No response*
10	We come from a place of knowing things happen that are out of our control and instead of getting justice with that person, we are concentrating on a life beyond that to heal
11	Not interested
12	*No response*
13	It is the worst feeling that I want to forget and not to describe
14	*No response*
15	I imagine another culture has different ways of thinking, perceiving and with a cast system and open misogyny, their process has got to be different.
16	DIFFERENT TO COMMUNITY OF WOMEN

Table 3.4: What were the potential barriers to your healing experience? Please describe, if possible.

Participant #	Response
1	There no way to really describe it
2	People get very uncomfortable with the subject of assault. They immediately want to know if you did anything to provoke it, how you were dressed, etc. there can be a lot of victim blaming.
3	We tend to not talk about deep, intimate things and care about appearance to others – at least in my experience. I think that made me even more uncomfortable to say anything at first.
4	None at all
5	Some of us care about appearance and not talking about deep, intimate things—at least in my experience. So I haven't really talked about it with my parents or family in general.
6	Stigma
7	NOT AT ALL
8	None
9	*No response*
10	It was hard to to because I did not know if I was going to be accepted or looked down on
11	Not interested to describe
12	*No response*
13	Sorry I can't
14	*No response*
15	Language
16	RELATED OTHER COUNTRY INDIA IS CULTURAL BEST.

Table 3.5: Anything else you would like to add about your experience?

Participant #	Response
1	No
2	Not any
3	No
4	N/A
5	Nothing
6	Nothing
7	*No response*
8	It was a hard time, but I do have big faith in my family who helped me
9	Yes women should be strong enough to overcome any situations in life
10	Good
11	Yes, Women should be very strong and build their strength very strongly to overcome whatever she come across in life and she should have the courage to take something lightly instead worrying a lot.
12	Good
13	No.
14	NO
15	*No response*
16	*No response*

Table 3.6: Lastly, what would you want a counselor/therapist to know when providing services?

Participant #	Responses
1	That its serious but it was something my family could help
2	That as an immigrant, I have taken a huge risk by seeking this kind of help in the first place.
3	That they're able to help me with the knowledge they have to heal in a healthy and proper way
4	That it is possible to overcome the odds in a situation like mine. Things of this nature don't mean the end.
5	Just everything that happened and that they're able to teach me how to deal with it properly
6	How I feel
7	Provide a good advice
8	Give a good advice
9	*No response*
10	My family is very important and I want there help in emotional support over all. So giving me and them tools to help in that service would be great
11	Should not made them to remember the worst experience
12	*No response*
13	They should understand the inner feelings and should not keep remembering things that we tend to forget.
14	Deciding that the issues you face are more than you can handle alone is a a very difficult decision to make, but it ultimately puts you on the path to better mental health in general. You're making a big step to a happier, healthier you.
15	It would not matter to me what they were
16	WORKING HARD

Chapter 5: Summary, Conclusions, and Recommendations

Discussion

Previous research examining sexual violence within South Asian communities is limited and primarily focuses on factors that contribute to prevalence of violence in India. There is limited research on clinical implications for professionals working with this population and factors that may contribute to the recovery process. Utilizing the online confidential survey, this study gathered some information on resiliency and cultural factors, in addition to barriers to healing, which will likely assist professionals in providing culturally competent care.

Regarding demographic data, the results evidenced a range of age (18-60+) and various locations of the traumatic experience, indicating a variety of individual experiences. Results also demonstrated that although majority (about 74%) of participants identified their perpetrator of sexual violence as someone outside the home (other than a spouse/partner), approximately 24% of participants reported the perpetrator as someone inside the home. This may impact women's comfort disclosing the experience, seeking support, and clinical implications (e.g. severity of clinical symptoms), which will likely affect the provision of treatment (Hunjun & Towson, 2007; Kallivayalil, 2007). For example, it could impact immediate risk and safety concerns, or limit a client's support system if they are unable to disclose the experience to their immediate social circles. Additionally, it is uncertain how many of the women who identified their perpetrator as someone outside the home experienced sexual violence from a spouse or partner. The literature often focuses on intimate partner violence and reports that survivors often know their assailants (3 out of 4 times); therefore, it may be highly likely that the participants experienced violence from an intimate partner (RAINN, 2015). As stated, this will be important information for

professionals to gather to provide effective care, in addition to demonstrating cultural awareness and competence.

Regarding cultural factors, participants identified several factors that contributed to the resiliency and healing from their unwanted sexual experience, including: connection to their culture, family, religion, and beliefs about women. Results suggested that participants typically described a strong connection to Indian culture and values, which reportedly contributes to resiliency. This is consistent with the literature, as community relationships, traditions, and values were often described as contributions to one's resiliency in the face of adversity, traumatic experiences, and violence (Sabina & Banyard, 2015). Many participants also reported the importance of having their family as a primary support system. One participant even stated that although her family did not discuss the traumatic experience "…their presence helped me not feel alone." Although previous research often describes family reputation, expectation, and gender roles to be a factor in the prevalence of sexual violence in South Asian communities, the results suggested that this is not always the case. Despite this, the research indicated that South Asians typically prefer utilizing family support instead of formal support systems outside the home (e.g. mental health services) (Kumar, 2002; Tavkar, et. al, 2008).

Another factor of resiliency, as evidenced from the results, was the importance of religion. A few participants described "Siddha and Ayurveda" as a cultural tradition that aided them with the healing process. *Siddha* is an Indian practice involving spiritual enlightenment or bliss (NIS, n.d.). According to the National Center for Complementary and Integrative Health (2015), *Ayurvedic* medicine is one of the most traditional forms of health care in India. Although there was limited research on the impact of religion and Eastern medicinal practices on the recovery process for survivors of sexual violence within South Asian communities, professionals

working with this community should inquire about client's religious backgrounds and importance of religion to their daily living.

Another common theme in participant responses was the idea that women "should be strong." Although it is unclear what participants meant by this, the responses suggest a belief regarding the inner strength and courage of Indian women to handle stressors, which is considered a positive cultural norm. Despite the literature indicating that women are often taught to make scarifies and place the needs of others before herself (Hunjun & Towson, 2007; Sharma et. al, 2014), the responses may also suggest that women are capable to handle adversity, highlighting their resiliency.

There were several barriers to healing described by participants, including: stigma, difficulty with disclosure, accessing formal support, victim blaming, and language barriers. Many participants reported fear of negative responses from others, especially fear of victim blaming and ostracization. Consistent with the literature, women are often shamed, blamed, or shunned from members of the community in response to disclosing sexual assault (Chadhuri et. al, 2014; Hunjun & Towson, 2007; Ullman, 2010;). Furthermore, participants reported a cultural tendency to refrain from discussing intimate experiences with members outside the home/community and reported feeling fearful of damaging their reputation and valuing appearances, which was also a barrier described in the literature.

In addition to culturally bound resiliency factors and barriers to healing, acculturation appeared to be an important factor in the results. For example, one participant described herself as "white-washed," which is a common colloquial phrase to indicate a stronger connection to Western traditions. However, she still identified family as a primary source of support, which was consistent with culturally bound resiliency factors. Several other participants reported a low

score on their connection to the Indian culture (less than 4 on a 10-point scale), as well. The literature suggests that the increased growth in economy, technology, and lifestyle often parallels Westernized communities, which impacts the role of family and perceptions of acceptable sexual practices (Sharma et. al, 2014). Furthermore, research suggests that acculturation has an impact on rape-supportive beliefs and rape-myth acceptance (Devdas & Rubin, 2007; Koo et. al, 2012).

Regarding acculturation, there appeared to be several common barriers to healing within both Western and South Asian communities, such as victim blaming, stigma, and difficulty with disclosure. However, there were also differences that may impact the course of treatment and provision of services. For example, one woman stated, "We come from a place of knowing things happen that are out of our control and instead of getting justice with that person, we are concentrating on a life beyond that to heal." This may be different from common Western beliefs, as demonstrated by several current sociopolitical movements such as Times Up and Me Too. Many women began speaking out and against their perpetrators of violence, demanding justice for the crimes. Whereas, this participant described an acceptance that she may never obtain justice (a belief that is common and supported by rape crime statistics in India), and instead, is focused on moving forward with her healing beyond the traumatic experience.

The literature described mental health stigma as an additional barrier to accessing mental health support, which was consistent with participant responses as well (Tavkar, 2008). Participants also reported the importance of validating resiliency, inner strength, and treating them as survivors not victims, when providing services. Lastly, consistent with the literature, participants also perceived mental health service providers as medical professionals (Tavkar, 2008). Therefore, many women requested clinicians provide "advice" or "tools" to help "deal with [the trauma] properly."

In conclusion, both the literature and survey results indicated that professionals working with this population should typically utilize curiosity and openness to the individual's experience. This will likely encourage clients to describe their own experience, relationships with family and community, potential stigma and other barriers, and factors that contribute to their resiliency. Additionally, professionals should be mindful of the stigma associated with the trauma and mental health services, by utilizing language that will be supportive and encouraging, emphasizes one's resiliency and strength, and is easily accessible (i.e. void of technical jargon). Lastly, professionals should also allow a natural progression to discussion of traumatic experiences, as this may be a difficult topic for many women, as evidenced by both the literature and participant responses.

Clinical Implications

Based on the results of this study and literature, training for professionals should include several factors such as, presence of somatic responses, family dynamics, religious practices, role of culture and socialization, and barriers to treatment. There should be an emphasis on understanding the general difficulty of obtaining services for many clients to allow them the opportunities to describe their individual experience to determine sources of additional support or barriers to healing.

Additionally, despite the limited research on the impact of religion and Eastern medicinal practices on the recovery process for survivors of sexual violence within South Asian communities, professionals should inquire about client's religious backgrounds and importance of religion to their daily living. It would also be beneficial for professionals to consult other professionals more familiar with these practices to better provide culturally competent care. Additionally, professionals should be aware of potential cultural messages that may have been

internalized, in addition to allowing participants the space to explore their own resiliency and strength that is impacted by their identity as a woman.

As described, there are several barriers both in the results and literature. These barriers will likely impact the accessibility and comfort with seeking out formal support, such as therapy services. Therefore, professionals should seek guidance from culturally competent agencies that can provide training in working with South Asian women who have experienced trauma.

According to the results and literature, the role of acculturation is a significant factor when providing services to South Asian women survivors of assault. Therefore, professionals should be mindful of a client's level of acculturation to help decrease assumptions and increase rapport with clients to provide effective, culturally competent care. Additionally, clients who may be more acculturated within Western communities, may be more comfortable with Western therapeutic practices than clients who hold more traditional values.

Due to stigmatization of mental health, impact of familial structure and shaming, it is suggested that professionals provide normalizing, validating, and supportive statements in order to help clients feel more comfortable. Professionals need to create an environment that is safe, trusting, open, and warm. Also, it will likely be beneficial to utilize psychoeducation and accessible language (i.e. void of technical jargon), to decrease misinformation and stigma and increase participation in therapy services. Furthermore, professionals should be mindful of these perceptions and engage clients in a discussion of mental health services, providing psychoeducation as necessary. This will likely increase participation, strengthen the therapeutic alliance, and decrease potential client frustration and resistance. Lastly, due to the stigmatization of mental health and sexual violence within this community, it may be beneficial for

professionals to utilize support groups, to provide survivors a place to explore their experiences, in a format that may feel less isolating.

Limitations and Future Research

There were several limitations to the current study including, participation selection, difficulty accessing participants, and limited information. Participations were self-selected via open social media platforms and self-identified their unwanted sexual experiences. Therefore, the validity and reliability of participant eligibility is uncertain. Also, there was no participant ID number or designation, which meant it was impossible to link any of the individual responses to one another (i.e. responses to the follow-up questions after the Likert scales). Furthermore, the current study experienced difficulty with accessing this population and participation, which may be impacted by the difficulty of the topic and fear of potential negative consequences from disclosure and participation. Due to the methodology (i.e. online, confidential survey), there was limited information provided, which impacted the ambiguity of the responses. For example, it is unclear what participants meant by the "strength of women."

Future research should continue to explore the barriers and resiliency factors described in this study, to further our understanding of these factors, which will increase cultural competence. Additionally, future research may also investigate the impact of other identifying factors, such as socioeconomic status, education, employment, role of acculturation, and impact of religion and Eastern medicinal practices. Furthermore, it would be beneficial to also investigate the intersectionality of sexual orientation, gender, and ethnicity (e.g. a South Asian woman who also identifies as LGBTQ), as there is limited information in this area of research. Lastly, as mentioned, this study experienced difficulty accessing this population, which is likely due to the stigma associated; however, it appeared participants were more likely to engage in the study via

an online, confidential survey than other methods (e.g. face-to-face interviews). Therefore, utilizing anonymous sites may assist future research in accessing the population.

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Appendix A: Survey Questions

You've indicated that you've had unwanted sexual experience in the past, please answer the following questions regarding your experience.

1. Where did this experience occur (e.g. United States, India, etc.)? (Comment box)
2. On a scale of 1-10, how strongly do you identify with the Indian culture? (Likert scale)
3. How much was the Indian culture a factor in the recovery process of your unwanted sexual experience? (Likert scale)
4. What were the cultural beliefs or traditions that helped with the healing process? (Comment box)
5. How different do you believe your experience of healing was from women who may have been raised outside the Indian community? (Likert scale)
6. If possible, please describe this response (Comment box)
7. How comfortable did you feel disclosing your unwanted sexual experience with members of the community? (Likert scale)
8. What were potential cultural barriers to your healing experience? Please describe, if possible. (Comment box)
9. Anything else you would like to add about your experience? (Comment box)
10. Lastly, what would you want a counselor/therapist to know about working with you or someone who shared a similar experience as an Indian woman? (Comment box)

Appendix B: Recruitment Document

Hello,

My name is Ashley Jacob and I'm currently a graduate student at The Chicago School of Professional Psychology. I am currently researching the resiliency and impact of culture on the recovery process of Indian women who have experienced sexual assault. For the purpose of this study, the term *resiliency* is defined as: the capacity to recover quickly from difficulties (e.g. sexual assault).

If anyone is interested in participating, they will be asked to complete an approximately 10-25-minute survey. The survey will be completely confidential and anonymous! The questions will offer participants the opportunity to talk about their recovery and resiliency factors, in addition to providing information they believe would be helpful for clinicians to know.

If you're interested in participating, please see the eligibility criteria and link to the survey below!

Eligibility criteria:
Criteria includes individuals who identify as heterosexual cisgender women, over the age of 18, are survivors of sexual assault (by a partner or stranger), & identify as first-generation United States immigrants of Indian descent (i.e. ethnicity), with proficiency in speaking English. Survivors of one or more incidents of sexual assault will be included. The assault must have occurred when the participant was an adult (18 or older). Participants must have previously received therapy or must currently be in therapy.

Click here to participate!

The Chicago School of Professional Psychology Institutional Review Board approved this study on **September 27, 2017**. It is being completed in partial fulfillment of a degree requirement. You may contact me at amj5242@ego.thechicagoschool.edu(email) or 586-879-5953 (phone). Questions or concerns regarding the study may be directed to my supervisor, Dr. Braden Berkey at bberkey@thechicagoschool.edu or 312-467-2351.

Thank you for your consideration,

Ashley Jacob, M.A.
Graduate Student
The Chicago School of Professional Psychology

Appendix C: Demographic questions

**Note: Questions on the survey were multiple choice and individuals who did not meet eligibility criteria were redirected to the end of the survey.*

1. What is your age?
    a. Under 18
    b. 18-25
    c. 26-33
    d. 34-41
    e. 42-50
    f. 51-59
    g. 60+
2. Do you identify as a cisgender (gender matching sex assigned at birth), South Asian, female?
    a. Yes
    b. No
    c. Prefer not to answer
3. You indicated you had a previous unwanted sexual experience. Was the perpetrator of this experience someone outside your home (i.e. other than a spouse/partner)?
    a. Yes
    b. No
    c. Prefer not to answer

Appendix D: Informed Consent

Investigators: Ashley Jacob
Study Chair: Dr. Braden Berkey

Study Title: Ab bas: A program development for women working with South Asian women survivors of sexual assault.

*(*Ab bas in Hindi is loosely translated to "enough" in English.)*

I am a student at The Chicago School of Professional Psychology. This study is being conducted as a part of my dissertation requirement for Clinical Psychology Psy D program.

I am asking you to participate in a research study. Please take your time to read the information below and feel free to ask any questions before providing consent.

Purpose: The survey questions will offer you the opportunity to talk about your recovery and resiliency factors, in addition to providing information you believe would be helpful for clinicians to know.

Note: For the purpose of this study, the term resiliency is defined as: the capacity to recover quickly from difficulties (e.g. sexual assault).

Procedures: There will be a series of questions that will allow you the opportunity to share your experience, if you wish. And provide additional information that may be helpful for professionals to know. Some questions may require a response, but majority of the questions are optional. The survey will take approximately 10-25 minutes to complete. All responses will be confidential and anonymous.

Risks to Participation: Due to the content being discussed (i.e. sexual assault experiences), there is a possibility that the participants may experience emotional feelings of discomfort through recalling past experiences that have been traumatic during the study.

Obtaining online consent will decrease the risk of connecting you to the study. All information obtained by the online survey will be confidential and anonymous. You can choose to not answer a question if you do not want to, or can choose to drop out of the survey at any time.

You will be provided referrals for mental health services that counsel survivors of sexual assault at the end of the survey. Additionally on the same document, you will be given the contact information of the researcher and the study's supervisor, in case you have any questions or concerns.

You may also contact the study's supervisor (i.e. dissertation chair) Dr. Braden Berkey with any concerns or questions.

Benefits to Participants: Although there is no direct benefits of this project, the benefits of the study include a further understanding of the impact culture has on healing of sexual assault. This may aide professionals in providing better and more culturally competent care, in addition to a possible development of techniques that may assist in increase comfortability and healing.

Alternatives to Participation: Your participation in this research study is completely voluntary. You have the right to choose not to participate and you may withdraw your consent to participate at any time. You will not be penalized in any way should you decide not to participate or to withdraw from the study.

Confidentiality: The purpose of obtaining online consent is to further protect your identity, as there is no link to your information and the responses given. All responses are anonymous and confidential.

All survey material will be kept password protected, on a personal computer, that only I will have access to. The material will be deleted from the computer and removed from the hard drive following the minimum of 5 years.

We will do everything we can to protect your privacy. Your identity will not be revealed in any publication resulting from the study. Your information will not be shared with any member of your counseling center or outside agencies.

In accordance with the American Psychological Association guidelines, all material will be kept for 5 years after publication.

Your research records may be reviewed by federal agencies whose responsibility is to protect human subjects participating in research, including the Office of Human Research Protections (OHRP) and by representatives from The Chicago School of Professional Psychology Institutional Review Board, a committee that oversees research.

Questions/Concerns: If you have questions related to the procedures described in this document please contact Ashley Jacob at The Chicago School of Professional Psychology via phone 586-879-5953 or via email amj5242@ego.thechicagoschool.edu. Additionally, you may contact the study's supervisor, Dr. Braden Berkey via phone 312.467.2351 phone or via email bberkey@thechicagoschool.edu.

If you have questions concerning your rights in this research study you may contact the Institutional Review Board (IRB), which is concerned with the protection of subjects in research project. You may reach the IRB office Monday-Friday by calling 312.467.2343 or writing: Institutional Review Board, The Chicago School of Professional Psychology, 325 N. Wells, Chicago, Illinois, 60654.
Consent to Participate in Research

By clicking "Yes" below, I am agreeing to participate in the survey. I have read the above information and have received satisfactory answers to my questions. I understand the research project and the procedures involved have been explained to me. I agree to participate in this study and provide my consent. My participation is voluntary and I do not have to provide consent if I do not want to be part of this research project. I also understand that my responses will be kept confidential and anonymous. I may ask to receive a copy of this consent form for my records.

Note: On the survey site there will be a place to check "Yes" or "No" for consent:

I have read and understand the agreement above. And I consent to my participation in this study.

- *Yes*
- *No*

Appendix E: Resources

Thank you for your participation!

As a reminder, all responses are anonymous and confidential. If you have any questions or concerns, feel free to email the researcher at: amj5242@ego.thechicagoschool.edu or the study's chair, Dr. Braden Berkey, at: bberkey@thechicagoschool.edu.

Please continue to the next page for resources for mental health agencies that provide culturally competent care.

(IRB approval date: 4/9/2018)

Resources

Chicago agencies:

· **Apna Ghar- (Chicago, IL-North side):** "Apna Ghar provides holistic services and conducts outreach and advocacy across immigrant communities to end gender violence."
Apna Ghar, Inc. (Our Home)
4350 N Broadway, 2nd Floor
Chicago, IL 60613
Office: (773) 883-4663
Email: info@apnaghar.org

· **Rape Victim Advocates (Chicago, IL):** "RVA is an independent, not-for-profit organization dedicated to the healing and empowerment of sexual assault survivors through non-judgmental crisis intervention counseling, individual and group counseling, and medical and legal advocacy in the greater Chicago metropolitan area. RVA provides public education and institutional advocacy in order to improve the treatment of sexual assault survivors and to effect positive change in policies and public attitudes toward sexual assault."
Rape Victim Advocates
180 N. Michigan Ave.
Suite 600
Chicago, IL 60601
Phone: (312) 443-9603
info@rapevictimadvocates.org

· **YWCA- (Evanston, IL):** "The YWCA is dedicated to eliminating racism, empowering women and promoting peace, justice, freedom and dignity. At the YWCA Evanston/North Shore, we carry out this mission by providing a wide range of programs and services to meet the needs of the unique and diverse communities we serve, including: domestic violence services; flying fish aquatics; building healthy relationships, violence prevention programming for youth; young women's leadership; economic empowerment; and racial justice initiatives."
1 N LaSalle Dr #1150,

Chicago, IL 60602
Phone: (312) 372-6600

24-Hour Support Hotlines

· Chicago Rape Crisis Hotline: 1-888-293-2080
· National Suicide Prevention Hotline: 1-800-273-8255
· Warm Line- Peer and Family Support (9-5pm): 1 (866) 359-7953