ISSN 2380-727X

PSYCHOLOGY AND COGNITIVE SCIENCES

Open Journal

Openventio PUBLISHERS

Systematic Review

A Review of Barriers to Treating Domestic Violence for Middle Eastern Women Living in the United States

Guy Balice, PhD*; Shayne Aquino, MA; Shelly Baer, MA; Mallory Behar, PsyD; Anushree Belur, PsyD; Jessica Flitter, PsyD; Tyler Howard, PsyD; Noah Laracy, PsyD; Fereshte Mirzad, PsyD; Roseta Patanian, BS; Elizabeth Quintero, BA; Kelly Scheneman, MA; Tanya Abughazaleh, MA; Linda Placencia, PsyD

The Chicago School of Professional Psychology, Los Angeles, CA, USA

Corresponding author
Guy Balice, PhD
Professor, Department of Clinical Psychology, The Chicago School of Professional Psychology, 617 W 7th Street, Los Angeles, CA 90017, USA;
Tel. 213-615-7254; Fax. 213-615-7274; E-mail: gbalice@thechicagoschool.edu

Article information
Received: March 27th, 2019; **Revised:** April 25th, 2019; **Accepted:** May 13th, 2019; **Published:** May 18th, 2019

Cite this article
Balice G, Aquino S, Baer S, et al. A review of barriers to treating domestic violence for Middle Eastern women living in the United States. *Psychol Cogn Sci Open J.* 2019; 5(1): 30-36. doi: 10.17140/PCSOJ-5-146

ABSTRACT

Purpose
This review examined the literature that addresses Domestic Violence (DV) and Intimate Partner Violence (IPV) in Middle Eastern women living in the United States.

Methods
The authors reviewed literature, including reviews and empirical studies, that examined DV and IPV that included: (1) females of Middle Eastern descent, (2) these participants were 18 years of age or older, (3) they have a history of domestic violence or intimate partner violence.

Results
This literature review indicated DV is a worldwide epidemic, with IPV affecting 30% of the female population. IPV is seen in higher rates amongst minority communities, especially among immigrants. Domestic violence can lead to both long-term psychological problems and physical problems, the most serious of which is death. Due to stigma surrounding mental health in Middle Eastern cultures, many women in this population do not seek psychological services. Moreover, in many Middle Eastern communities, DV is seen as a non-significant personal issue.

Conclusions
Fears of further violence, loss of support and relationships, cultural expectations and family reputation are some reasons why Middle Eastern women do not seek services for domestic violence. Future considerations and research are needed to better understand these women's perceptions of the risks and benefits associated with psychological help in order to better assist them and their needs.

Keywords
Domestic violence; Middle Eastern women; Treatment barriers; Cultural sensitivity; Cultural stigmas; Cultural norms; Marital relationships.

Abbreviations
DV: Domestic Violence; IPV: Intimate Partner Violence.

INTRODUCTION

Although domestic violence (DV) has been a problem throughout history, it is only in the past two decades that researchers have shown interest in analyzing how cultural values and social norms relate to aggression and violence towards women.[1] DV, as noted by Hawcroft et al[2] "includes violence perpetrated by a family member or intimate partner towards another adult. Much of the current international evidence focuses on intimate partner violence (IPV), which is a subset of domestic violence" (p. 2). The Center for Disease Control's Intimate Partner Surveillance publication defines IPV as including "physical violence, sexual violence, stalking and psychological aggression (including coercive tactics) by a current or former intimate partner" (p. 11).[3] Current statistics

indicate DV is a worldwide epidemic: The World Health Organization (WHO) released a report in 2013 indicating the prevalence of IPV is at least 30% of the female population.[4] IPV may be more problematic for minority women: The Centers for Disease Control and Prevention reported data obtained from the National Intimate Partner and Sexual Violence Survey (NISVS) indicating that Black non-Hispanic women and multiracial non-Hispanic women had a higher lifetime prevalence of physical violence and stalking than White non-Hispanic women.[3] Although Asian Americans report lower rates of DV,[5,6] researchers suggest such instances may be underreported due to stigma, language difficulties, and cultural values.[7,8] In addition, rates of DV are higher in Asian American communitiespartly because they are influenced by the patriarchal culture.[9,10] Research shows acculturation may also serve as a stressor causing DV.[11] This may relate to many other immigrant groups, who like Asian Americans, often experience acculturative stress when they are unable to adapt to or cope with the process of acculturation.[12]

There are other problems associated with DV; for example, when compared to not having encountered a DV relationship, women within violent dyads report more frequent DV, and are more likely to report headaches, chronic pain, difficulty sleeping, activity limitations, and overall poor physical health.[3] These individuals (regardless of culture, age, or gender) can suffer from mental health problems such as depressive and anxiety symptoms, post-traumatic stress, and suicidal ideation. While these are all serious issues that may be relatively short-lived, DV can also have significantly long-lasting or permanent effects like physical trauma, profound psychological trauma, and even death.[13] In fact, research shows that 45.8% of women with depressive disorders reported domestic violence; 27.6% of women suffering from anxiety disorders reported experiencing domestic violence, and 61% of women suffering from post-traumatic stress disorder reported experiencing domestic violence.[14] Moreover, studies show that 36.4% of female victims of DV indicate a need for services during their lifetime. These statistics highlight domestic violence as a correlate of various mental health disorders and therefore, a public health and safety problem. However, among victims of lifetime domestic violence, only 21.1% disclosed their victimization to a doctor or nurse.[3]

While incidence and prevalence data on DV in Middle Eastern regions are scarce, existing evidence indicates many women are affected.[15] The 2013 WHO report showed instances of DV have been especially high in the Eastern Mediterranean region and Southeast Asian region.[4] This may be especially problematic because despite the long-term effects of such violence, women are unable or unwilling to seek services due to the cultural stigma surrounding mental health and therapy in these regions. Within the Middle East, the social and cultural stigmas surrounding seeking professional mental health services are significant barriers to getting help for the effects of psychological issues.[13,16-18] Other barriers include fear of further violence, loss of support, loss of relationships, concern for children, insecure immigration status, disruption to family life and cultural network, and involvement of child protective services.[19]

The purpose of this literature review is to highlight (1) the gap in research in supporting people of Middle Eastern descent regarding DV, and (2) the barriers that people of Middle Eastern descent often face when seeking out mental health services, especially as it relates to DV.

METHODOLOGY

Data collection for this systematic literature review follows current guidelines outlined in the Systematic Reviews and Meta-Analyses (PRISMA) statement.[20]

Eligibility and Search Strategy

The Greater Middle East[21] region is widespread, encompassing the Eastern Mediterranean countries (e.g., Afghanistan, Egypt, Iran, Morocco, Pakistan, United Arab Emirates, etc.), as defined by the World Health Organization (WHO) and the Near East countries (e.g., Israel, Algeria, Tunisia, etc.) as defined by the U.S. Department of State. To be included in the current literature review, eligible studies needed to meet the following criteria: (1) include females of Greater Middle Eastern decent, (2) participants must be 18 years of age or older, and (3) have a history of DV or IPV. While this literature review seeks to understand the barriers to treatment for Middle Eastern women living in the United States, "living in the US" was not included as a study limiter in an effort to seek the broadest analysis on Middle Eastern cultures. Limiting studies to those conducted only with Middle Eastern women living in the United States was believed to be limiting and presented a possibly misleading analysis of current literature and its clinical applications.

Data collection occurred firstbetween September 2015 and January 2016 and later in April 2019 utilizing the following databases: ProQuest, ProQuest Dissertations, SAGE, Taylor and Francis, EBSCO, APA PsycNET, and PsychINFO. Search criteria were limited to peer-reviewed articles and dissertations published in the English language. Research reports were also selected from specialized U.S. government agencies and the WHO to provide valuable supplementary data for this review. Finally, studies older than January 2000 were eliminated from the consideration set to ensure the most accurate and relevant understanding on Middle Eastern cultures, their beliefs regarding domestic violence, and barriers to seeking treatment.

Selection Process

A subset of authors was tasked with screening the final peer-review articles, dissertations, and research reports to determine their appropriateness and eligibility for this literature review. Figure 1 outlines a sampling of key search terms, as well as the strategy forhow keywords were utilized in this study. Figure 2 provides a flow diagram of the initial literature review, highlighting how items were selected or eliminated from the consideration set. There were 32 studies included in the final selection of studies.

Figure 1. *Literature Review Search Terms and Process*

"Middle Eastern Women" OR "Middle Eastern Females"

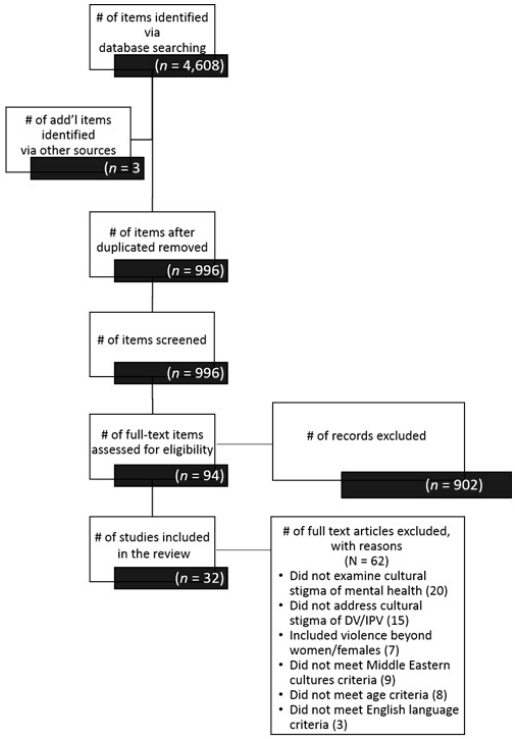
Combined with one of the following terms:
Domestic violence OR interpersonal violence OR ipv OR violence against women

– AND

Combined with one of the following terms:
Barriers to treatment OR treatment barriers OR cultural barriers to treatment OR stigma OR mental health OR mental health stigma

Limiters: English language, Middle Eastern women/females, 18 years and older, peer-reviewed, full-text, published between January 2000 and January 2016

Figure 2. *Flow Diagram of Included Studies*



THE MATIC REVIEW

The Influence of Culture on DV Levels toward Middle Eastern Women

Researchers examining the multidimensional perspectives of DV and how they relate to cultural factors, behavioral beliefs, normative beliefs, and control beliefs, contribute to understanding help-seeking behaviors in Middle Eastern women. While the findings discussed below are generalized to all Middle Eastern cultures, it is critical to note variations on beliefs, norms, and behaviors likely exist among the range of Middle Eastern cultures. For example, research Jaghab K[22] indicates that for Arab-American women, patriarchal perspectives and values regarding egalitarian roles about marriage and family life were related to DV. However, in a study of Egyptian women, household standard-of-living, and history of corporal punishment were associated with physical violence.[23] A study by Zakar et al[24] indicated that marriage at an early age and women's unemployment status were strong predictors of DV among Pakistani women. Other studies also highlight that people from the Greater Middle Eastern region are heterogeneous. For example, Daoud et al[25] found a difference in rates of IPV among Arab and Jewish women in Israel, with Arab women reporting higher rates of IPV. However, their research suggested that improving social connectedness and improving contextual aspects, such as socioeconomic status, may serve as protective factors against IPV. Alzoubi et al[26] found that Jordanian men and women's acceptance of DV was lower in general compared to other Arab nations; however, they also found that similar to other studies, IPV was more generally accepted among people who were unemployed and living in rural areas.

With these considerations in mind, research suggests normative beliefs regarding familial disclosure of DV affect the likelihood of seeking help.[27] In many Middle Eastern communities, people see DV as a non-significant personal issue.[28] Moreover, the emphasis on the well-being of the family in Middle Eastern cultures contributes to the stigma about mental health.[28] Family reputation, cultural expectations, religious values, and interdependence contribute to Middle Eastern women viewing domestic violence as a private family matter.[13] Acculturation, enculturation, cultural congruity, and social support serve to predict psychological help-seeking attitudes among various minority cultural groups.[29] For example, minority cultural groups who are more acculturated into their non-native society, as well as those who demonstrate a higher level of cultural congruity, are more likely to seek psychological services.[29] Conversely, research has found help-seeking attitudes and behaviors among minority cultural groups decrease with higher level of enculturation in one's own society or when they perceive a higher level of social support from friends and family.[29]

Although patriarchy within the Middle Eastern region is difficult to measure, research indicates that social and cultural norms within patriarchal societies encourage male dominance, which legitimizes aggression towards women.[30-32] In these societies, individuals consider DV a private and familial matter, which deprives victims of DV from accessing a range of helpful services, including medical aid, family support, community and social services, psychological help, and legal services.[13] Similarly, Raj et al[19] suggested that traditional cultural beliefs regarding marital roles and religious beliefs influence people's attitudes toward DV. In fact, a study conducted by Haj-Yahia et al[31] found marital roles accounted for the three principle reasons Arab women regarded

IPV as acceptable, including: (a) a wife's failure to obey her husband (64%); (b) a wife's desecration of her husband or husband's family's image, either inside or outside the home (61%); and (c) a wife's neglect of household and/or child-rearing duties (55%).

A constant power struggle in marital relationships in traditional Arab cultures is related to increased DV against women.[33] DV is not an issue that is widely addressed among many Middle Easterner cultures due to the belief that violence is an appropriate form of discipline.[34] This cultural acceptability provides Middle Eastern women with the ability to keep their victimization silent, and therefore not seek help.[35] However, research suggests that greater awareness of what DV entails, having more resources available to report DV, as well as improved financial independence for women may help change the perception of DV. For example, researchers in the Republic of Cyprus found that middle-aged women reported the highest percentage of DV due to more knowledge about the types of DV, as well as having greater social support.[36] Decreasing the instances of DV may increase the overall quality of life for women, as suggested Asadi et al,[37] who found that various types of DV was associated with lower quality of life among Iranian women. These findings suggest a public health policy highlighting the definitions of DV, as well as the harmful effects of DV may be beneficial as a preventive measure.

Stigma against Psychotherapy in Middle Eastern Cultures

Despite a strong correlation between verbal, emotional, physical, and sexual violence and depression,[38] within Middle Eastern populations, the stigma towards mental illness and seeking psychological help is strongly associated with negative attitudes towards Western psychotherapy.[39] Women in Muslim immigrant cultures often do not seek out mental health resources because of the value of preserving family relationships and the fear of being stigmatized and isolated from their community.[31,40,41] Abu-Ras et al[42] found that Muslim women of tenconceal psychological issues to avoid the potential loss of marriage proposal prospects, which disclosure might engender. Abu-Ras et al[42] found that 70% of women expressed shame regarding seeking professional mental health resources. Equally, Youssef et al[43] found shame and stigma around mental health within Middle Eastern populations are significant barriers to the utilization of mental health resources. Notably, an Iranian study illuminated the presence of a "self-perceived stigma" of mental illness, despite how available and well-developed mental health services were in the country.[44]

Another barrier to accessing psychotherapy for individuals of Middle Eastern descent lies in the perception that the pursuit of western psychotherapy is self-serving and culturally incompatible, especially given that western psychotherapy was developed in individualistic societies.[45] Mirsalimi et al[45] outlines the struggles that individuals of Middle Eastern descent experience with western psychotherapy, including: (a) the client's level of acculturation in American culture; (b) the political context in which the client grew up; (c) the client's perception of self-actualization, which is rooted in conflicting beliefs and goals between individualistic and collectivistic societies; (d) the client's ascribed meaning towards Americans and American culture; and (e) the level of trust and connection that exists for the client due to the environmental events that have occurred throughout their lifetime.Additionally, many Muslim leaders in the Middle East rely on Islamic principles as guide posts for mental health, which explicitly emphasize the overall health of the family rather than the individual.[46] Middle Easterners more often rely on spiritual rather than psychological approaches when addressing emotional problems. Padela et al[47] found that American Muslims often recited the Quran to cope with their mental health struggles rather than seek therapy.

While perceptions of increased social support with regards to seeking mental health and resources can increase the likelihood of a person seeking treatment,[48,49] it seems there is a steep climb toward that goal in many Middle Eastern countries. To begin with, there appears to be a dearth of literature and research regarding the reduction of stigma surrounding therapy in Middle Eastern cultures-remedying this would hopefully lead to more positive social support for seeking therapy, and therefore better treatment outcomes for Middle Eastern women who are victims of DV. Another recommendation may include targeted outreach on the part of mental health practitioners to Middle Eastern communities *via* culturally relevant resources, such as religious institutions, given that religion and spirituality are important avenues Middle Eastern populations use to cope with mental health struggles.

Furthermore, as research suggests that DV is related to poor health outcomes (i.e., sleep problems, hypertension, etc.), physicians and other healthcare practitioners may be at the frontline of intervening and supporting survivors of DV.[2] Providing healthcare professionals with training on identifying signs and intervening in a culturally sensitive manner may prove to be beneficial, especially in regards to referring survivors to seek out mental health resources. Mental health interventions focusing on increasing hope may act as a protective factor, particularly against suicidal risk, as found by researchers studying the role of hope as a mediator between IPV and suicide risk among Turkish women.[50]

CONCLUSION AND IMPLICATIONS

There are several issues that mental health clinicians must consider when working with women of Middle Eastern descent who survive domestic violence. These include the patriarchal structure of Middle Eastern culture, what is considered normative behavior, responses to personal problems, and how one engages in help-seeking behavior. The literature reviewed here also has implications for social workers, especially as they can provide more personalized and effective resources to survivors of DV by knowing more about the family dynamics that exist within the larger Greater Middle Eastern cultural system. However, clinicians need more information about how and why Middle Eastern women who are survivors of DV seek help; investigators need to conduct more cross-cultural research on this population, directing their efforts tobetter understanding Middle Eastern women's perception of the risks and benefits associated with psychological help. The limitations of this

literature review is related to the gap in literature on effective interventions, for both providing individual services and implementing preventive programs for communities; clinicians and public health educators may benefit from research identifying ways to reduce incidents of domestic violence in the Greater Middle Eastern cultures, and moreover, report these instances as they occur to receive appropriate supportive services. This research needs to highlight Middle Easterners' views of psychotherapy and help-seeking to tailor therapeutic techniques to this population. The awareness of stigma of psychotherapy in Middle Eastern cultures will allow clinicians toboth educate clients and develop viable interventions. Moreover, developing cultural competency aids not only in the understanding of practices and behavior among specific populations but it also aids in shaping and adapting mental health services and approaches that are generally most effective for any targeted population.

CONFLICTS OF INTEREST

The authors declare that they have no conflicts of interest.

REFERENCES

1. Ellsberg M, Heise L. Researching violence against women: A practical guide for researchers and activists. https://www.popcouncil.org/uploads/pdfs/horizons/whopathresviolappb.pdf. 2005.

2. Hawcroft C, Hughes R, Shaheen A, et al. Prevalence and health outcomes of domestic violence amongst clinical populations in Arab countries: A systematic review and meta-analysis. *BMC public health*. 2019; 19(1): 315. doi: 10.1186/s12889-019-6619-2

3. Breiding MJ, Chen J, Black MC. Intimate Partner Violence in the United States-2010. National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. https://www.cdc.gov/violenceprevention/pdf/cdc_nisvs_ipv_report_2013_v17_single_a.pdf. 2014.

4. Pallitto C, García-Moreno C, Jansen H, et al. Intimate partner violence, abortion, and unintended pregnancy: Results from the who multi-country study on women's health and domestic violence. *Int J Gynaecol Obstet*. 2013; 120(1): 3-9. doi: 10.1016/j.ijgo.2012.07.003

5. Catalano SM. Intimate partner violence, 1993-2010. https://www.bjs.gov/content/pub/pdf/ipv9310.pdf. Revised September 29, 2015. 2012.

6. Tjaden PG, Thoennes N. *Extent, Nature, and Consequences of Intimate partner Violence: Findings from the National Violence Against Women Survey*. Wolcott, NY, USA: Scholar's Choice; 2000.

7. Chan B. Capitalising on the social resources within culturally and linguistically diverse communities for mental health promotion: Stories of Australian Chinese people. *Australian Journal of Primary Health*. 2009; 15(1): 29-36. doi: 10.1071/PY08058

8. Madelyn Hsiao-Rei Hicks. The prevalence and characteristics of intimate partner violence in a community study of Chinese American women. *Journal of Interpersonal Violence*. 2006; 21(10): 1249-1269. doi: 10.1177/0886260506291651

9. Chaudhuri S, Morash M, Yingling J. Marriage migration, patriarchal bargains, andwife abuse: A study of south Asian women. *Violence Against Women*. 2014; 20: 141-161. doi: 10.1177/1077801214521326

10. Parish WL, Wang T, Laumann EO, Pan S, Luo Y. Intimate partner violence in China: National prevalence, risk factors and associated health problems. *Int Fam Plan Perspect*. 2004; 30(4): 174-181. doi: 10.1363/ifpp.30.174.04

11. Caetano R, Cunradi CB, Clark CL, Schafer J. Intimate partner violence and drinking patterns among white, black, and hispanic couples in the U.S. *J Subst Abuse*. 2000; 11(2): 123-138. doi: 10.1016/S0899-3289(00)00015-8

12. John WB. Acculturation: Living successfully in two cultures. *International Journal of Intercultural Relations*. 2005; 29(6): 697-712. doi: 10.1016/j.ijintrel.2005.07.013

13. Abu-Ras WM. Cultural beliefs and service utilization by battered Arab immigrant women. *Violence Against Women*. 2007; 13(10): 1002-1028. doi: 10.1177/1077801207306019

14. Trevillion K, Oram S, Feder G, Howard LM. Experience of domestic violence and mental disorders: A systematic review and meta-analysis. *PLoS One*. 2012; 7(12): e51740. doi: 10.1371/journal.pone.0051740

15. Douki S, Nacef F, Belhadj A, Bouasker A, Ghachem R. Violence against women in Arab and Islamic countries. *Arch Womens Ment Health*. 2003; 6(3): 165-171. doi: 10.1007/s00737-003-0170-x

16. Awad GH, Martinez MS, Amer MM. Considerations for psychotherapy with immigrant women of Arab/Middle Eastern Descent. *Women & Therapy*. 2013; 36(3-4): 163-175. doi: 10.1080/02703149.2013.797761

17. Dwairy MA. *Counseling and Psychotherapy with Arabs and Muslims: A Culturally Sensitive Approach*. New York, NY: Teachers College Press; 2006.

18. Khan Z. Attitudes toward counseling and alternative support among Muslims in Toledo, Ohio. *Journal of Muslim Mental Health*. 2006; 1(1): 21-42. doi: 10.1080/15564900600654278

19. Raj A, Silverman J. Violence against immigrant women: The roles of culture, context, and legal immigrant status on intimate partner violence. *Violence Against Women*. 2002; 8(3): 367-398. doi: 10.1177/10778010222183107

20. Moher D, Liberati A, Tetzlaff J, Altman DG, PRISMA Group. Preferred reporting items for systematic reviews and meta-analyses: The PRISMA statement. *BMJ*. 2009; 339: b2535. doi: 10.1136/bmj.b2535

21. Özalp ON. Where is the Middle East? The definition and classification problem of the Middle East as a regional subsystem in international relations. *Turkish Journal of Politics*. 2011; 2(2): 5-21.

22. Jaghab K. Attitudes of Arab-American Women Towards Domestic Violence [dissertation]. 2005. Unpublished Dissertation. ProQuest Dissertations Publishing.

23. Yount KM, Li L. Domestic violence against married women in Egypt. *Sex roles*. 2010; 63(5-6) 332-347. doi: 10.1007/s11199-010-9793-3

24. Rubeena Z, Zakar MZ, Abbas S. Domestic violence against rural women in Pakistan: An issue of health and human rights. *Journal of Family Violence*. 2016; 31(1): 15-25. doi: 10.1007/s10896-015-9742-6

25. Daoud N, Sergienko R, O'Campo P, Shoham-Vardi I. Disorganization theory, neighborhood social capital, and ethnic inequalities in intimate partner violence between Arab and Jewish women citizens of Israel. *J Urban Health*. 2017; 94(5): 648-665. doi: 10.1007/s11524-017-0196-4

26. Alzoubi FA, Ali RA. Jordanian men's and women's attitudes toward intimate partner violence and its correlates with family functioning and demographics. *J Interpers Violence*. 2018; 886260518769368 doi: 10.1177/0886260518769368

27. Kulwicki A, Aswad B, Carmona T, Ballout S. Barriers in the utilization of domestic violence services among arab immigrant women: Perceptions of professionals, service providers & community leaders. *Journal of Family Violence*. 2010; 25(8): 727-735. doi: 10.1007/s10896-010-9330-8

28. Erickson CD, al-Timimi NR. Providing mental health services to Arab Americans: Recommendations and considerations. *Cultur Divers Ethnic Minor Psychol*. 2001; 7(4): 308-327. doi: 10.1037/1099-9809.7.4.308

29. Madni A. Do the Perceptions of the Usefulness of Academic Support Services Influence Ethnically Diverse Students' Help-seeking Attitudes and Behaviors? [dissertation]. Los Angeles, CA, USA: University of Southern California; 2008.

30. Haj-Yahia MM. Perceptions of abusive and violent husbands by engaged Arab men in Israel. *J Soc Psychol*. 1998; 138(6): 772-786. doi: 10.1080/00224549809603263

31. Haj-Yahia MM. Wife abuse and battering in the sociocultural context of Arab society. *Family Process*. 2000; 39(2): 237-255. doi: 10.1111/j.1545-5300.2000.39207

32. Hajjar L. Religion, state power, and domestic violence in Muslim societies: A framework for comparative analysis. *Law & Social Inquiry*. 2004; 29(1): 1-38. doi: 10.1111/j.1747-4469.2004.tb00329.x

33. Kulwicki A, Ballout S, Kilgore C, Hammad A, Dervartanian H. Intimate partner violence, depression, and barriers to service utilization in arab american women. *J Transcult Nurs*. 2015; 26(1): 24-30. doi: 10.1177/1043659614524000

34. Hajjar L. Domestic violence and Shari'a: A comparative study of muslim societies in the Middle East, Africa, and Asia. http://www.sistersinislam.org.my/files/downloads/domestic_violence_and_sharia.pdf. 2004.

35. Haddad LG, Shotar A, Younger JB, Alzyoud S, Bouhaidar CM. Screening for domestic violence in Jordan: Validation of an Arabic version of a domestic violence against women questionnaire. *Int J Womens Health*. 2011; 3: 79-86. doi: 10.2147/IJWH.S17135

36. Parlalis SK. Women aged 45-64 and IPV in Cyprus. *The Journal of Adult Protection*. 2016; 18(3): 184-194. doi: 10.1108/JAP-11-2015-0033

37. Sonia A, Mirghafourvand M, Yavarikia P, Mohammad-Alizadeh-Charandabi S, Nikan F. Domestic violence and its relationship with quality of life in Iranian women of reproductive age. *Journal of Family Violence*. 2017; 32(4): 453-460. doi: 10.1007/s10896-016-9832-0

38. Ahmadzad-Asl M, Davoudi F, Zarei N, Mohammad-Sadeghi H, Rasoulian M. Domestic violence against women as a risk factor for depressive and anxiety disorders: Findings from domestic violence household survey in Tehran, Iran. *Arch Womens Ment Health*. 2016;19(5): 861-869. doi: 10.1007/s00737-016-0626-4

39. Soheilian SS, Inman AG. Middle Eastern Americans: The effects of stigma on attitudes toward counseling. *Journal of Muslim Mental Health*. 2009; 4(2): 139-158. doi: 10.1080/15564900903245766

40. Gharaibeh M, Oweis A. Why do Jordanian women stay in an abusive relationship: Implications for health and social well-being. *J Nurs Scholarsh*. 2009; 41(4): 376-384. doi: 10.1111/j.1547-5069.2009.01305.x

41. Vogel DL, Wade NG, Hackler AH. Perceived public stigma and the willingness to seek counseling: The mediating roles of self-stigma and attitudes toward counseling. *Journal of Counseling Psychology*. 2007; 54(1): 40-50. doi: 10.1037/0022-0167.54.1.40

42. Abu-Ras, Wahiba M. Barriers to services for Arab immigrant battered women in a Detroit suburb. *Journal of Social Work Research and Evaluation*. 2003; 4: 49-66.

43. Youssef J, Deane FP. Factors influencing mental-health help-seeking in Arabic-speaking communities in Sydney, Australia. *Mental Health, Religion & Culture*. 2006; 9(1): 43-66. doi: 10.1080/13674670512331335686

44. Ghanean H, Nojomi M, Jacobsson L. Internalized stigma of mental illness in Tehran, Iran. *Stigma Research and Action*. 2011; 1(1): 11-17. doi: 10.5463/sra.v1i1.10

45. Mirsalimi H. Perspectives of an Iranian psychologist practicing in America. *Psychotherapy (Chic)*. 2010; 47(2): 151-161. doi: 10.1037/a0019754

46. Baasher TA. Islam and mental health. *Eastern Mediterranean Health Journal*. 2001; 7(3): 372-376.

47. Padela AI, Killawi A, Forman J, DeMonner S, Heisler M. American Muslim perceptions of healing: Key agents in healing, and their roles. *Qual Health Res*. 2012; 22(6): 846-858. doi: 10.1177/1049732312438969

48. Koydemir-ÖzdenSelda. Self-aspects, perceived social support, gender, and willingness to seek psychological help. *International Journal of Mental Health*. 2010; 39(3): 44-60. doi: 10.2753/IMH0020-7411390303

49. Nagai S. Predictors of help-seeking behavior: Distinction between help-seeking intentions and help-seeking behavior. *Japanese Psychological Research*. 2015; 57(4): 313-322. doi: 10.1111/jpr.12091

50. Muyan M, Chang EC. Hope as a mediator of the link between intimate partner violence and suicidal risk in turkish women: Further evidence for the role of hope agency. *J Interpers Violence*. 2016; 1: 886260516675465. doi: 10.1177/0886260516675465