Intimate Partner Violence Experiences of Middle Eastern Immigrant Women Living in Ottawa during the Perinatal Period

by

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   The team members from this organization played a key role as study partners by referring all the study participants. Also, they offered the study participants a safe space to meet.

Abstract

Background: Intimate partner violence (IPV) during the perinatal period is a significant problem for Middle Eastern immigrant women (MEIW) and requires comprehensive and culturally responsive interventions that address the underlying risk factors. Several risk factors (e.g., cultural norms, the perinatal period and language barriers) contribute to increasing women's vulnerability to IPV. Additionally, MEIW face multiple forces of oppression such as racism which are further intersected by factors associated with their immigrant status, creating a unique IPV experience that calls for a systematic investigation. However, there is limited research in this area, a critical gap in knowledge and practice which this study addresses. This study explored the experiences of IPV among MEIW living in Ottawa during the perinatal period.

Theoretical Framework: This study was guided by the Intersectionality lens and the Socio-Ecological Model to explore the intersections of gender and other factors as well as the multiple layers of issues associated with IPV.

Methodology: The study has two phases: phase 1, a scoping review of studies examining IPV within the context of MEIW during the perinatal period, and phase 2, an instrumental case study guided by Stake's (1995) approach to qualitative case study research. As part of Phase 2, research ethics approval was obtained from the Research Ethics Board prior to participant recruitment. Following approval, MEIW during the perinatal period were recruited using convenience and purposeful sampling techniques. Data collection involved in-depth individual interviews with 20 participants and one focus group discussion. The interviews were audio-recorded, transcribed verbatim and analyzed thematically as described by Braun and Clarke (2006). The FGD served as member-checking to establish the credibility of the data.

Results: Findings reveal that IPV among MEIW is not just an individual experience, but a socially embedded phenomenon influenced by patriarchal norms and systemic inequities. Five major themes were identified, 1. Defining IPV, 2. Forms of IPV, 3. IPV impact, 4. IPV vulnerabilities and help seeking behaviours, and 5. IPV coping strategies.

Discussion and Implications: It synthesizes four overarching themes, underscoring the need for culturally responsive interventions that more effectively support MEIW experiencing IPV.

Conclusion: This study deepens our understanding of IPV during the perinatal period for MEIW, providing insight into how cultural and systemic factors influence their experiences. The findings call for culturally responsive interventions and policies that consider the complex realities of IPV in Middle Eastern immigrant communities.

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List of Acronyms

CDC: Centers for Disease Control and Prevention

COVID 19: Coronavirus disease 2019

CS: Case Study

CT: Critical Theory

FGD: Focus Group Discussion

IDI: In-depth interview

IPV: Intimate Partner Violence

MEIW: Middle Eastern Immigrant Women

NHS: National Household Survey

SEM: Social Ecological Model

WHO: World Health Organization

Glossary

Ethnicity: A group of people who have a common ancestral origin, a sense of group belonging, and may have either minority or majority status in a larger society (Ashcroft, Griffiths & Tiffin, 2007).

Experience: refers to the things that have happened to somebody that affect their way of thinking and behaviour (Oxford Learner's Dictionary, 2021).

Gender: a social construct of norms, roles and behaviours that varies between cultures and societies over time. Gender is categorized as male, female or nonbinary (WHO, 2021).

Health inequalities: refer to the differences in the health of individual persons or groups (Kawachi et al., 2002).

Intersectionality: An approach employed to understand the interactions of multiple social positions, such as ethnicity, gender, class, and how those interactions can marginalize people in several ways (Crenshaw, 1990).

Marginalized population: Communities and groups that encounter multiple discriminations and deprivations because of unequal power relations over social, economic and cultural aspects of life. This population often feels if it has no power. (Oxford Learner's Dictionary, 2021).

Middle East: An area that covers south-west Asia and north-east Africa, stretching from the Mediterranean to Pakistan and including the Arabian Peninsula. It includes Bahrain, Jordan, Saudia Arabia, Cyprus, Kuwait, Syria, Egypt, Lebanon, Turkey, Iran, Oman, Iraq, Qatar, Palestine, Yemen, United Arab Emirates. Several major religions have their origins in the Middle East, including Judaism, Christianity, and Islam. Their languages may include Arabic, Turkish, Greek and Farsi (Oxford Learner's Dictionary, 2021).

Perinatal period: is the period from the time of planning a pregnancy to up to two years after the birth of the child (Liu & Proulx, 2023).

Power relationships: Power is one's ability to influence and control others. It refers to the ability to affect the actions and behaviours of the subordinate through the control of resources. The power relationship is a changing dynamic process which explains how power influences a relationship between two or more people in which one of them is an agent and the other is a target. Power relations are dynamic and shaped not only by interpersonal interactions but also by intersecting social factors including gender, race, class, and immigration status that contribute to unequal dynamics between individuals (Crenshaw, 1990).

Race: A term used to categorize human beings, and it presumes that human beings can be divided into separate groups, distinguishable based on their physical characteristics (Ashcroft, Griffiths & Tiffin, 2007).

Refugees: Individuals who "owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of [their] nationality and is unable or, owing to such fear, is unwilling to avail [themself] of the protection of that country (United Nations Convention Relating to the Status of Refugees, 1951).In Canada, refugee protection is provided under the *Immigration and Refugee Protection Act (IRPA)* to Convention Refugees and Persons in Need of Protection.

Social determinants of health: are the non-medical factors that influence health outcomes such as unemployment, poverty, education and social inclusion (Canadian Nurses Association 2017).

Social identity: refers to a person's sense of self on their group involvement(s). Examples of social identities are race, gender, social socioeconomic status, sexual orientation, and religion (Haslam et al., 2021).

Chapter One - Problem

1.1. Introduction

The starting point for this thesis was a significant concern about the widespread but underexamined nature of intimate partner violence (IPV) during the perinatal period, particularly among Middle Eastern immigrant women (MEIW). IPV is widely recognized as a serious public health issue with serious consequences for women, their children and the wider society (Jofre-Bonet, Rossello-Roig & Serra-Sastre, 2024; World Health Organisation, 2024). Periods of transition, such as the perinatal period, are linked to increased risk of IPV (Mojahed et al., 2021). For MEIW, additional factors such as economic hardship, restrictive immigration policies and cultural norms compound these risks (Clark et al., 2009; Okour & Badarneh, 2011; Oweis, Gharaibeh & Alhourani, 2010). However, despite the heightened and compounded risk factors for IPV that perinatal immigrant women face, there remains a critical gap in research that adequately explores their experiences.

This thesis seeks to address this gap by exploring how MEIW experience IPV during the perinatal period. It will use a critical and intersectional lens to explore how structural and cultural factors shape these women's experiences and consider how policies and interventions can be made more responsive to their needs. Through this research, the study aims to centre the voices of MWIE, and to ensure that their lived realities inform both academic discussions and practical approaches to IPV.

This first chapter is structured as follows. The Background section provides an overview of IPV, outlining its various forms and prevalence while situating the issue within the broader context of immigration and the perinatal period. Next, the ways patriarchal structures and power

dynamics shape IPV experiences for MEIW in Canada are examined. After which, the Statement of the problem is presented to highlight the urgency of addressing IPV among this population and identify key gaps in existing research. Following this, the Research Purpose and Objectives are presented, followed by the Significance of the Study, which discusses the research's contribution to academic and scientific knowledge and its implications for policy and practice.. Finally, my Positionality as a researcher is presented to reflect on my personal and professional background, considering how my experiences inform the study's approach and focus.

1.2. Background

1.2.1. Intimate Partner Violence: An Overview

IPV is a significant problem for public health, human rights, and society that continues to impact women's lives in every part of the world (Barbara et al., 2020; Krigel & Benjamin, 2021; World Health Organization, 2021). While women are disproportionately affected, it is crucial to recognize that men also experience IPV, though in different ways and with distinct challenges (Scott-Storey et al., 2023). Throughout this thesis, the term "women" has been used purposefully with a specific reasoning. While terms like "individual" and "person" are gender-neutral and inclusive, using the term "women" throughout the thesis provides clarity and ensures that the experiences, perspectives, and issues specific to "women" are directly acknowledged. In Middle Eastern cultural and linguistic contexts, sex and gender are often more tightly coupled, with gender identity closely aligned with biological sex at birth. This differs from more fluid or expansive understandings of sex and gender in other contexts, such as in Canada. Therefore, the use of the term 'women' in this thesis reflects the cultural specificity of how gender is socially constructed and experienced among MEIW. This choice aims to ensure that the visibility of these

women is maintained in the Middle East context, where their experiences and needs may otherwise be overlooked.

Defining IPV is crucial for understanding its causes and implications (Daoud, 2019). Although there is no agreed-upon definition of IPV, in this thesis, IPV is used to refer to any physical violence, sexual violence, controlling behaviours, verbal abuse, emotional abuse, stalking, or psychological aggression perpetrated by a current or former intimate partner (Stewart, MacMillan, & Wathen, 2013). Despite this stipulation, it is important to note that the term IPV continues to be used variably across cultures and countries, and as a result, can be applied to refer to a range of behaviours, definitions, and social perceptions (Mehta & Gagnon, 2016). This is challenging for services seeking to reduce IPV because, in different cultural contexts, what is considered abusive can differ significantly. For example, behaviours such as controlling a partner's movements or finances may be normalized or seen as expressions of care in some cultures, whereas in another culture, these behaviours are clearly recognized as forms of coercive control and abuse. This variation is influenced by norms, gender roles, and social expectations. Therefore, understanding and addressing IPV requires interventions that are responsive to cultural backgrounds and the specific challenges individuals may face within their social environments (Sabri, Lee & Saha, 2022).

1.2.2. IPV in the Canadian Context

In Canada, IPV continues to be one of the most pervasive forms of gender-based violence, with women and girls disproportionately represented among survivors. Burczycka & Conroy confirmed that IPV constituted approximately 30% of all police reported violence (2018). Also, police-reported data from 2022 revealed that women and girls accounted for 78% of IPV

survivors among all reported cases (Government of Canada, 2022). Despite the severity of IPV, underreporting remains a major concern, an estimated 80% of individuals who experienced IPV in 2019 did not report it to police, with women reporting incidents only 22% of the time (Government of Canada, 2022). Many survivors perceive IPV as a private matter, minimize its importance, or express fear and distrust toward the criminal justice system which leads to further invisibility of cases (Park et al.,2021).

Self-reported data indicate that 44% of Canadian women aged 15 and older, about 6.2 million women, have experienced psychological, physical, or sexual IPV in their lifetime (Statistics Canada, 2021). Women were significantly more likely than men to experience severe forms of IPV, including forced sex (10% versus 2%), choking (7% versus 1%), and threats toward pets (4% versus 0.8%). The psychological toll of IPV is also notable: over one-third of women (37%) who experienced IPV reported being afraid of their partner, a marker of coercive and controlling violence. A 2018 Canadian survey, found that 12% of young women aged 15-24 who had experienced IPV, reported symptoms consistent with post-traumatic stress disorder (PTSD) (Burczycka, 2019). Also, it was found that 36% of women in Canadian shelters for survivors of abuse, noted mental health issues as one of the top challenges they faced (Statistics Canada, 2020).

In Canada, certain groups experience elevated risks of IPV. For example, Indigenous women are particularly affected, 61% reported lifetime experiences of IPV compared with 44% of non-Indigenous women. Also, visible minority women report similar overall rates of IPV (29%) but face distinct barriers to help-seeking, including cultural stigma, language limitations, and systemic discrimination. Moreover, women living with disabilities and younger women aged

15–24 experience disproportionately high rates of IPV and are more likely to experience repeated or severe forms of abuse (Statistics Canada, 2020).

The experiences of immigrant women with IPV in Canada remain underexplored, and research in this area is still developing (Okeke-Ihejirika et al., 2020). Many large-scale epidemiological studies or reports have historically excluded equity denied groups such as immigrant women which may indicate that mainstream IPV research has been shaped by dominant perspectives that overlook intersectional and migration-related dimensions of IPV (Fonteyne et al., 2024). This limited focus poses significant challenges in a multicultural society such as Canada, where immigrants constitute approximately 22% of the national population (Statistics Canada, 2020).

IPV among immigrant women in Canada often shaped and exacerbated by migration-related vulnerabilities, cultural norms, and systemic barriers (Holtmann & Rickards, 2018). For example, while Canadian-born women may have access to established support networks such as family and friends, immigrant women often lack comparable social support systems in Canada which can exacerbate their exposure to IPV (Du mont et al, 2012). In this context, immigrant women face specific hurdles to seeking appropriate help due to language barriers and lack of knowledge about the available services (Holtmann & Rickards,2018). However, Holtmann and Rickards (2018) argue that there remains insufficient empirical evidence demonstrating that immigrant women face higher rates of IPV than their non-immigrant counterparts.

In an effort to address IPV, Canada has introduced several policy initiatives such as It's Time: Canada's Strategy to Prevent and Address Gender-Based Violence (Government of Canada, 2017). This federal initiative launched in 2017 by Women and Gender Equality Canada

(WAGE) to provide a coordinated national response to gender-based violence, including IPV. The strategy focuses on three pillars, prevention, support for survivors and their families, and the promotion of responsive legal and justice systems (Government of Canada, 2023).

1.2.3. Middle Eastern Immigrant Women in Canada

Migration and resettlement introduce unique vulnerabilities that shape immigrant women's experiences of IPV, often compounding existing risks (Bolter, 2019). Exposure to IPV tends to increase during times of conflict and crisis such as war (Kelly et al., 2018) and global pandemics (Gosangi et al., 2021) which often lead to unplanned migration and displacement, as experienced by refugees, asylum seekers, and internally displaced persons (Okeke-Ihejirika et al., 2020).

In 2022, an estimated 437,000 people immigrated to Canada (Statistics Canada, 2023). In 2021, the Census of population confirmed that there are approximately 4,379,200 immigrant women in Canada, representing approximately 24% of Canada's total female population (Statistics Canada, 2023). According to Statistics Canada projections, 11 million immigrants will live in Canada by 2031 (NHS, 2011). Out of these 11 million immigrants, approximately 5.8 million (52.3%) will be women. Immigrant women are expected to constitute around 27% of Canada's female population. Immigrant women tend to settle in the most populated provinces of Canada such as Ontario. In 2011, 53 % of female immigrants were settled in Ontario including the National Capital Region.

The 2021 Census found that Asia, including the Middle East, was the birthplace reported by 65% of immigrant women who arrived in the country since 2016. In 2021, 69.3% of immigrant women belonged to a visible minority group. The survey also showed that 46.3% of

immigrant women aged 15 and over were living with a partner, and 13.4% of immigrant women were living with a common-law partner (Statistics Canada, 2023).

The linguistic profile in 2022 revealed that approximately one in four females living in Canada spoke a non-official language as their mother tongue with 27.1% of these being immigrants. The employment rate for immigrant women is approximately 76%, while the rate for Canadian-born women reached 84% according to the most recent 2022 census (Statistics Canada, 2023). Many immigrant women face challenges in their new countries due to language barriers, low socioeconomic status, social isolation, economic inequalities, confusion over their legal and family rights, immigration status, sponsorship, and the stress of adapting to new cultural and social structures (Ahmadzai, Stewart & Sethi, 2016). For example, language is a barrier to non-English or French speaking women as it limits their opportunities to benefit from existing community services, specifically services for helping women fleeing IPV (i.e., access to shelter information) (Durieux-Paillard, 2011). Among the diverse groups of immigrant women in Canada, MEIW face unique challenges that shape their experiences of IPV, particularly during the perinatal period. The following section provides a more detailed examination of these experiences.

MEIW in Canada are considered one of the vulnerable groups for IPV, particularly when their immigration status intersects with the perinatal period (Mojahed et al.,2021). Since 1948, many political conflicts and repressive regimes have created a huge outflow of immigrants from different parts of the Middle East to Western countries (Baser & Halperin, 2019). Major conflicts, including the Israeli Palestinian conflicts and the Syrian civil war have led to the largest Middle Eastern refugee resettlements. As a result, Canada has become a major destination

for refugee resettlement, receiving large numbers of refugees, asylum seekers, and displaced individuals from conflict-affected regions. Many of these immigrants have come to Canada under different immigration categories (e.g., family class, refugee class and student visa).

The Middle East is the area that covers south-west Asia and north-east Africa, stretching from the Mediterranean to Pakistan and including the Arabian Peninsula. It includes Bahrain, Jordan, Saudia Arabia, Cyprus, Kuwait, Syria, Egypt, Lebanon, Turkey, Iran, Oman, Iraq, Qatar, Palestine, Yemen, and the United Arab Emirates, as shown in Figure 1.1

Figure 1.1: *Map shown Middle Eastern Countries where study participants come from.*

Source of the map: https://geology.com/world/middle-east.shtml.

While there is a rise in the number of MEIW living in Canada, they are under-represented in health and social research (Alsrayheen, Aldiabat & Aquino-Russell, 2022). There is also a gap

in knowledge about the diverse experiences of MEIW in Canada, with many research, policy and journalistic descriptions portraying the diaspora as a monolithic group with shared beliefs, values and behaviours (Alsrayheen, 2019; Barkho, Fakhouri & Arnetz, 2011). MEIW often lack access to their host country's resources and social assistance programs because of language barriers, structural racism and limited knowledge of available resources (Ozturk, 2019). Such an experience can be acutely felt during the perinatal period when women may be seeking support for themselves and their children. These women may be reluctant to report IPV due to fear of the police and authorities, as well as concerns about the potential apprehension of their children by child protection agencies. The intersection of these factors can further deepen the marginalization experienced by MEIW. These diverse experiences and their intersections should be highlighted in the research to better understand the unique challenges they faced (Crenshaw,1989) and to inform the development of more culturally responsive and equitable interventions (Hancock and Siu, 2009)

IPV has persisted in societies like the Middle East because of the masculine culture, social context, and legal system that sustain male control over female partners. For perinatal immigrant women, these issues may increase their vulnerability to an even greater extent as their lives straddle two often conflicting cultures, which creates a context in which they may feel isolated and lonely (Niroomand, Gholizadeh & Baird, 2024). MEIW in Canada may experience clashes between their traditional cultural norms and the more liberal, diverse norms of Canadian culture. This tension mainly manifests in challenges related to gender roles, social norms, and balancing cultural practices with the desire for autonomy and integration into Canadian life. For example, MEIW are raised in a culture that emphasizes collectivism, family honour, and clearly

labeled gender roles (Alteneiji, 2023). Woman are taught to prioritize marriage, caregiving, and obedience to males including parents and partners.

Upon arrival in Canada, MEIW often encounter a liberal, individualistic culture that emphasizes gender equality, personal autonomy, and career advancement (Mohrdar, 2023). This can stand in stark contrast to the traditional expectations within their families and communities, which may include maintaining conservative dress, limiting interactions with men outside the family, and marrying within their ethnic or religious group. Navigating these conflicting expectations can lead to feelings of social isolation, internal conflict, and strained family and community relationships.

For some women, these challenges are further compounded by their precarious legal status. Undocumented immigrant women often lack formal protection, which can heighten their vulnerability to abuse. In many cases, abusive partners exploit this lack of legal recognition as a means of coercive control, trapping women in violent relationships (Raj & Silverman, 2002).

To fully grasp the experiences of IPV among MEIW, it is crucial to examine not only the specific forms of IPV they may experience but also how these experiences may intersect with cultural, legal, and social factors. The following section explores the various manifestations of IPV within this population.

1.2.4. Presenting IPV among MEIW living in Ottawa

Ottawa has seen a rise in reported IPV incidents, which was significantly exacerbated during the COVID-19 pandemic due to factors like social isolation and financial stress. While data collection methods and the pandemic's impact on reporting make it complex to fully gauge, Ottawa Police Service statistics show a consistent increase in reports since 2021, indicating a

continuing trend (Ottawa Police, 2024). Ottawa police have described IPV as a "epidemic"; in 2021 alone, 6,385 women were affected, with numbers steadily rising each year, underscoring an urgent need for further research and intervention.

IPV among MEIW in Ottawa represents a critical yet underexplored public health and social issue. Ottawa, as one of Canada's most ethnoculturally diverse cities, is home to a growing Middle Eastern population, with immigrants from countries such as Palestine, Lebanon, Jordan, Syria, and Iraq, forming a significant part of the city's newcomer community (Statistics Canada, 2021). To date, no empirical study has specifically examined the experiences of IPV among MEIW in Ottawa. While national and provincial research has explored IPV among immigrant and refugee populations in Canada more broadly, there remains a lack of localized studies focusing on the unique social, cultural, and structural contexts of immigrant women including MEIW residing in Ottawa. Overall, the phenomenon of IPV among MEIW in Ottawa must be understood as both a gendered and intersectional issue shaped by the interplay of migration status, cultural expectations, economic dependency, and systemic barriers. Understanding these dynamics is vital to inform policy, community programming, and further research aimed at promoting empowerment and social inclusion for MEIW in Ottawa.

1.2.5. IPV, Migration and the Perinatal Health

Although all women are at risk of IPV at all life stages, vulnerability is higher for both immigrant and ethnic minority women (Cho, 2012; Daoud, 2019) and others during the perinatal period (Hahn, Gilmore & Rheingold, 2018). Migration can heighten vulnerability to IPV, as factors like isolation, legal dependency, cultural barriers, and limited access to support services can increase risk and hinder help-seeking. For example, MEIW face distinct barriers to accessing

care including language, stigma, limited social networks, and systemic discrimination which increase their vulnerability to IPV. In addition, factors such as migration stressors, precarious legal status, economic hardship, cultural norms, and gender expectation further shape their vulnerability and help-seeking behaviors (Tabibi & Baker, 2017).

The perinatal period is a time of heightened risk of IPV for immigrant women including MEIW due to several factors including structural inequities, financial hardship and changing family dynamics (Henriksen et al, 2023; Mojahed et al, 2021). Issues such as increased stress, inadequate healthcare and rigid cultural norms can create an enabling environment for IPV and reducing women's ability to seek help (Daoud, O'Campo & Heaman, 2012; Mehta & Gagnon, 2016).

Pregnancy itself may contribute to the onset and the increase of IPV (Edin et al., 2010; Izaguirre & Calvete, 2014; Williams & Brackley, 2009). Unplanned pregnancy, partner jealousy that attention might shift from partner to child, lack of social support, and poverty are all risk factors associated with increased IPV during pregnancy (CDC, 2021; Grace et al.,2022). Pregnancy may also lead to changes in the nature of existing IPV from verbal or emotional to physical form (Finnbogadóttir & Dykes, 2012). Exposure to IPV makes pregnancy an even more stressful experience as it compounds physical and emotional challenges with fear, anxiety, and instability (Alhusen et al., 2015; Mantovani & Thomas, 2014). While the perinatal period is a risk factor for IPV for all women. Being an immigrant adds another layer of vulnerability. For MEIW, this vulnerability is further amplified by cultural norms, gender roles, and stigma, creating compounded risks and barriers to safety and care seeking.

1.3 Understanding Intimate Partner Violence for MEIW during the Perinatal Period

Understanding IPV among MEIW requires recognizing how multiple forms of abuse intersect with cultural norms, gender roles, and migration-related vulnerabilities. MEIW often experience these forms of violence in ways shaped by patriarchal expectations, family obligations, and limited social or legal protection. The following section outlines the main forms of IPV and the specific factors that shape MEIW's perinatal IPV experiences.

1.3.1 Forms of IPV

While the WHO's 2012 definition of violence and abusive behaviours broadly encompasses various forms of harm, including physical, emotional, sexual, and economic abuse, the Power and Control Wheel focuses mainly on the dynamics of IPV (Figure 1.2). Both models highlight how IPV involves not just physical harm but tactics of control, such as manipulation, isolation, and economic dependency. The WHO definition provides a general understanding of violence, while the Power and Control Wheel offers a more detailed explanation of how abusers maintain power and control in relationships, making them complementary in understanding the complexities of abuse.

Physical abuse includes but is not limited to throwing objects, pushing, kicking, biting, slapping, strangling, hitting, beating, threatening with weapons, or using weapons (Stewart & Cecutti, 1993). Psychological or emotional abuse diminishes a woman's sense of self-worth and can include behaviours that humiliate and belittle the woman.

Figure 1.2: *Power and Control Wheel*

Note. *This figure is a useful lens for examining IPV, these are tactics an abusive partner may use in a relationship. From Domestic abuse intervention project.* https://www.theduluthmodel.org/

It includes all behaviours that result in psychological trauma, including anxiety, depression, or post-traumatic stress disorder (PTSD). IPV can also be verbal which includes using words to harm a woman such as name-calling, swearing, degradation, and verbal threats (Stewart,

MacMillan, & Wathen, 2013). Controlling behaviours include isolating the woman from the community, family, and friends as well as depriving her of essential life needs such as food, money, phones, access to the internet, transportation, and health care (Sumner et al., 2011). Spiritual abuse includes denying or manipulating religious beliefs or practices to force victims into subordinate roles or to justify other forms of IPV, while cyber abuse involves using electronic devices and social media to monitor, harass or intimidate (Choi, Elkins, & Disney, 2016).

The different types of IPV can intersect, for example, manipulative tactics intended to control and undermine a victim's sense of self-worth and autonomy may include using verbal abuse to achieve the abuser's aims. While verbal abuse, emotional abuse and coercive control are distinct, they can reinforce and escalate each other. Some researchers consider verbal abuse as a form of emotional abuse, while others frame it as a separate category that can cause emotional abuse (Koller & Darida, 2020).

Another type of IPV is sexual violence which includes a continuum of sexual acts that encompass unwanted kissing, touching, and rape (Bagwell-Gray, Messing & Baldwin-White, 2015; Stewart et al., 2012). Rape is a form of sexual assault involving non-consensual sexual activity, where one person forces another to engage in sexual acts against their will (Dowds, 2020). This act is mainly carried out through physical force, threats, manipulation, or exploitation of a person's inability to give consent. The literature has illustrated that immigrant women are at higher risk for sexual abuse and, specifically, rape within a marriage (Ivanova et al., 2019).

Reproductive coercion is also a form of IPV that involves exerting power and control over a partner's reproductive health. It includes behaviours such as pressuring or forcing a partner to become pregnant, sabotaging contraception, interfering with pregnancy outcomes, or coercing them into having unprotected sex (Grace & Anderson,2018). MEIW may face increased vulnerability to reproductive coercion which is often overlooked but serious form of abuse within intimate relationships (Coll et al., 2020; Grace & Fleming, 2016; Tarzia, Douglas & Sheeran, 2022). This is any act employed to maintain power and control in an intimate relationship related to reproductive health. The risk of reproductive coercion is increased for women in relationships where other forms of IPV are already present (Clark et al., 2014). It has been noted that immigration status is likely to reduce reproductive coercion reporting, increasing women's exposure to sexual violence within marital relationships (Grace et al., 2020).

A woman's immigration status not only intensifies her vulnerability to IPV, but it can also exacerbate the nature of the abuse she experiences (Tabibi et al., 2018). Immigration-related abuse includes threat of deportation or withdrawal of petitions for legal status. For example, non-status immigrant women face extreme vulnerabilities as they do not have any legal status (e.g., temporary resident or undocumented women) in their host country. As such, they are reluctant to call the police as they fear deportation and loss of their children (Couture-Carron, Zaidi, & Ammar, 2022). These women will continue to experience and tolerate different types of IPV with no way to escape.

Furthermore, immigrant women who have a refugee claimant status may not recognize that they can separate their refugee application from that of their abusive partner during the refugee process (Fonteyne et al., 2024). As such, they will continue to feel threatened and unable

to escape the abusive relationship. The partners may take advantage of this lack of knowledge and convince these women that they cannot get permanent residence status if they leave the relationship (Usher et al., 2023). In some cases, abusive husbands threaten to withhold immigration sponsorship as a means of control, warning their wives that they will not file the necessary immigration paperwork if the IPV is reported. Hass, Ammar, and Orloff (2006) found that 72.3% of abusive husbands who were eligible to sponsor their partners' immigration applications deliberately chose not to file them and used their immigration status as a form of coercion. While these forms of IPV may appear as isolated incidents, they are often embedded within a broader system of patriarchal control. The following section explores how structural gender inequalities and power imbalances sustain IPV within Middle Eastern communities.

1.3.2 The Influence of Culture, Patriarchy and Power on MEIW's Perinatal IPV Experiences

Middle Eastern societies are strongly shaped by patriarchal structures that define clear gender roles and expectations within families and communities. Men are commonly positioned as primary providers and decision-makers, while women are expected to focus on caregiving and household responsibilities. This division of roles is often framed as a sign of mutual respect and protection, contributing to family stability and cultural identity.

These cultural norms are not inherently harmful; in fact, many families view them as expressions of care and support. However, they can also create power imbalances that restrict women's autonomy, mobility, and access to resources particularly during the perinatal period, when traditional expectations of obedience, modesty, and family honour are often intensified.

These dynamics can become even more complex when women migrate to Canada, where cultural expectations emphasize individual rights, autonomy, and gender equality, which may

contrast sharply with the traditional gender norms they have known. This cultural shift can lead to internal conflict, family tensions, and social isolation.

Abusive partners can employ different strategies to create hardships for MEIW in order to assert their control and power. In Middle Eastern patriarchal society, men use violence to express power and control over their female partners (Niroomand, Gholizadeh & Baird, 2024). Domination lies at the core of control which drives behaviours that seek to limit autonomy and impose power over the female partner (Walby & tower, 2018). The principal purpose for all these behaviours is total domination. Stark (2013) explains that coercive control involves tactics that are designed to enforce a woman's general obedience to male authority. He further argues that these patterns of control are closely linked to rigid gender roles, where male dominance and female submission are shaped and sustained by broader social structures. Consequently, the individual motivations behind IPV against MEIW are likely to be inextricably enmeshed with the structural mechanisms that enable it to occur and persist.

Pulerwitz et al. (2015) argue that our understanding of IPV is incomplete if we do not distinguish that IPV is about gender and power. Similarly, Conroy (2014) notes that men may commit IPV because their society allows them to use their power in this way. She further points out that power in an IPV context is not an individual act by a man, but a social order in which men have more power and privilege than women. Additionally, societal structures such as family, judicial and educational systems accept and support male privilege. Consequently, masculine power is socially constructed and culturally approved (Valsecchi et al., 2023).

In the Middle Eastern context, patriarchal structures and gender inequality reinforce social norms that justify coercive control of female partners (Aboulhassan & Brumley, 2019).

For example, in many Middle Eastern communities, patriarchal family structures become even more pronounced during pregnancy and early motherhood. Women are often expected to prioritize childbearing and caregiving, while men maintain financial authority and decision-making power. While this woman's role is often understood as a complementary and shared contribution to family harmony, some men could use it to reinforce gendered dependency, limiting women's mobility and access to outside support during the perinatal period. In some cases, cultural expectations of "obedience" and "family honour" are used to justify monitoring their movements, restricting medical decisions, or controlling interactions with health and social services, normalizing coercive control and silencing disclosure of IPV (Adisa, Abdulraheem & Isiaka, 2019). To reinforce this dominance, the male partner may use verbal insults and other forms of abuse to undermine the psychological or emotional wellbeing of their female partner to assert control (Crossman & Hardesty, 2018). Physical harm and threats of physical harm may also be used to gain control over the female partner (Dichter et al., 2018).

While patriarchal structures provide an important lens for understanding the dynamics of IPV among MEIW, they are not the sole cultural factor shaping these experiences. A range of intersecting cultural norms and expectations play a significant role in influencing how IPV is perceived, experienced, and responded to in this population. For example, Middle Eastern cultures are predominantly collectivist, prioritizing the welfare of the family and community over individual autonomy (Khan et al., 2022). Within this context, IPV is frequently considered a private family matter rather than a social or legal issue. MEIW may be expected to resolve conflicts through family elders or religious figures instead of external authorities. This often results in pressure to reconcile rather than separate, placing women in situations where their

personal safety is secondary to communal harmony (Raj & Silverman,2002). Cultural expectations around motherhood and caregiving are particularly heightened during the perinatal period. Middle Eastern women are often expected to demonstrate selflessness, patience, and loyalty to their families, which can normalize controlling or abusive behaviours by partners (Gharaibeh & Oweis, 2009). This dynamic may discourage women from disclosing abuse or leaving violent relationships, especially when children are involved.

Although Islam, which is the predominant religion among MEIW, emphasizes justice, dignity, and mutual respect, religious texts are sometimes misinterpreted through patriarchal cultural lenses to justify controlling or abusive behaviour (Hassan,1995). Abusers may invoke religious justification to reinforce male authority, while community or religious leaders may inadvertently perpetuate these narratives. This misinterpretation can discourage Middle Eastern women from seeking help and contribute to internalized beliefs that normalize control and limit agency (Truong et al., 2022).

While these cultural norms may heighten the vulnerability of MEIW to IPV, migration to a Western context such as Canada introduces contrasting cultural expectations that emphasize gender equality, personal autonomy, and individual rights (Ahmadzai,2015). This shift can create an additional layer of vulnerability, as MEIW often experience cultural dissonance, feeling torn between traditional gender norms and the values of their host society (Ozturk & Nelson-Gardell, 2024). Such conflict can lead to social isolation, family tensions, and internal struggles as women navigate competing cultural expectations during a period already characterized by heightened vulnerability, particularly in the perinatal stage (Mojahed et al., 2021).

While patriarchal power structures shape IPV in both Middle Eastern and Western societies, their expression and impact differ significantly. In the Middle Eastern communities, patriarchal norms are reinforced through cultural, religious, and familial expectations, including rigid gender roles and male guardianship, which normalize male control and discourage reporting of abuse. In contrast, Western communities tend to have more flexible gender norms, stronger legal protections, and greater public discourse on IPV, which can enable more avenues for support and resistance.

Understanding the IPV experiences of MEIW requires an approach that goes beyond surface-level descriptions to critically examine the power relations, structural inequalities, and systemic barriers shaping these experiences. Therefore, this study is grounded in Critical Theory, which supports the investigation of how intersecting forms of oppression affect women's lives and their access to support systems. Critical Theory will be discussed further in chapter three.

1.4. Gaps in IPV Research for MEIW

Scholars have studied etiology, prevalence rates, health consequences, and possible interventions and prevention strategies for IPV. However, research on immigrant communities remains limited, especially regarding the link between the social positions of immigrant women and IPV (Ahmadzai, Stewart & Sethi, 2016). In addition, little is known about how women from diverse ethnic backgrounds can communicate their IPV experiences during the perinatal period (Garnweidner-Holme et al., 2017). This may be attributed to the lack of research on the perceptions of women from diverse ethnic backgrounds and how they experience IPV during the perinatal period. Furthermore, IPV studies mainly highlight the interpersonal risk factors and how to treat these individual factors to minimize IPV risk. Hardesty and Ogolsky (2020)

highlight that much of the IPV literature centers on interpersonal dynamics while giving little to no attention to broader community or societal influences. For instance, limited education is frequently cited as a risk factor for IPV, yet the structural conditions and societal responsibilities that contribute to women restricted educational opportunities are rarely examined.

However, even when individual factors are taken into account, contextual factors are often overlooked. This can be seen in a study by Weitzman (2018) which proposed education-based interventions for women experiencing IPV without considering the societal norms which hinder access to education. These norms, such as rigid gender roles within the home and cultural norms about women's autonomy, significantly constrain educational opportunities and in turn heighten vulnerability to IPV. For IPV research to be truly effective, it must adopt a more holistic picture of IPV that addresses all the factors that may expose immigrant women to IPV. Consequently, this could inform a comprehensive and preventive approach in which the risk factors exposing immigrant women to IPV can be tackled simultaneously (Rollero, 2020).

Some intervention and prevention programs may tend to focus on individual and relational drivers of IPV because they are built on research that largely addresses only these factors (De La Rue et al., 2017).). Yet, several factors increase immigrant women's vulnerability of IPV such as cultural beliefs, financial dependence, language barriers, settlement issues, and a lack of knowledge about community resources (Erez & Harper, 2018). To better account for the intersection of these risk factors, this study will draw on the Social Ecological Model (SEM) (Heise, 1998) to ensure a holistic perspective of IPV throughout the thesis. The use of SEM as a framework will be explained in Chapter Three.

1.5. Interventions for IPV

In examining interventions for IPV, it is essential to consider those that have been available for mainstream populations in Canada. These interventions are available to the mainstream population but do not directly target MEIW. This section summarizes the main interventions available in Canada's National Capital Region. There are different types of interventions targeting women who experience IPV during the perinatal period including IPV screening, safety assessment, and treatment options. The following paragraphs explain some of these available resources.

The Ottawa Hospital offers the Sexual Assault and Partner Abuse Care Program. The program is staffed by specialized health professionals who are available at the hospital 24 hours a day, 365 days a year. It is designed to provide support, health care, and advocacy to victims of IPV. The program typically focuses on offering comprehensive care for survivors of IPV to address both the immediate and long-term needs of the survivors. It offers services such as injury assessment, documentation and treatment of injuries, referrals to specialists, head injury clinic, orthopaedics, ear/nose/throat, neurology, crisis counselling, safety planning and risk/threat assessment. It also offers mental health assessments with screening for depression and post-traumatic stress disorders (SAPACP,2025).

In Ottawa, there are six key publicly funded shelters for abused women and their children such as Interval House, Nelson House and Harmony House. These shelters are essential resources that provide temporary safe accommodations, emotional support, and advocacy services for women fleeing IPV. Moreover, they offer access to counseling, legal assistance, and help with finding long-term housing. These shelters also offer programs aimed to help women

rebuild their lives including but not limited to job training, childcare access, and financial literacy support (CNEO,2025). In addition to these shelters, Ottawa has several other nonprofit organizations and community-based resources, including telephone hotlines, support groups, and outreach programs, all of which contribute to the network of care for women experiencing IPV and to help them regain independence and safety. For example, The Western Ottawa Community Resource Centre (WOCRC) offers a variety of services to support women who are experiencing IPV such as counselling, housing, and referrals (WOCRC,2025). Additionally, Ottawa Victim Services (OVS) which is a not-for-profit organization offers counselling, peer support and housing (OVS,2025). Finally, Ontario Works is a social assistance program in Ontario, Canada, designed to provide financial assistance to those in need while encouraging employment and self-reliance, including women fleeing IPV (Ontario, 2025).

Although these interventions are generally available for many individuals, there are critical considerations when applying them to MEIW during the perinatal period. They may not fully address the unique needs of MEIW. Cultural differences, language barriers, immigration status, and IPV complexity for this group may affect the effectiveness of these interventions. For example, while routine IPV screening may work in some situations, it may need to be adapted to respect cultural sensitivities and integrate community-based resources that resonate more with MEIW. Furthermore, IPV interventions might not always consider the specific cultural and religious beliefs of MEIW, which can affect their willingness to engage with available services. This disconnection between mainstream interventions and the specific needs of MEIW highlights a significant gap in delivering inclusive, accessible, and effective support for this population. The

need for culturally responsive interventions will be discussed in chapter three and six of this thesis.

1.6. Statement of the Problem

Estimates of IPV incidence during the perinatal period vary widely and are strongly associated with social and economic factors, sociodemographic characteristics, and gender inequalities (Reichel, 2017). A Canadian study reports that the prevalence of physical intimate partner abuse ranged from 0.9% to 30.0% during pregnancy (Taillieu & Brownridge 2010). Further, a Canadian national research study by Kingston et al. (2016) focusing on pregnant women found that 10.5 % experienced abuse in the two years before their interview, with 4.3 % categorizing that abuse as 'severe'. It is noteworthy that the perinatal period is a time of greater risk for IPV, as it is a significant transition that can cause individual, relationship, and family upheavals (Meleis, 2010; Mercer, 2004).

Immigrant women in Canada are no exception to IPV occurrence (Adams & Campbell, 2012). Culture plays an essential role in IPV against women among immigrant women, including male entitlement or ownership of women, strict gender roles, and interpersonal IPV tolerance (Bhabha, 2012). In addition, some cultural beliefs place women in a lower social class than men, in which women have no freedom, respect or financial security (Niroomand, Gholizadeh, & Baird, 2024). The immigration process also increases these women's vulnerability to IPV and worsens their life situation during the perinatal period (Tavrow et al., 2023).

However, the knowledge about IPV in immigrant communities is limited. There are fewer recent studies about the prevalence of IPV for immigrant women during the perinatal period. Underlying issues such as IPV's prevalence, nature, causes, consequences and coping

strategies are still under-researched (Shalabi et al., 2015). According to Statistics Canada (2017), there are no local data on the impact of IPV on immigrant women during the perinatal period, specifically, among MEIW in Canada. Studies have confirmed that IPV is often not identified by victims, and they are reluctant to report it as a crime (Logan et al., 2015). Due to gender-specific cultural beliefs, women may also believe that IPV committed against them was their fault (Boy & Kulczycki, 2008). For example, immigrant women from the Middle East often hesitate to disclose IPV to avoid social stigma. IPV in the Middle Eastern community is often considered a private issue and is typically addressed within the family. Sharing information about IPV can damage the family's reputation (Moshtagh et al., 2023). In Iraq, IPV is widely accepted as a way to resolve marital conflicts and women do not have the right to report or talk about it (Tran, Nguyen & Fisher, 2016). The outputs from empirical research are believed to be a driving force in proposing possible solutions to overcome this problem (Feder et al., 2011).

By focusing on MEIW, this study aims to contribute to addressing the problem of IPV by examining the multiple factors that shape their experiences during the perinatal period. Despite the growing awareness of IPV during the perinatal period, there remains a lack of empirical studies focused specifically on MEIW and the intersections of their experiences of IPV. This gap may be partly due to cultural barriers and dominant gender norms, such as beliefs in male superiority, that contribute to the silencing of women's experiences and limit research access to this population. These normative constructions limit the production of new knowledge and hinder a deeper understanding of IPV. This research aims to amplify the voices of perinatal MEIW and provide them with a safe space to share their experiences, ensuring that their experiences inform future research and interventions.

1.7. Research Purpose and Objectives

This study aims to explore the experiences of IPV among MEIW during the perinatal period while living in Ottawa. To shed light on the problem, the following research objectives were addressed.

1. To describe how Middle Eastern immigrant women define intimate partner violence
2. To examine the factors influencing Middle Eastern immigrant women's experiences of IPV during the perinatal period.
3. To discuss the impact of IPV on abused women, their infants, their other children, family, and society.
4. Identify IPV interventions and strategies that are culturally and contextually responsive to the needs of MEIW experiencing IPV during the perinatal period.

1.8. Significance of the Study

IPV during the perinatal period amongst MEIW demands careful attention and targeted intervention. This study centers the voices of perinatal MEIW, providing evidence to inform practice, research, and policy. This will be valuable information for perinatal health care professionals, including nurses and other social and community workers, who are required to provide culturally responsive interventions to immigrant women (Khanlou et al., 2017). In addition to health care professional community agencies and frontline workers play a crucial role in supporting MEIW experiencing IPV. These agencies often provide resources, legal and social support, and act as critical access points for services, particularly for women facing language barriers, undocumented status or social isolation.

A key contribution of this thesis will be its focus on the intersection between IPV, perinatal vulnerabilities and immigration status. To have well-developed IPV interventions for MEIW, it is essential to study the risk factors of IPV and find out how these risk factors play a role in creating unique IPV experiences for these women. This study accounts for the ways risk factors of IPV may intersect with other factors related to the immigration process and host country, such as undocumented status and social isolation.

Additionally, this study will bring attention to the complex nature of IPV among MEIW during the perinatal period. The complexity of IPV within this context results from the intersection between the associated factors of IPV and the axes of power in the host countries. By applying the SEM (Heise,1998), this research study will contribute to a more comprehensive understanding of IPV among MEIW by uncovering the multiple layers of their experiences, specifically during the perinatal period.

This research will add to current practice knowledge regarding various risk factors that may increase IPV vulnerabilities for MEIW. This can then contribute to creating more comprehensive interventions that better serve these communities. Current IPV research rarely asks women about their IPV experiences while employing the intersectionality lens or seeking an understanding of how different oppressions exacerbate these experiences (Ahmadzai, Stewart & Sethi, 2016). Including immigrant women's voices in this research will provide significant insight into IPV.

While the SEM provides a structured lens to analyze how factors at individual, relational, community and societal levels shape IPV experiences, intersectionality is employed as complementary a lens to examine how overlapping systemic barriers (e.g. gender, race,

immigration, language and cultural norms) interact within these levels. Using SEM as the analytic lens and intersectionality as the critical lens allows for A more nuanced and multidimensional understanding of IPV among MEIW.

Further, as a Middle Eastern immigrant woman, I believe that MEIW, as members of an ethnic minority group that has been historically marginalized, have the right to share their experiences and be heard. Given this perspective, it is also necessary to acknowledge my positionality as a researcher. The following section discusses my personal and professional background and how it informs my approach to this research.

1.9. Situating the Researcher

My perspective on IPV among the immigrant population is informed by working and providing services to MEIW in Jordan while I was a nurse in a hospital there, and in Canada, while I was working as a crisis counsellor in a non-profit organization. The IPV experiences among MEIW are increased by the challenges of settlement in the new country, and the lack of culturally responsive services and stigma, which makes fleeing IPV a complex process. Yet, MEIW specifically possess considerable strength and show significant resilience. This inspired me to reflect on my own personal and professional experiences, including how these beliefs inform my nursing practice. Coming from the same culture and background as study participants and living similar experiences of immigration and settlement, I developed a good understanding of immigrant women’s challenges, cultural strengths, and the multiple oppressions they may encounter. Additionally, I respect MEIW's experiences and believe that by communicating and sharing their experiences, they can construct new knowledge that informs more culturally responsive research and practice interventions. These personal and professional experiences led

me to focus my research on IPV among MEIW during the perinatal period, as I wanted to move beyond providing individual support to contributing to broader structural change. My background gives me unique insight into the cultural nuances shaping these women's experiences, which in turn shaped my research question and objectives and choice of theoretical frameworks.

Based on my background and my professional knowledge of IPV, I approached this study with the following assumptions:

- My personal experience impacts how I view MEIW's experiences as well as how it contributes to my desire to give these women a voice.
- My health professional background contributes to advocating for culturally responsive interventions.
- My understanding of intersectionality and the SEM highlights the different and multilevel risk factors of IPV including different oppressions affecting the immigrant women in host countries.
- My strong commitment to social justice, coupled with an awareness of the cultural, structural, and systemic barriers faced by MEIW, drives my desire to improve their experiences and advocate for meaningful change and the use the principles of critical theory within an intersectionality lens.

By positioning myself within this research, I acknowledge the ways in which my background, experiences, and assumptions shape my approach. This study is not just an academic endeavour but a personal commitment to raising the voices of MEIW and informing the development of interventions that recognize the complexities of their lives. By drawing on

my lived experience and professional knowledge, I aim to contribute to a more culturally responsive understanding of IPV during the perinatal period. Ultimately, this research seeks to bridge the gap between policy, practice, and the lived realities of MEIW during the perinatal period, ensuring that their experiences inform culturally responsive interventions.

1.10. Summary of Chapter One

In this chapter, I have outlined the context, purpose and significance of this study, highlighting the urgent need for research on IPV among MEIW during the perinatal period. Finally, I have situated myself as a researcher, acknowledging my perspective and its influence on the study. In the next chapter, I will review the existing literature, identifying the various dimensions of what is already known about IPV in this context and where critical gaps remain. This will provide the foundation for the study's research questions, theoretical framework, and methodological approach.

Chapter Two - Literature Review

2.1 Introduction

This chapter reviews the existing literature on IPV among MEIW during the perinatal period. It provides an overview of key themes, including the prevalence, risk factors, coping strategies, and barriers to seeking support. This review provides a basis for this thesis by identifying gaps in the current research on the IPV experiences of MEIW during the perinatal period. The chapter opens with an outline of the methods used to conduct the review, after which the findings of the review are set out in two parts: firstly, a summary of the characteristics of the ten studies included in the review and secondly, a thematic synthesis of the papers. Next, the gaps in the reviewed literature are considered, and future directions for research are set out. The chapter ends by exploring some of the implications for future research.

2.2 Literature Review Methodology

The literature review for this study was based on a scoping review method using the guidelines of the Joanna Briggs Institute (JBI) and the scoping review framework set out by Arksey and O'Malley (2005). This framework includes the following five steps:

1. Specify the research questions
2. Identify relevant databases and literature
3. Select articles
4. Make a chart of findings
5. Collate, summarize, and report the results

This scoping review aims to map, clarify, and develop an understanding of IPV among MEIW during their perinatal period. It seeks to identify the IPV experiences including but not limited to risk factors, coping strategies, and help-seeking barriers among MEIW during the perinatal period.

The research questions for this scoping review are as follows.

1. What are the experiences of MEIW facing IPV during the perinatal period?

The sub questions are:

2. What is the nature and extent (including concepts, ideas, topics, characteristics, contexts, and methods used) of IPV research among MEIW during the perinatal period?
3. What are the gaps in IPV research for this population?
4. What are the existing interventions to address IPV among this population during the perinatal period?

2.2.1 Search Strategy and Sources

Search strategies were developed by a University of Ottawa librarian and peer reviewed using the PRESS Peer Review of Electronic Search Strategies guideline for reviews. The keywords and search for scoping review are reported in Appendix A. The following electronic databases were searched:

- CINAHL (EBSCOHost)
- APA PsycInfo (OvidSP)
- MEDLINE(R) ALL (OvidSP)
- Embase (OvidSP)

- Web of Science
- Applied Social Sciences Index & Abstracts (ProQuest).

The selected electronic databases were chosen to ensure comprehensive, interdisciplinary coverage of literature relevant to IPV, reproductive health, immigrant populations, and perinatal care. For example, CINAHL was included for its focus on nursing and allied health literature (Fishel, 2008), while APA PsycInfo provided access to psychological research essential for understanding the mental health impacts of IPV. MEDLINE and Embase were selected for their extensive public health content, including reproductive and perinatal health. Web of Science offered multidisciplinary coverage and citation tracking to identify influential studies and Applied Social Sciences Index & Abstracts (ProQuest) contributed valuable insights from social work, policy, and sociology. Together, these databases allowed for a thorough and holistic examination of the research topic.

Each database was searched for the concepts of "perinatal," "immigration," and "IPV" using a combination of subject headings and keywords. Search terms, synonyms, and terms specific to each database were searched in the multipurpose set of fields. Drafting of the search strategy was completed by two independent researchers. Other sources were also searched such as Google Scholar. Handsearching references from chosen articles was also done. Also, a manual search of key journals, such as Partner Abuse and SAGE journals (health and nursing, sociology), assisted in detecting additional studies to ensure no relevant studies were missed.

2.2.2 Study Selection Process

Articles retrieved by the search were uploaded to Covidence (Better Systematic Review Management) and the titles and abstracts were screened according to the inclusion and exclusion

criteria for scoping review in Appendix B. Articles that met these criteria were advanced to full-text screening, where the same criteria were applied. Studies were eligible for inclusion if they reported primary research employing quantitative, qualitative, or mixed methods designs. Commentaries and editorials were excluded. Studies had to focus on MEIW in their perinatal period (pregnancy, prenatal, or postpartum). Commentaries and editorials were excluded because they do not present original research data. Unlike primary research articles, commentaries and editorials typically offer opinions, reflections, or discussions rather than systematically collected and analyzed evidence. Excluding them helps ensure that the findings of the review are grounded in empirical research, which strengthens the credibility and rigor of the synthesis.

The review was also designed in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analysis Extension for Scoping Reviews (PRISMA-ScR) procedures. The PRISMA-ScR Diagram presents the flow of information and the process throughout the stages of the review and can be found in Appendix C.

2.2.3 Data Extraction and Analysis

Data were extracted from the retained studies. Related data were extracted in the following categories:

- General article information, including author name, article title, and publication year
- Country, study context, study design, and sample size
- Population features including perinatal characteristics such as prenatal health and postnatal care
- Methods of collecting and analyzing data
- Theoretical perspective utilized

- Social Ecological Model level
- IPV issues discussed, such as risk factors, coping strategies, etc.

The data extraction table was created with guidance from other IPV scoping reviews in the same field (Peters et al., 2020; Pollock et al., 2021).

A thematic mapping approach was used to synthesize the data for this scoping review taking into consideration the research questions. As described by Etowa et al. (2024), thematic mapping is a method used to systematically integrate and interpret qualitative findings across multiple studies. This approach involves identifying, organizing, and analyzing key themes within the data through a narrative lens, allowing researchers to tell a coherent story about the patterns and trends emerging from the studies. By focusing on recurring themes, the narrative thematic synthesis provides a structured yet flexible way to examine complex, multilayered phenomena, often revealing insights about how various themes intersect and interact within broader social or contextual frameworks.

The final stage of this scoping review process was summarizing and reporting the results. I developed a preliminary synthesis by grouping research studies that discussed similar concepts into a tabular format. Using conceptual mapping, I connected multiple pieces of evidence from individual studies to emphasize key concepts and ideas (Green, Johnson, &Adams, 2006; Popay, 2006). Using Excel, I extracted the data in a structured manner to systematically map existing literature and identify areas that are underexplored. Then a narrative thematic analysis was completed, and three themes emerged from this literature review related to IPV among MEIW during the perinatal period including A) Forms of IPV , B) IPV Risk factors and Help Seeking Barriers and C) Coping and Help seeking strategy. The following section will explain the results

of this scoping review in two main sections, first in 2.3.1 the Characteristics of Included Studies and secondly in 2.3.2 The Narrative Synthesis.

2.3 Results

2.3.1 Characteristics of Included Studies

The scoping review included ten studies (Damra 2022; Damra & Abujilban, 2022; Daoud, 2021; Daoud, Sergienko & Shoham-Vardi, 2017; Hammoury et al., 2009; Hammoury and Khawaja 2008; Khawaja et al. 2008; Mishkin, Ahmed & Maqsood, 2022; Ozturk, 2019; Ozturk and Nelson-Gardell, 2023). While there was no time limit for this search, all 10 articles were published between 2008 and 2023, with three quarters (n=7) of the 10 published after the year 2015. The newer published articles add to the relevancy of the research collected. Of the 10 articles, the largest number originated in Middle Eastern countries namely Lebanon, Jordan and Israel (n=8) indicating a significant focus on IPV within this regional context. However, it is noteworthy that there is a lack of studies addressing IPV among MEIW during the perinatal period outside of this geographical scope, with only two studies originating from the USA. This limited representation suggests a gap in the research concerning the experiences of Middle Eastern women with IPV in broader international contexts or among diaspora populations.

In terms of study settings, over half (n=7) were conducted in health clinics (i.e., prenatal care clinics, maternal and child health clinics and a community health center). The remainder (n=3) were set in non-profit organizations and shelters. Although the studies provide valuable insights into IPV through settings such as health clinics, shelters, and non-profit organizations, focusing only on these contexts limits our understanding of the full range of IPV experiences. Many women may experience IPV in other settings such as their homes which is not captured in

these studies. For example, the experiences of MEIW who visit these settings may vary considerably from those who do not seek help, those who only access family support, or those who do not engage with any services. It is very important to recognize that each of these limited settings comes with limitations related to sample bias, underreporting or over reporting of IPV, and the narrow focus on certain types of IPV or outcomes. This restriction in the variety of research settings draws attention to the need for more varied research environments to gain a thorough understanding of the multifaceted nature of IPV across different social, cultural, and institutional contexts such as domestic, educational and religious settings. These limitations will be acknowledged and addressed in this study and related recommendations for broader IPV research or intervention will be proposed.

Among the study populations, four studies specifically targeted pregnant women, while the remaining studies were conducted during the perinatal period without specifying the stage of the perinatal period (i.e., prenatal, peripartum, or postnatal). Nine studies are peer reviewed articles, and one is a PhD thesis. There are four studies consisting of qualitative evidence (n=4), the rest (n=6) are quantitative in nature. The quantitative studies were generally cross-sectional, employing surveys to collect data. Interviews were the only data collection method in the qualitative research. Nine studies focused on the perspective of MEIW, and the last study highlighted both MEIW and the healthcare providers. The quantitative studies primarily employed logistic regression or statistical analyses for their data analysis, while the qualitative studies exclusively used thematic analysis to interpret their findings (Maguire & Delahunt, 2017). The predominance of quantitative studies presents a limitation in capturing the experiences related to IPV among these women. Qualitative studies would allow for a deeper

understanding of how IPV experiences evolve, particularly among MEIW who may face complex circumstances.

The studies aimed to investigate various aspects of IPV among MEIW. Three studies sought to understand the factors influencing MEIW's decisions to seek professional help for IPV and examined the triggers and perpetuating factors of IPV against them in refugee camps in Jordan. Other studies assessed the effectiveness of interventions, such as group psychodrama, in reducing IPV and enhancing the quality of life for MEIW in these camps. A few studies investigated the prevalence, types, and risk factors of IPV, particularly during pregnancy, among MEIW in Lebanon and Iraq. Additionally, two studies focused on the experiences of MEIW in the United States by exploring their coping strategies in dealing with IPV. Overall, the ten studies collectively intended to gain deeper insights into the prevalence, risk factors, impacts, and coping mechanisms related to IPV among MEIW. These objectives show limited exploration of the intersecting factors impacting IPV such as immigration status, race, ethnicity, and socioeconomic status. All the studies focused on individual factors, overlooking the complexity of IPV experiences among these women.

These results directly address research question 2 (by mapping the scope and characteristics of IPV research on MEIW during the perinatal period. They show that research is largely quantitative, regionally concentrated, and conducted in clinical settings, leaving significant gaps in qualitative narratives and research outside the Middle East.

2.3.2 Thematic Synthesis of Research on IPV Experiences among MEIW during the Perinatal Period

Through thematic analysis and synthesis of the reviewed studies, three themes were generated:

- Theme A) Forms of IPV
- Theme B) Risk Factors and Help Seeking Barriers
- Theme C) Coping and Help Seeking strategies

While the themes generated by this literature review may not be specific to MEIW living in Ottawa, they highlight the gaps in knowledge about MEIW's experiences in general around the world including Ottawa, which this literature review seeks to address.

2.3.2.1 Theme A: Forms of IPV

Across the reviewed studies, IPV manifested through intersecting physical, sexual, psychological, and controlling forms of abuse, often reinforced by patriarchal power structures, migration-related vulnerabilities, and cultural expectations of silence. Multiple forms of IPV were presented and discussed across the studies. Physical violence, including slapping, beating, and threats of harm, was consistently reported but often under-acknowledged during pregnancy due to social taboos and normalization. In Lebanon, 11.4% of women experienced physical violence during their current pregnancy, while lifetime exposure was substantially higher (Hammoury & Khawaja, 2007). Similarly, Palestinian refugee women described being beaten, dragged, and slapped by husbands or in-laws (Hammoury et al., 2009). Although physical IPV sometimes declined during pregnancy, it remained a core mechanism of male control, frequently co-occurring with other forms of abuse.

Sexual abuse, including sexual coercion and marital rape, emerged as a recurrent and pervasive theme. In a sample of 349 women, 26.2% reported sexual coercion in the past year (Hammoury & Khawaja, 2007). Forced intercourse was significantly associated with low education and fear of the husband (Khawaja & Hammoury, 2008). In refugee contexts, sexual violence intersected with displacement-related power asymmetries and women's dependency on their partners.

In addition, psychological and emotional abuse were widely discussed in the reviewed studies. Emotional violence, manifested through insults, humiliation, intimidation, and fear, was among the most prevalent and enduring forms of IPV. Approximately 16% of women experienced emotional abuse, typically characterized by persistent fear of their husbands (Hammoury & Khawaja, 2007). MEIW also described experiences of psychological manipulation, threats of divorce or deportation, jealousy, and social isolation, which eroded their confidence and reinforced obedience (Damra & Abujilban, 2022; Daoud, 2021). Emotional abuse often preceded or accompanied physical and sexual violence, operating as a central mechanism of control and domination.

Controlling and coercive behaviours were also central to the IPV dynamics identified in all studies. Male partners restricted women's mobility, access to healthcare, financial independence, and contact with family or social networks. Finally, economic abuse was described both as a risk factor and as a form of IPV. Women reported being denied financial autonomy, prevented from working, or having their income controlled by their partners (Daoud et al., 2021). This financial dependency was further magnified in displacement settings, where access to employment, banking systems, and legal protections was limited. The lack of economic

independence frequently forced women to remain in abusive relationships as a means of survival (Damra & Abujilban, 2022).

These results directly address research question 1 (What are the experiences of MEIW facing IPV during the perinatal period?) by demonstrating that MEIW experience multiple forms of IPV during the perinatal period.

2.3.2.2 Theme B: IPV Risk Factors and Help Seeking Barriers

Multiple studies acknowledge cultural norms as a driver of IPV and as a barrier to seeking help for MEIW during the perinatal period. Cultural norms in this context mean the beliefs, values and morals that people live by (Gelfand & Jackson, 2016). They also include the shared expectations and principles that guide people's behaviours within social groups and communities. Cultural norms can play a significant role in shaping the occurrence, perception, and response to IPV, according to the reviewed studies. Notably, gender inequality reinforced by cultural norms was identified as a relevant factor for women experiencing IPV in a range of papers (Daoud, 2021; Daoud, Sergienko & Shoham-Vardi, 2017; Hammoury & Khawaja, 2008; Mishkin, Ahmed & Maqsood, 2022; Ozturk, 2019). In many Middle Eastern cultures some women are raised in patriarchal societies where men are used to having more privilege and power in society. At the societal level, destructive gender and cultural norms that normalize IPV and power inequities in marital relationships are positioned in the reviewed papers as key drivers of IPV (Daoud, 2021).

In order to fully understand the IPV in Middle Eastern societies, it is essential to consider how gender roles and cultural norms shape women's experiences and responses to violence. As Daoud, Sergienko, and Shoham-Vardi (2017) argue, these factors influence not only the

perception of abuse but also the willingness and ability to seek help. Supporting this, Ozturk and Nelson-Gardell (2023) found that in some Middle Eastern contexts, IPV may be culturally normalized or accepted, which can further silence victims and hinder effective interventions. Building on this, Mishkin, Ahmed and Maqsood (2022) also note that in Middle Eastern culture, women who have lower levels of education and are unemployed will be more dependent on their husbands for their financial needs, and as such, they will be more vulnerable to IPV. This also may lead to social isolation, making it more difficult for these women to seek help or break away from an abusive relationship.

These types of socio-demographic factors - including age, level of education and unemployment - have consistently been recognized as significant risk factors for IPV in Middle Eastern marriages. For example, Ozturk's (2019) work shows that the risk of IPV in young MEIW is higher than that of their older counterparts. Young MEIW may experience the highest rates of IPV, with rates declining with increasing age (Khawaja & Hammoury, 2008). Young women have certain contextual risk factors that influence their vulnerability to IPV compared to older women, including limited autonomy in making decisions about their lives and lower financial independence. Furthermore, young immigrant women have less experience and may get involved in volatile relationships in which they confuse control and love. They may also experience violence in a relationship due to an arranged marriage (Khawaja et al., 2008).

Also, immigrant women in the younger age groups are most likely to attempt to flee violent relationships, which increases their vulnerability to IPV, as the abuser feels that his control is lessening and resorts to more violence in his effort to stop the object of his obsession from running away. This example helps us to understand the association of interpersonal-related

factors with IPV during the perinatal period. Khawaja et al. (2008) discussed the impact of the perinatal period itself on increasing the IPV among these women. For example, undesired pregnancy and gestational age were identified as key risk factors for sexual abuse. Another study by Hammoury and Khawaja (2008) also identified pregnancy itself as a risk factor for IPV, suggesting that the perinatal period can intensify relationship tensions and power imbalances, thereby increasing the risk of IPV.

Two of the reviewed studies argue that having a social support system, where women can access help, engage in social interactions, and participate in community activities, serves as a protective factor against IPV (Hammoury et al., 2009; Oztruk,2019). MEIW may have limited social support systems in their host countries, positioning social isolation as a risk factor for IPV (Hammoury et al., 2009; Oztruk,2019), and suggesting that MEIW experiencing IPV are likely to report further social isolation than non-immigrant abused women (Hammoury et al., 2009).

Social support plays many important roles in MEIW's lives. Firstly, family or friends serve as a source of social cohesion in which women can be heard and receive emotional support and solutions if needed, which may decrease stressful life events. Social support, in this case, serves as an outlet for the women to discuss IPV and in challenging situations in which women can develop better coping and partnership strategies. Also, family and friends can provide some economic and social opportunities to help these women integrate into the community. MEIW who integrate and have social connections in the community are less exposed to IPV(Ozturk, 2019). However, when MEIW's need for social connections is not met, they are at risk of IPV victimization (Ozturk & Nelson-Gardell, 2023). Secondly, social support can include instrumental and family support, such as caring for children and helping with household chores,

building a trusted connection through which stressful events can be better addressed, and IPV exposure can be minimized. Thirdly, the family can provide a safe environment for women when needed. MEIW may have no relatives or social support in host countries, resulting in more exposure to IPV. Ultimately, at the community level, the lack of social support from institutions and social structures in the community has a negative influence on abusive relationships.

Linguistic differences may intersect with social isolation and hinder women's ability to seek help and access services (Oztruk,2019). At the interpersonal level, language barriers may further restrict immigrant women's ability to know the resources available in host countries, hindering them from seeking help. For example, language barriers may prevent immigrant women from seeking legal protection from their abusive partners or communicating their experiences with health care professionals (Oztruk, 2019). In addition, MEIW's limited ability to use the host country's language makes it easier for their partners to take control and authority over the family's issues, and partners may become the only connection to outside society. The combination of these elements places MEIW in vulnerable situations that may lead to IPV. Language barriers for MEIW may create an acculturative stress environment.

It has been found that women with limited proficiency in using the new language in the host country are more exposed to IPV (Oztruk, 2019). In addition, it is very difficult for these women with limited English ability to share their concerns with others and decide which resources and services are available in community centers or other local organizations. These women are likely to rely on their family members, partners or community members who speak their language to assist in speaking, reading, and writing, which may make it very challenging for them to seek help or leave an abusive relationship. Language barriers hinder MEIW's ability

to access services. They may be denied access to programs in community organizations because the organization may not provide services in their languages (Ozturk & Nelson-Gardel, 2023). Also, the woman's inability to communicate or seek help regarding IPV can be employed by the abuser who can take advantage of abusing his female partner with no fear of legal or formal consequences. Ultimately, language barriers and the inability of the women to access resources reinforce the abusive partners' ability to practice their power to control the women.

These results directly address research question 1 and research question 3, as they highlight key risk factors contributing to IPV among MEIW during the perinatal period and the barriers preventing them from seeking help. The evidence suggests that addressing social isolation and language barriers could improve these women's help-seeking behaviours (Mishkin, Ahmed & Maqsood 2022; Ozturk,2019).

2.3.2.3 Theme C: Coping and Help-Seeking Strategies

Across the reviewed studies, MEIW navigate IPV through a mix of informal, formal, and survival-oriented strategies that are deeply shaped by culture, migration status, and structural constraints. One of the primary coping strategies used by MEIW involves drawing on informal, faith-anchored, and social supports. MEIW may first seek comfort and guidance from trusted friends or relatives who provide emotional and practical assistance, while simultaneously relying on faith, prayer, and spirituality as central sources of strength, meaning, and endurance. These forms of informal and faith-based coping help buffer the effects of isolation, fear, and depressive symptoms, enabling MEIW to maintain day-to-day functioning despite ongoing abuse. MEIW also engage in personal practices (e.g., prayer/meditation, creative activities, exercise) that restore self-worth, reduce anxiety, and support identity reconstruction after abuse (Ozturk,2019;

Ozturk & Nelson-Gardell, 2024). The same two studies discussed the formal help-seeking under escalation (police, shelters, counseling, legal services) that were used by MEIW. When violence intensifies, some women access shelters, call police, seek protection orders, or engage in counseling and group programs, actions associated with greater safety, knowledge of rights, confidence, and a renewed sense of agency (Ozturk, 2019; Oztruck & Nelson-Gardell, 2024). A structured therapeutic approach, psychodrama, demonstrated significant reductions in physical/sexual, psychological, and controlling violence, and improved physical and mental health and social relationships among Syrian refugee women, highlighting the value of group-based, trauma-focused interventions in displacement contexts (Damra, 2022).

These three themes show that MEIW's perinatal IPV experiences are multi-layered: they face overlapping forms of abuse, shaped by intersecting socio-demographic, cultural, migration-related and structural risk factors, and respond through a combination of informal, faith-based, and formal coping and help-seeking strategies. At the same time, the reviewed studies tend to prioritise prevalence estimates, risk factor profiling, and broad descriptions of services over rich, in-depth accounts of how MEIW themselves understand different forms of IPV, negotiate cultural and structural constraints, and experience perinatal-specific vulnerabilities in their daily lives. This imbalance highlights important conceptual, methodological, and contextual gaps in the current literature, which the next section will critically examine. This theme addresses question number one and four.

2.4 Gaps in the Literature and Future Directions

It must be acknowledged that this review is based on a very small set of studies. The decision to move forward with the review, despite the paucity of available literature, was taken to

acknowledge and tackle the critical gaps that exist in this field. To ensure sufficient literature appears across this thesis, significant engagement with a wider field of IPV research is presented in the final chapter.

2.4.1 Gaps in Research Populations and Settings

Through this scoping review, it is clear that the included studies only conducted their research within the United States of America, Lebanon and Jordan. Three studies focused on Palestinian refugees in Lebanon and two on Palestinian immigrant women in Jordan and Israel. The two studies conducted in the United States included immigrants from different Middle Eastern backgrounds. The studies conducted in Lebanon were led by the same research teams, who utilized the same dataset to explore various dimensions of the issue, resulting in multiple publications that examine the data from different perspectives. While this approach is deemed to be important in bringing different concerns to the surface without having to gather new data, it has been found that the perspectives in these studies are very similar (Hammoury et al., 2009; Hammoury & Khawaja, 2007; Khawaja & Hammoury, 2008). As such, I suggest that it is important to conduct more studies in the immigrant context while presenting different perceptions and investigating IPV issues during the perinatal period such as IPV perception, consequences and the intersection of multiple risk factors. Additionally, all studies included in this review did not consider the intersectionality of perinatal IPV among MEIW where multiple factors (e.g., socio-economic status, immigration status, access to healthcare, cultural norms, etc.) interact and influence the experiences of IPV during the perinatal period.

While IPV research in general has a good amount of attention, the research focus on IPV among MEIW during the perinatal period is scarce. The most common topics examined were the

prevalence of IPV and the risk factors of IPV. Most of the research was quantitative and cross-sectional in nature. Eighty percent of the studies were conducted in Middle Eastern countries and examined the experiences of immigrant or refugee women within those regions. A particularly significant gap revealed through the inclusion and exclusion criteria of this scoping review is the lack of intervention-based research: only one study in the entire sample evaluated an actual intervention targeting IPV in the perinatal period. Although the study by Damra (2022) evaluated an intervention using a quantitative approach, it lacked attention to culturally responsive practices, which are essential when working with immigrant populations. This research had a very small sample as well as having no published follow-up on its interventions. All these factors decrease the utility of the research and make it difficult to draw conclusions to clearly inform the interventions for IPV settings or policy. Intervention research and specifically culturally responsive interventions is therefore a priority to determine the best ways in which IPV may be addressed among these women. Ultimately, stronger evidence regarding effective and culturally responsive interventions among these women may be most useful to help stakeholders and decision makers to tailor policies specifically for this population. For example, federal-and provincial-level governments in Canada should establish a comprehensive framework that considers the diverse cultural needs of these women, such as developing culturally tailored resources and support systems and engaging these women in designing IPV programs.

MEIW experiencing IPV are underrepresented in the research, especially through the different stages of their lives. Given the complex challenges that this population may face including immigration, and language barriers compounded by a lack of culturally responsive interventions, it may be especially crucial to devote research efforts to learn how these women

experience intersectional risk factors that complicate their IPV experience. Furthermore, there is a need for researchers to clearly report these factors using the intersectional lens, specifically for these women in order to highlight their experiences.

There is also a lack of research investigating IPV among MEIW during the perinatal period in Canada. Only five studies in this review used qualitative research to address the IPV issues for the perinatal population, three of them were conducted in Lebanon and the last two were conducted in the USA (Hammoury et al., 2009; Hammoury & Khawaja, 2008; Khawaja & Hammoury, 2008; Oztruk, 2019; Oztruk & Nelson-Gardell, 2023). Canadian research reveals a noticeable lack of attention to IPV among immigrant women during the perinatal period, which may be linked to limited awareness, training, and knowledge among service providers who interact with this population. Ultimately, this population's needs are falling through the cracks as no research addresses their needs and challenges. More Canadian research needs to be in place to design and test interventions for IPV in this context.

2.4.2 Methodological Weaknesses in Existing Studies

In this review, only five studies used semi-structured interviews as a data collection method. Interviews were mainly to hear the voices of MEIW in these reviewed studies. For a long time, immigrant women's voices were ignored, especially in IPV research, which further marginalized this group of women. Meleis and Im (1999) describe marginalization as, "the extent to which they (people) are stereotyped, rendered voiceless, silenced, not taken seriously, peripheralized, homogenized, ignored, dehumanized and ordered around" (p. 96). I suggest that immediate consideration should be placed on conducting research studies that allow the voices of abused MEIW living in the Ottawa to be heard through interviews and community focus group

discussions. Currently, little is known about the dynamics that are applied in their lives, and thus, prevention and intervention endeavors might not be fully responding to the existing barriers and needs. In-depth interviews will support the women's awareness and understanding of their situations which may enhance their sense of control over their past, present, and future. Using a case study approach could help provide a comprehensive understanding of these experiences (Bassey, 1999). My thesis will employ a case study approach and interviews, giving the voice for these women to share their IPV experiences (Ayres, Kavanaugh & Knafl, 2003; Crowe et al.,201; Gerring, 2004).

In this review, I examined the studies that describe multiple risk factors in which various dimensions of IPV were studied in association with the immigration experience. The reviewed studies presented a broad understanding of IPV experiences deemed necessary to reflect the different facets of IPV risk factors among MEIW. In general, these risk factors fall into three broad categories: interpersonal, community and society levels. These three categories align with the layers of the social-ecological model (SEM) (Heise, 1998; Li et al., 2010), however none of the studies applied the SEM or any similar model to their data. Using a model like the SEM helps in understanding the range of factors that place these women at risk for IPV by highlighting the complex interplay between interpersonal, community, and societal factors.

The SEM allows the researcher to organize the range of factors that place people at risk into different layers. The SEM is crucial in framing IPV articles because it is important when a plan is needed to prevent and address IPV issues while employing a multilevel approach. As noted above, there was no implicit or explicit indication of the SEM in any reviewed studies. Given that many of the reviewed studies discussed the need for culturally sensitive IPV

interventions, I suggest that it would be very helpful to use the SEM as a comprehensive model which will allow the researcher to organize the associated factors of IPV within this population to thoughtfully inform the culturally responsive interventions.

Another methodological weakness in the reviewed studies was the lack of participant voices. I suggest that we need to have publications which engage community members to verify and validate the risk factors of IPV based on their experiences and other experiences that they witnessed. Community members can highlight the various factors that can lead to the multiple oppressions experienced by MEIW in Canada. The vulnerability of MEIW to IPV needs a special focus as it is a result of risk factors interacting with each other. Ultimately, an intersectional perspective of abused women and community members needs to inform the studies related to IPV to better find solutions to this problem. An intersectional approach is essential to this research, as individuals simultaneously experience both privilege and oppression depending on their unique social positions. These positions are shaped by the intersecting axes of identity such as gender, race, ethnicity, and other social determinants (Collins, 2000; Crenshaw, 1990).

2.4.3 Need for Intersectional Approaches

All the studies included in this review have identified individual characteristics (unemployment, age) and features of social context (social acceptability to IPV, cultural norms) that may be crucial for understanding IPV in Middle Eastern communities. These studies overlook the power dynamic and influence of social identities shaping individuals' living experiences, increasing their vulnerability and placing them at the margins of society. By not applying a multilevel framework, such as the SEM the studies failed to capture how factors at the at the different levels interact to shape MEIW's experiences of IPV.

None of the studies employed an intersectional approach or framework to examine the issue of IPV. Using intersectionality will help improve our understanding of how these social identities overlap and shape the individuals' experiences in society. We need to appreciate that no individual factor can explain the complexity of MEIW's experiences of IPV. Instead of examining characteristics such as age, socioeconomic status, cultural norms and previous experience of IPV independently, an intersectional lens views the impact of these factors on each other as a process within a structural context which includes intersecting and interlocking identities. IPV is a multidimensional problem for MEIW, and it has serious outcomes based on their overlapping social identities. Research should appreciate the multiple interlocking social identities of Middle Eastern women including race, class and gender, which in turn may affect their experience of IPV. Consequently, employing the intersectional lens in the reviewed studies was required to understand the IPV nature for this specific context.

2.4.4 Need for Culturally Responsive Interventions

None of the articles included in this review discussed the need for culturally responsive interventions. Culturally responsive interventions respect the unique cultural values, beliefs, and practices of these women, particularly when addressing sensitive issues like IPV. Without this consideration, the research fails to acknowledge the value of tailoring prevention and support programs to the specific needs of different cultural groups such as MEIW. These findings directly address research question 4 by showing that few interventions have been developed to address IPV among MEIW.

2.5 Implications for Future Research

The implications of this scoping review are primarily directed toward future research. Given the limited evidence base, methodological weaknesses, and lack of intersectional and culturally responsive approaches, future studies should focus on developing a more comprehensive understanding of MEIW's experiences of IPV during the perinatal period. Specifically, there is a need for studies conducted in diverse migration contexts (including Canada), using qualitative and participatory designs that consider MEIW's voices as well as applying intersectional approach. Employing models such as the SEM in research may also strengthen analytical depth by situating IPV within structural, community, and interpersonal contexts.

2.6 Scoping Review limitation

As the main form of literature review in this research, a scoping review offers valuable breadth but limited depth. While it provides a comprehensive overview of existing evidence and highlights key gaps in knowledge on IPV experiences among MEIW during the perinatal period, it does not critically appraise study quality. Relying on a scoping review as the primary literature review also restricts the range and depth of evidence that can be incorporated in the discussion chapter, as the available evidence is confined to the studies meeting the inclusion criteria in the scoping review.

Another limitation of this review is that only English-language citations were included. This may have contributed to a lack of diversity in the geographic distribution of studies, as most of the included research originated from the United States and Middle Eastern countries. Moreover, noticeable contextual differences were observed between these two regions: studies conducted in the United States often reflected distinct patterns of IPV risk factors and help seeking behaviours compared to those conducted in Middle Eastern settings. These variations

may be attributed to differences in the experiences including immigration experiences and access to services. Despite these limitations, the synthesis of findings was possible due to the consistency of major themes across the literature. Consequently, the results of this scoping review should be interpreted as an exploratory mapping of existing evidence rather than a comprehensive evaluative synthesis.

2.5 Summary of Chapter Two

The research on IPV among MEIW during the perinatal period is growing and diverse. While some topics that have been explored in-depth such as the prevalence of IPV, others have not. This is the gap my doctoral thesis seeks to fill by exploring the understanding of IPV experiences based on the women's perspectives as well as assessing their coping strategies and the importance of responsive cultural interventions.

Chapter Three – Theoretical Perspectives

3.1 Introduction

This chapter outlines the theoretical and conceptual foundations of the study, guided primarily by an intersectionality lens and the socioecological model (SEM), both of which are informed by principles of Critical Theory. Critical Theory provides the overarching philosophical orientation that interrogates power, structural inequities, and the sociopolitical conditions shaping marginalized lives. Within this orientation, Intersectionality serves as the analytical framework for understanding how overlapping identities and interlocking systems of oppression shape women's experiences, while the SEM offers a structural model for situating IPV across individual, relational, community, and societal levels. The chapter begins by outlining philosophical assumptions before introducing Critical Theory, its relevance to IPV research, and its connection to Intersectionality. It then explores how Intersectionality extends this analysis by highlighting multiple, overlapping systems of oppression. Followed by explaining the role of intersectionality in shaping culturally responsive interventions for IPV (Bilge, 2010). The chapter concludes by introducing the Social–Ecological Model, which extends these perspectives by systematically analyzing how intersecting influences operate across four interrelated levels: individual, relational, community, and societal.

3.2 Philosophical Assumptions of Research

This section outlines the philosophical assumptions that inform this study, including ontological, epistemological, axiological, and methodological considerations. Qualitative research such as this study of MEIW are grounded in the belief that reality is multiple and socially constructed (ontology), and that knowledge emerges through situated, co-constructed, interpretive

engagement between researchers and participants (epistemology) (Lincoln & Guba, 2005). In this qualitative study, reality is seen as socially and structurally constructed (ontology); knowledge emerges through co-created, culturally situated interactions (epistemology); values such as cultural respect, safety, and equity guide the research (axiology); and methodologies grounded in intersectionality, critical theory, and the SEM shape the design and analysis (methodology) (Poth and Creswell, 2018). Given this study's critical orientation, it assumes that knowledge is situated, relational, and shaped by power structures (Guba & Lincoln, 2005; Wilson, 2001). Within this worldview, participants' experiences are not treated as objective facts but as socially and culturally constructed narratives that reflect broader systems of inequities. These assumptions underpin a commitment to critical reflection, ensuring that research remains culturally responsive and actively engaged in promoting social justice.

3.2.1 Ontological and Epistemological Assumptions

Researchers hold philosophical assumptions that inform their worldview and influence the beliefs they bring to the research process (i.e. ontology). In this study, I believe that what we understand as "realities" are not neutral or absolute, but shaped by cultural assumptions, historical contexts, and social values that determine what becomes visible or remains overlooked in people's experiences. This ontological stance reflects critical theory's emphasis on unmasking structural inequality and understanding reality as socially and historically constituted. (Guba & Lincoln, 2005). For example, in the context of IPV among MEIW, the concept of "violence" itself is not experienced and understood as a single universal reality (Ghafournia, 2014). What constitutes "abuse" or "acceptable behaviour" can differ according to cultural norms, gender roles, and historical power relations within a given society (Gunarathne et al.,2024 ; Tran et

al.,2016). In some cultural contexts, certain controlling behaviours, such as restricting a partner's mobility, decision-making, or access to finances, may be normalized as part of traditional gender expectations(Alothman et al., 2024 ;Hynes et al., 2016), whereas in another culture these same behaviours are recognized as forms of coercive control and psychological abuse(Hamberger, Larsen & Lehrner, 2017). This illustrates that "realities" in this context does not exist independently of social constructions, cultural meanings, and historical values. it is context-dependent and shaped by cultural and collective beliefs. From a critical theory perspective, Guba and Lincoln (2005) argue, that knowledge and truth are co-created between the researcher and participants, rather than objectively "discovered" , and they are shaped by power, culture, and social position. Therefore, the study adopts a critical, intersectional epistemology.

How these factors and processes intersect to form realities is never static; instead, these factors and processes constantly evolve in response to new theoretical insights and social circumstances (Cannon, Ferreira, & Buttell, 2019). These numerous realities are "as limiting and confining as if they were real" (Guba & Lincoln, 2005, p. 111). To me, new interpretations of meaning are made by appreciating the importance of multiple influences (such as male dominance and gender) and how such influences continue to affect social, cultural and psychological consequences (Cannon, Ferreira, & Buttell, 2019).

Since reality is shaped by intersecting power structures, the epistemological stance that guides this research contends that knowledge is also constructed through engagement with these structures. Therefore, I believe that knowledge is constructed through multiple means and that subjectivity and values are integral to the research process. As a result, these values will inevitably shape the research findings. Kincheloe and McLaren (2011) state that the interactions

between the researcher and the participant create a two-way discussion in which new knowledge of what has been observed will be developed. While multiple interpretations exist, the result is a form of cultural criticism that uncovers power dynamics within social contexts. From my perspective, new knowledge serves a dual purpose, it acts as a social critique that raises awareness while also creating opportunities for transformational social change at the interpersonal, community and societal levels.

3.2.2 Axiological and Methodological Assumptions

Axiology concerns the role of values in shaping knowledge production (Edelheim et al., 2022). This study is based on the premise that all research is value-laden, influenced by the researcher's perspectives, experiences, and cultural and societal contexts (Creswell & Poth, 2018). As critical theory acknowledges that all research is value-laden. This study's axiological stance is grounded in equity, social justice, anti-oppression, and cultural humility. I acknowledge that this research is shaped by an ethical commitment to social justice and an awareness of power dynamics in knowledge production (Guba & Lincoln, 2005). As Wilson (2001) suggests, knowledge is relational and must be understood in connection to the communities and contexts it emerges from.

This aligns with intersectionality, which highlights how values shape the framing of research questions, the prioritization of certain voices, and the interpretation of findings (Gopaldas, 2013). Rather than aiming for detached objectivity, this study embraces a commitment to equity and transformation, positioning research as a way to challenge systemic injustices and improve culturally responsive interventions for MEIW experiencing IPV. This value-conscious approach ensures that the research does not simply observe but actively engages

with the realities of participants to describe, examine, and explore how power, culture, and identity intersect in shaping their experiences of IPV. In doing so, the study situates participants' narratives within broader systems of inequality while remaining consistent with its descriptive and interpretive objectives.

Because this study assumes that research is inherently value-laden and committed to justice, its methodological approach must align with these values. A case study is well-suited because it foregrounds lived experiences, amplifies marginalized voices, and examines power structures (Baxter & Jack, 2008). Examining experiences is essential in this study because it allows the complex, culturally embedded realities of IPV among MEIW to emerge from their own perspectives rather than being filtered through dominant Western or institutional narratives. In critical theory, knowledge is produced through a process of exposing, critiquing, and dismantling oppressive systems. The goal of this knowledge production is transformation, to empower equity denied groups, challenge dominant ideologies, and inform policies that promote social justice. Within the context of this study, knowledge is generated not only to understand MEIW experiences of IPV but also to uncover how migration, culture, and systemic exclusion shape those experiences and to inform more just, culturally responsive interventions. Guided by dialectics, the study explores social contradictions such as empowerment versus dependence and belonging versus constraint as sites of meaning-making and resistance. Rooted in dialogue rather than one-way knowledge transfer, this approach values participants as co-creators of knowledge and fosters critical awareness. Together, dialectical and dialogic inquiry illuminate how diverse, sometimes conflicting voices contribute to understanding and transformation. (Guba & Lincoln, 2005). This approach allows for an iterative process of meaning-making in which knowledge is

constructed through engagement between the researcher and participants. The goal is to uncover subjugated knowledges and examine how power and oppression shape individual and collective experiences.

As a critical researcher, I intend to explore how power relations and knowledge systems interact, shaping what is considered true (Kincheloe & McLaren, 2011). The research methodology must therefore enable an in-depth exploration of intersecting inequalities and provide a framework for transformative social change. In alignment with critical theory's emphasis on structural analysis and lived experience, I employ case study methodology, which allows for a nuanced, contextualised examination of IPV among MEIW (Baxter & Jack, 2008). The case study design, which will be explained in detail in Chapter Four, supports a dialectical approach, as it examines contradictions, power imbalances, and systemic injustices that shape the phenomenon under study (Van Wynsberghe & Khan, 2007).

This study assumes that knowledge is situated, relational, and shaped by social and historical contexts (Wilson, 2001) and that realities are socially constructed, and shaped by intersecting power structures (Guba & Lincoln, 2005). A critical case study approach aligns with these assumptions by allowing for an in-depth, context-sensitive investigation of IPV experiences. Rather than seeking universal truths, this methodology foregrounds participants' voices and their lived realities, reinforcing the axiological assumption that research is value-laden and must engage with issues of social justice (Creswell & Poth, 2018).

3.2.3 A Note on Critical Reflection

I believe that nursing research plays a critical role in addressing gaps in IPV intervention for women during the perinatal period. Reflexivity is central to this process because it allows

researchers to examine their own biases, assumptions and positionality which ensures a deeper understanding of the social and cultural contexts that shape research. Through critical reflection, researchers not only analyze participants' experiences but also interrogate their own positionality to ensure that the research remains ethically engaged with issues of power, justice, and equity. When applied effectively, critical reflection ensures that research remains culturally responsive and tailored to specific populations. It also enables the researcher to navigate the multiple dilemmas inherent in the research process, including analysing experiences, integrating feedback, uncovering underlying risk factors, and discovering new meanings.

The assumptions outlined in this section actively shape my research design, the framing of questions, and the interpretation of findings. By integrating critical theory, intersectionality, and critical reflection, this study ensures that the research process itself remains consistent with its commitment to social justice.

3.3 Critical Theory as a philosophical lens

Having established the ontological and epistemological perspective of this study, this section further explores the value of critical theory as a philosophical lens(Worldview) . It begins by defining critical theory before examining its relevance to IPV research and noting its connection to intersectionality.

3.3.1 Defining Critical Theory

Critical theory emerged in the early 20th century as a response to the works of Kant, Marx, Hegel, and Weber (Welch, 1999), evolving into an approach that critiques and transforms society by interrogating power structures, challenging oppression, and highlighting social inequalities (Fraser, 1989). Critical theory builds on Kant's "critical philosophy," extending his examination

of reason and moral action from individual ethics to the critique of social and political systems that reproduce domination and constrain human emancipation. From Marx, it drew the critique of power, class, and material inequality; from Hegel, the dialectical view that understanding emerges through confronting and resolving contradictions; and from Weber, insights into how cultural and institutional systems perpetuate domination. Building on these foundations, critical theory evolved into both a lens for critique and a call to transform the social structures that sustain oppression. Therefore, research grounded in critical theory should aim to uncover and dismantle systemic barriers, empower marginalized groups, and promote equity (Nelson, 2021). For example, critical theorists may begin by acknowledging systemic biases against certain groups, such as women and ethnic minorities, and design research that actively facilitates the transformation of inequitable structures (Guba & Lincoln, 2005). This aligns with the broader goals of critical research, which seeks to challenge dominant power relations and contribute to social justice. While this study aligns most closely with the feminist and postcolonial streams of critical theory, it draws on the general principles of critical theory and intersectionality as a broader guiding lens. This approach allows for a comprehensive critique of power and inequality without being limited to one disciplinary tradition, supporting the study's purpose to understand the IPV experiences by exploring how intersecting systems of patriarchy, racism, and migration shape MEIW's experiences of IPV and access to support.

3.3.2 Critical Theory and IPV Research

Critical theory provides a useful lens for analyzing IPV because of its focus on exposing how power, ideology, and systemic inequalities sustain and normalize harmful actions in society such as IPV against women. In relation to IPV, this means recognizing that survivors' experiences are

not solely personal or psychological but are shaped by gendered oppression, institutional barriers, and cultural norms that influence how violence is experienced, interpreted, and responded to. Understanding these structural dimensions reveals that survivors' stories reflect both personal struggle and systemic injustice.

This perspective is particularly relevant for understanding IPV among MEIW during the perinatal period, as their experiences are influenced by intersecting forces such as immigration policies, economic precarity, and racialized healthcare systems. The following three sub-sections expand on critical theories potential to support a deeper analysis of IPV by providing a lens to examine systemic barriers and power relations, and to illuminate pathways toward more culturally responsive interventions and practices.

3.3.2.1 IPV as a Structural and Ideological Problem.

Critical theory requires that IPV be understood within broader structural and ideological inequalities rather than as an individual problem. Unlike positivist approaches that isolate risk factors, critical theory interrogates systemic forces, including gendered power relations, economic precarity, legal barriers, and cultural norms that sustain violence.

Fraser (1989) argues that social hierarchies and ideological structures work to maintain systemic barriers, and critical theory seeks to expose and challenge these forces. IPV is frequently framed as a private issue rather than as a symptom of systemic inequality (Dobash & Dobash, 1981), a perspective that limits effective intervention and is rejected by approaches rooted in critical theory.

For MEIW, IPV is shaped by intersecting systemic barrierss, including restrictive visa policies that tie their legal status to their spouse, economic dependency, and racialized

assumptions within legal and healthcare systems (Magnussen, 2011). These barriers are embedded in broader institutional failures, which must be critically examined to understand how IPV is sustained through systemic inequalities.

3.3.2.2 Systemic Barriers and Institutional Failures in IPV Responses.

Critical theory is particularly valuable for IPV research involving immigrant and racialized women because it highlights how state institutions shape access to justice and support. Systemic barriers, as conceptualized by Galtung (1969), refers to systemic harm embedded in legal, economic, and social institutions that regulate IPV responses. MEIW experiencing IPV frequently encounter legal and institutional barriers that prevent them from securing protection and intervention, including restrictive immigration policies, economic dependence, and racialized healthcare systems that fail to provide culturally competent care (Erez & Globokar, 2009). In addition, many mainstream IPV interventions assume a universal model of care that does not account for the distinct challenges faced by immigrant women, such as fear of deportation, social isolation, and a lack of culturally appropriate services.

3.3.2.3 The Need for Culturally Responsive Interventions.

Another strength of critical theory in IPV research is its commitment to culturally responsive interventions that challenge dominant, one-size-fits-all approaches to survivor support. Many IPV services and legal frameworks are designed around Western, middle-class norms that may not reflect the lived experiences of immigrant and racialized women. For MEIW, IPV cannot be understood in isolation from cultural, religious, and familial expectations that shape their decisions about seeking help and navigating state institutions.

Traditional IPV interventions often fail to address these complexities, assuming all survivors have equal access to legal protections, financial resources, and social support networks. Instead of placing the burden on survivors to adapt to existing systems, a critical theory approach argues that systems themselves must be transformed to better meet the needs of marginalized women (Collins, 2015). This requires shifting from top-down service provision to community-based approaches that consider the intersection of gender, race, and immigration status.

3.3.2.4 Summarizing the Benefits of Critical Theory as a Philosophical lens

Critical theory provides a set of principles and rigorous lens IPV research by foregrounding power, systemic barriers, and institutional failures. It ensures that research not only describes IPV but critiques the structures that sustain it. While critical theory examines the structural forces and power relations that shape IPV, Intersectionality builds on this foundation by making explicit how multiple, intersecting social identities such as gender, race, immigration status, and class, interact to shape survivors' experiences, vulnerabilities, and access to support. . For this study, critical theory informed the framing of the study by positioning IPV not as an individual or private matter but as a socially and institutionally produced phenomenon. It directed the focus toward understanding how power, oppression, and social structures shape the IPV experiences of MEIW during the perinatal period. This perspective encouraged a deeper exploration of how gender norms, immigration status, language barriers, cultural expectations, and systemic discrimination intersect to reinforce vulnerability and constrain women's choices and access to support.

This worldview also guided the methodological design, particularly the development of the in-depth interview guide. The questions were constructed to elicit participants' voices, challenge

silences, and uncover hidden power dynamics operating in their lives. For example, participants were invited to discuss how immigration, culture, and social systems influenced their IPV experiences, their access to resources, and their help-seeking behaviours. This approach reflects critical theory's emphasis on empowerment and emancipation, as it positions MEIW as knowledgeable agents rather than passive subject.

The critical theory further shaped my stance and reflexivity through the research process. I approached each interview with awareness of my own positionality and power within the research relationship. Ongoing reflection was used to ensure that participants' voices were valued and that interpretations did not reproduce existing hierarchies or biases. For example, as an interviewer who shares the same immigration experience with the participants, I remained attentive to how this familiarity could both facilitate trust and risk assumptions or biases. During one interview, a participant hesitated to discuss her interactions with healthcare providers, assuming that I might "already understand" her experience as an immigrant woman. From a critical perspective, I gently encouraged elaboration and clarified that her individual story was central to the study, not my own interpretations.

Finally, critical theory informed the interpretation of findings by linking individual narratives to broader systems of power and inequity. Rather than treating MEIW's stories as isolated experiences, the analysis sought to identify how structural and cultural contexts such as patriarchy and migration systems shaped their realities. For example, a participant explained the dependence on her partner for immigration sponsorship and financial stability during the perinatal period. This dependency and instability limited her ability to leave abusive relationships, as she feared deportation, loss of child custody, or community stigma. This finding

was interpreted through a critical lens that exposes how institutional structures such as immigration policies and economic systems reinforce MEIW's vulnerability and sustain unequal power relations within intimate relationships.

While critical theory seeks to expose and transform the structural and institutional systems that perpetuate oppression, culturally responsive interventions often operate within those same systems. The aim of such interventions is to adapt existing structures such as healthcare or social services to be more inclusive and equitable for equity denied populations. This may create tension: by working within existing frameworks, culturally responsive approaches risk reinforcing the institutions that critical theory critiques. However, acknowledging this tension reflects a critical awareness that transformation must often begin with reform the existing systems. Within this study, a call for culturally responsive interventions is viewed as pragmatic pathways toward social change, incremental actions that can challenge systemic inequities and foster conditions for deeper transformation over time. In this way, the study aligns with critical theory's emancipatory intent while recognizing the practical realities of advancing equity within existing social structures.

In this study, critical theory serves as the worldview that undergirds the use of Intersectionality. Critical theory provides the philosophical grounding for understanding power, oppression, and inequity as socially constructed and historically produced. Intersectionality extends this critical view by offering an approach to examine how these systems of domination such as patriarchy, and racism interact to shape MEIW's IPV experiences. In this study, intersectionality is not employed as a stand-alone analytic frame, but rather as a manifestation of critical theory in research. Intersectionality implements a critical worldview by examining how

power operates across intersecting identities which position MEIW within unequal social hierarchies that influence their experiences of IPV during the perinatal period. The next section explores how intersectionality offers a more nuanced analysis of IPV among MEIW during the perinatal period.

3.4 Intersectionality as a Theoretical Framework

Building on the foundations of critical theory, this section introduces intersectionality as a theoretical framework that helps explain how multiple, overlapping systems of systemic barriers shape women's lived experiences. Given the complexity of IPV, intersectionality is particularly useful in highlighting the ways in which perinatality, race, immigration status, and cultural norms interact to affect vulnerability and access to support. This section begins by defining intersectionality and tracing its origins before exploring its relevance to IPV research and its application to the experiences of MEIW.

3.4.1 Defining Intersectionality

Intersectionality, a term coined by Crenshaw (1989), emerged as a critical response to the limitations of feminist and anti-racist frameworks that treated gender and race as separate axes of systemic barriers. Crenshaw originally introduced intersectionality to illustrate how Black women's experiences of discrimination could not be fully understood through a single-axis approach, either gender or race, but rather as an interaction of multiple, overlapping systems of marginalization. Building on this foundation, intersectionality has since developed into a broad theoretical framework used to examine how multiple social identities, such as race, gender, class, immigration status, and disability, intersect to shape individuals' lived experiences (Collins & Bilge, 2016). Davis (2008) defines intersectionality as: "The interaction between gender, race,

and other categories of difference in individual lives, social practices, institutional arrangements, and cultural ideologies and the outcomes of these interactions in terms of power." (p. 68).

This definition highlights that intersectionality is not merely a way to categorise differences but an analytical tool for examining how systemic barriers operate within social structures. It shifts the focus from isolated factors, such as gender-based violence, to the broader socio-political conditions that shape vulnerability to IPV. As Burgess-Proctor (2006) states: "Systems of power such as race, class, and gender do not act alone to shape our experiences but rather are multiplicative, inextricably linked, and simultaneously experienced." (p. 31).

For MEIW experiencing IPV during the perinatal period, intersectionality provides a critical lens through which to understand their unique vulnerabilities. These women's experiences cannot be examined solely through the lens of gender-based violence because their experiences are also shaped by immigration policies, cultural norms, economic precarity, and racialized healthcare systems. As Collins and Bilge (2016) assert: "The events and conditions of social and political life and the self can seldom be understood as shaped by one factor. They are generally shaped by many factors in diverse and mutually influencing ways." (p. 2).

By providing a framework for examining how different forms of systemic barriers intersect, intersectionality offers a critical lens for understanding social inequalities, including those that shape experiences of IPV. This study applies intersectionality as a theoretical foundation to explore IPV as a phenomenon shaped by multiple, interlocking systems of power.

3.4.2 Intersectionality and IPV Research

Intersectionality is particularly relevant for understanding IPV among immigrant women, whose experiences are shaped by multiple and intersecting risk factors, including race, cultural norms,

legal status, and economic constraints (Norris et al.,2020). Crenshaw (1989) originally introduced intersectionality to highlight the limitations of feminist and anti-racist frameworks that treated gender and race as separate structures of systemic barriers. While early feminist analyses often centred gender as the primary axis of marginalization (Biana, 2020; Nash, 2019), intersectionality challenged this approach by demonstrating how power operates through multiple, overlapping systems (Collins, 2015). As feminist scholars such as Angela Davis, Bell Hooks, and Patricia Hill Collins argued, discrimination is not experienced in isolation but is shaped by the interlocking nature of race, class, gender, and other social hierarchies (Carbado et al., 2013; Hooks, 1990).

3.4.3 Applying Intersectionality to MEIW's Experiences of IPV

The intersectionality framework is particularly useful for analysing how structural inequalities shape IPV experiences among MEIW. As Denis (2008) states, subordination is not uniform but varies depending on its combination with other sources of marginalization. For MEIW, intersectionality is crucial in examining how structural inequalities shape their experiences of IPV. Their vulnerabilities are compounded by restrictive immigration policies, economic precarity, racial discrimination, language barriers, and cultural norms that may discourage disclosure or seeking support. Research has shown that factors such as immigration status (Daoud, 2019), perinatal vulnerabilities (Mojahed et al., 2021), and racialized healthcare systems (Duhaney, 2022), contribute to the challenges immigrant women face when seeking IPV support.

By examining IPV through an intersectional lens, we can better understand how oppression operates at interpersonal, community, and societal levels. For MEIW, IPV cannot be separated from broader systems of exclusion, including limited access to culturally responsive

services, economic dependence on abusive partners, and fear of legal repercussions such as deportation. This multidimensional approach is essential for producing knowledge that informs meaningful interventions and policy responses tailored to their unique needs.

3.5 Applying Intersectionality to IPV Interventions

Applying Intersectionality to IPV interventions is essential because it recognizes that survivors' needs and risks are shaped by overlapping factors such as gender, race, culture, immigration status, and socioeconomic position. This perspective ensures that interventions move beyond one-size-fits-all approaches to address the unique barriers and strengths within diverse communities

3.5.1 Barriers to IPV Support for Immigrant Women.

Applying intersectionality as a theoretical framework provides a deeper, more comprehensive understanding of the barriers immigrant women face when seeking IPV support. Traditional approaches often treat gender-based violence as a standalone issue, failing to account for how race, culture, social class, and immigration status intersect to shape experiences of IPV. Intersectionality allows for a more nuanced analysis, revealing how power structures such as patriarchy, racism, and economic inequality create unique vulnerabilities for immigrant women (Garneau & Bouchard, 2013). For instance, patriarchal norms may constrain women's roles within families, while racism and economic exclusion restrict access to jobs, housing, and safety together creating unique vulnerabilities for immigrant women.

Many immigrant women navigate restrictive immigration policies, financial instability, cultural stigma, and language barriers, all of which influence their ability to disclose abuse or access IPV interventions (Crenshaw, 1990; González & Collins, 2019; Njeze et al., 2020). A lack

of culturally responsive services further compounds these difficulties, leaving women isolated or dependent on abusive partners.

By moving beyond one-dimensional analyses, an intersectional approach highlights how these barriers are not simply additive but mutually reinforcing. Rather than viewing social identities and structural inequalities in isolation, intersectionality uncovers how they interact to shape each woman's lived experience of IPV. This theoretical framework is essential for understanding how immigrant women's health, safety, and autonomy are constrained by broader systems of power, and for designing interventions that address the root causes of exclusion rather than just its symptoms.

3.5.2 Improving Cultural Responsiveness of IPV Interventions

While numerous IPV interventions have been implemented by hospitals and social organizations in Canada, there remains a critical need for culturally responsive approaches (Henriksen et al., 2023). Culturally responsive interventions are those that adapt strategies, programs, and services to reflect the unique needs, values, and beliefs of diverse populations. These interventions promote equity, inclusivity, and effectiveness by acknowledging cultural differences and tailoring responses accordingly (Durieux-Paillard, 2011).

However, many available IPV interventions fail to account for the specific experiences of MEIW. Services often overlook the importance of family dynamics, religious beliefs, and language barriers, which significantly influence these women's ability to access and benefit from support (Rai et al., 2023). Without cultural responsiveness, IPV services risk leaving survivors feeling misunderstood, excluded, or hesitant to seek help, thereby increasing their vulnerability

(Khan et al., 2022). To be effective, interventions must integrate the perspectives of MEIW and address the intersecting barriers they face, particularly during the perinatal period.

Intersectionality is central to this study because it allows for a deeper understanding of how multiple identities shape IPV experiences. Research applying intersectionality has shown how age, socio-economic status, and immigration status interact with broader systemic factors, such as access to formal support resources and legal protections, to exacerbate women's vulnerabilities (Erez & Harper, 2018; Hardesty et al., 2013). These structural inequalities not only impact women's health and well-being but also intensify IPV risks during the perinatal period. Rather than viewing social identities and structural barriers in isolation, intersectionality reveals how these factors operate within a broader system of power and oppression (Collins, 2002; Mojahed et al., 2021). For instance, a MEIW who faces language barriers, unemployment, and social isolation will experience IPV differently from an immigrant woman who has financial stability, English proficiency, and a local support network.

By applying intersectionality as a theoretical framework, this study moves beyond single-axis analyses of IPV to examine how women's lived experiences are shaped by overlapping forms of oppression. This approach provides a more comprehensive and nuanced understanding of IPV among MEIW during the perinatal period and offers a foundation for developing interventions that are not only trauma and violence informed but also culturally and structurally responsive.

While intersectionality highlights the interconnected systems of power shaping MEIW's vulnerability to IPV, the SEM expands this understanding by illustrating how these forces manifest across multiple levels, from personal relationships to broader social and structural

contexts. The following section applies the SEM to situate these overlapping influences within a multi-layered framework for analysis and intervention.

3.6. The Social Ecological Model (SEM)

The SEM provides a multi-layered model for understanding the complex and interrelated factors that contribute to IPV. Originally grounded in Bronfenbrenner's (1979**)** ecological systems theory, the model was later adapted by Heise (1998) to explain the causes and perpetuation of violence against women. Heise's model emphasizes that IPV results from the interaction of factors operating at multiple levels individual, relationship, community, and societal rather than from a single cause. At the individual level, Heise highlights personal and historical factors such as exposure to childhood abuse, mental health challenges, and attitudes that tolerate violence. For MEIW, additional risks may include language, age, and dependency on partners during the perinatal period. While framed at the individual level, these factors are not meant to imply fault on the women, but rather to illustrate how structural inequities and contextual stressors manifest in personal experiences at the individual level. The relationship level focuses on interpersonal dynamics and power imbalances within intimate and family relationships. Heise (1998) notes that patriarchal family structures and traditional gender norms can reinforce male dominance and female subordination, increasing the likelihood of coercion and control. Within MEIW communities, cultural expectations surrounding motherhood, marital harmony, and family honour can further discourage women from disclosing abuse or seeking help. At the community level, the model examines the influence of institutional and social environments such neighbourhoods and cultural norms on IPV risk. Limited access to culturally and linguistically appropriate services, social stigma, or lack of trust in formal systems can isolate women and prevent intervention. Finally, at the societal level, Heise (1998) identifies broader structural

factors such as economic inequality, immigration policies, gender discrimination, and systemic racism that shape social norms and institutional responses to IPV. These structural forces interact with community and interpersonal contexts, reproducing the conditions that sustain IPV.
By drawing on Heise's adaptation of the SEM, this study situates IPV among MEIW within a dynamic system of interacting influences that extend beyond the individual to encompass structural and cultural determinants.

In this study, the SEM was not used solely as a conceptual framework but as an organizing lens that guided data collection, coding, and interpretation. The model's four levels were translated into analytic categories that structured both the interview guide and the thematic analysis. At the individual level, questions explored women's definitions of IPV, emotional responses, and coping behaviours. The relational level focused on family dynamics that influence IPV and help-seeking. Community-level inquiry addressed social networks, cultural norms, and access to community services, while the societal level examined broader systemic factors such as discrimination and immigration policy. For example, during the interviews, some questions focused on individual-level risk factors for IPV, such as unemployment, while others explored community-level factors such as having a baby girl or other cultural norms. Additionally, during the analysis and theme development process, the SEM played an important role in organizing ideas. For instance, when analyzing the impacts of IPV, the effects were categorized according to their influence on women themselves, their children and families, and the broader society. Lastly, in the discussion chapter, while developing the overarching themes, the SEM was employed to integrate and interpret the findings across its levels. For example, at the relational level, intergenerational trauma reflected the transmission of emotional and behavioural effects of

IPV within family systems, while at the societal level, the theme Navigating Unfamiliar Systems Alone emerged, highlighting systemic and institutional challenges. This application of the SEM ensured that IPV was interpreted not as an isolated event but as a product of interacting factors embedded within overlapping ecological systems. The model thus provided a coherent approach linking participants' narratives to the broader social structures discussed throughout this research.

This study integrates critical theory, intersectionality, and the SEM as complementary approaches that together provide a multi-dimensional understanding of IPV among MEIW during the perinatal period. Within the critical theory worldview, intersectionality functions as the theoretical lens that illuminates how multiple, intersecting identities, such as gender, migration status, language, and socioeconomic position, combine to shape unique experiences of risk and coping strategies. To translate these theoretical insights into practical analysis, the SEM serves as the analytic model that maps how these intersecting forces operate across individual, relational, community, and societal levels. Together, these approaches move the study beyond individual or cultural explanations toward a critical, systemic interpretation of IPV and it guide the development of interventions that are trauma and violence, and culturally informed.

3.7. Summary of Chapter Three

This chapter has outlined the theoretical perspectives guiding this study, integrating critical theory and intersectionality to examine IPV among MEIW during the perinatal period. The chapter began by discussing the philosophical assumptions underpinning this research, emphasising that knowledge is socially constructed, shaped by power structures, and embedded in experiences. It also highlighted the role of critical reflection in ensuring that research remains

culturally responsive and ethically engaged with social justice issues. Critical theory helps in understanding IPV as a structural issue rather than as an individual problem.

Building on this, intersectionality extends the analysis by examining how multiple systems of oppression interact, including gender, race, immigration status, economic constraints, and cultural expectations. It moves beyond single-axis approaches, highlighting how compounding barriers shape survivors' experiences. It encourages healthcare professionals including nurses to recognise structural barriers, such as language barriers, immigration policies, and financial dependence, and to develop interventions that are both trauma and violence informed and contextually relevant. Then, the chapter examined intersectionality’s role in IPV interventions, arguing that universal models of IPV interventions often fail to reflect the realities of MEIW. Finally, the SEM role in this research was explained as a conceptual tool, allowing for a multi-level analysis of IPV that accounts for the interplay between individual behaviours, family dynamics, community expectations, and societal structures.

Chapter Four –Research Methods

4.1 Introduction

This chapter outlines the research methods employed in this study. It begins by describing the qualitative approach and methodology underpinning the investigation to address the research purpose and questions. The chapter then discusses ethical considerations, setting, sampling, and procedures, followed by an explanation of data collection methods and analytical techniques. The chapter concludes with a summary of the trustworthiness measures employed throughout the study.

4.2 Research Design and Methodology

4.2.1 Qualitative Research Approach

There is a lack of research on MEIW's experiences of IPV during the perinatal period (Ahmadzai, Stewart & Sethi, 2016; Mojahed et al., 2022). To explore this under-researched area, a qualitative approach was deemed most appropriate for this study (Showalter & McCloskey, 2021). Qualitative research enables a detailed exploration of human experiences within their natural context (Korstjens & Moser, 2017), focusing on behaviours, social phenomena, and meaning making from the perspectives of those involved. Unlike quantitative methods, which rely on statistical analysis, qualitative research provides rich, detailed descriptions that help to interpret complex social issues (Aspers & Corte, 2019).

This approach is particularly suited for marginalized groups, such as immigrant women facing IPV, as it can illuminate complex social phenomena and the meanings participants assign to their experiences (Heywood, Sammut & Bradbury-Jones, 2019; McLane & Chan, 2018). Previous research has highlighted that immigrant women who experience IPV are often socially isolated (Njie-Carr et al., 2021). Given the social isolation often faced by these women, a

nuanced exploration of their lived realities is essential to uncover hidden experiences, understand their coping mechanisms, and inform culturally sensitive support strategies.

A qualitative approach was chosen for this study to examine the complex and varied ways MEIW experience IPV during the perinatal period (Creswell & Poth, 2018; Dekel & Andipatin, 2016; Denzin, Lincoln & Giardina, 2006). This methodology aligns with the study's critical and intersectional lens, which emphasises the role of social and cultural contexts, power relations, and gender issues in shaping experiences of IPV. By situating IPV within these broader structures, qualitative research enables for a deeper understanding of the factors that place women at risk and impact their access support services.

4.2.2 Case Study as a Methodology

Selecting an appropriate research design requires careful consideration of the methodological literature, reflection on the researcher's values, and alignment with the overarching research questions. Given the study's critical and intersectional foundation, a qualitative instrumental case study (Van Wynsberghe & Khan, 2007) was chosen as the most suitable approach. This design allows for a comprehensive exploration of IPV within its social and cultural context while capturing broader systemic and structural influences (Ellsberg & Heise, 2005).

4.2.2.1 Why an Instrumental Case Study?

An instrumental case study is used when the case itself is not the primary focus but rather serves as a means of understanding a broader phenomenon (Stake, 1995). This approach is particularly relevant to this study as it examines IPV among MEIW during the perinatal period as a way to understand larger structural and systemic issues related to migration, gender, and support services. This study uses an instrumental case study design, where the "case" is defined as MEIW living in Ottawa, who have experienced IPV and engaged with local service systems. The

purpose is not to study Ottawa per se, but to use this context to understand how migration, culture, and structural systems shape IPV experiences.

Rather than merely documenting participants' IPV experiences, this study explores:

- How MEIW understand and define IPV and how IPV manifest in this context.
- The risk factors of IPV.
- The influence of legal, social, and healthcare structures on their help-seeking behaviours.
- The impact of IPV on MEIW, their children and society.
- How critical and intersectional frameworks provide deeper insight into IPV among MEIW.

This study does not assume that the women's experiences are isolated or unique to this setting, but rather that their narratives reveal systemic issues that extend beyond individual cases (Baxter & Jack, 2008). While various qualitative approaches can be used to study IPV, this study adopts an instrumental case study design because it enables an in-depth and holistic examination of IPV experiences within their broader structural and systemic contexts (Stake, 1995).

4.2.2.2 How This Study Uses an Instrumental Case Study Approach

This study applies an instrumental case study approach in the following ways (Crow et al., 2011). First, the instrumental case study allows for a bounded case with a specific contextual focus. In this study, the case is clearly defined as MEIW in Ottawa who received IPV support services from Immigrants community organization. The process of bounding the case is given further attention in section 4.2.3 of this chapter. By establishing clear boundaries through the

case study approach, the research ensures a focused examination of the social and institutional context while still allowing for the exploration of broader systemic insights.

The instrumental case study approach is further operationalized through the use of semi-structured interviews as the primary data collection method. This approach facilitates in-depth exploration of the experiences of MEIW who have been exposed to IPV during the perinatal period. Moreover, the study's critical and intersectional framing ensures that the case study goes beyond mere description to critically examine how power dynamics, discrimination, and social structures shape participants' lived experiences. The intersectional lens enables the analysis of multiple axes of oppression (gender, migration status, socio-economic position, legal vulnerabilities) that are examined together within the case rather than treating these factors in isolation (Crenshaw, 1989; Baxter & Jack, 2008).

4.2.3 Bounding the Case

A defining characteristic of case study research is the establishment of clear boundaries, or "bounding" of the case, in order to focus the inquiry and enhance analytic clarity (Stake, 1995). In this study, the term perinatal period is defined as the timeframe extending from conception or pregnancy planning through pregnancy and up to two years postpartum. In this study, the case is bounded in several ways, as outlined in Table 4.1.

Table 4.1. Boundaries of the Case Study

Boundary Type	Description
Case Unit	Middle Eastern immigrant women who have experienced IPV during the perinatal period.
Time Boundaries	The study focuses on IPV experiences within a defined perinatal period. (is the period from the time of planning a pregnancy to up to two years after the birth of the child)
Geographic Boundaries	The study takes place in Ottawa, where Middle Eastern immigrant populations are growing.
Institutional Boundaries	The study was conducted in collaboration with immigrants community organization, an organisation supporting immigrant women fleeing abuse.
Methodological Boundaries	Data were collected through interviews with 20 MEIW, focus group, reflexive journal and document reviews.

MEIW represent a diverse and growing population in Canada. Between 2011 and 2016, over 300,000 immigrants settled in Ottawa, comprising approximately 23% of the city's population (Canada Statistics, 2016). Within this demographic, the Middle Eastern immigrant population in the Canada's Greater National Capital region now represents 4.6% of the total population. This demographic context underscores the value of examining IPV experiences within a defined cultural, social, and geographic framework.

Recruitment was targeted at MEIW who were receiving support from Immigrants community organization. Given the sensitive nature of IPV, participants were selected based on their ability and willingness to share their experiences. Cultural barriers, such as norms discouraging disclosure of IPV, were acknowledged as potential challenges in recruitment and participation, and efforts were made to address these sensitively and respectfully.

4.3 Ethical Considerations

This section outlines the ethical considerations relevant to this research study and includes the researcher positionality, informed consent, safeguarding participants' psychological wellbeing, confidentiality and anonymity.

4.3.1 Researcher's Role and Positionality

As a former crisis counsellor and caseworker at Ontario Works, and a specialist in diversity, equity, and inclusion, I have observed the intersection of the structural barriers, cultural beliefs, and systematic discrimination facing immigrant women. These complexities often intensify during the perinatal period, a time marked by increased vulnerability. My professional experiences prompted critical reflection on whether the unique needs of these women are fully understood and whether existing health and social support systems are adequately equipped to address these challenges.

Given my professional background, I am aware that power dynamics (e.g. those between a researcher with clinical experiences and participants who are IPV survivors) and potential biases (e.g. my assumptions about healthcare and support systems), may shape my interactions with participants. To mitigate these effects, I adopted a reflexive approach, that prioritizes participants' voices and minimizes researcher interference. Reflexivity measures included keeping a research journal, explicitly acknowledging my positionality and ensuring transparency throughout the research process.

Reflexivity was an ongoing process throughout all phases of the research, extending beyond data collection to analysis and interpretation. My position as both an insider (sharing cultural and linguistic background with participants) and an outsider (occupying an academic and professional role) provided both opportunities and challenges. While cultural proximity might

facilitate trust and openness during interviews, it also required conscious awareness to avoid over-identification or assumptions of shared meaning. Regular supervision meetings and the reflective journal were used to examine how my own perspectives, emotional reactions, and professional experiences might shape theme development and interpretation. This continuous reflexive practice ensured that findings were grounded in participants' narratives rather than my preconceptions.

4.3.2 Informed Consent and Voluntary Participation

Written informed consent form to participate in the individual interview (Appendix D), and the informed consent form for focus group discussion (Appendix E) were obtained from the participants prior to data collection. The consent form outlined the purpose of the study, potential benefits and risks, available resources, and all other relevant information necessary to support an informed and voluntary decision to participate in the study. It also included explicit permission to audio-record the interviews. Obtaining informed consent ensured that participation was both free and voluntary, meaning that women participate in this research process based on their values and perspectives without coercion or undue influences (Tri-Council Policy Statement, 2010). To further uphold voluntariness, participants were informed that they could withdraw from the study at any point without giving a reason (Edwards, 2005).

To acknowledge the time and effort required for participation, each participant received a $20 Walmart gift card at the conclusion of the interview. This compensation was not intended as an incentive but rather as a token of appreciation for their contribution. It also served to offset incidental costs, such as childcare, transportation, or parking, ensuring that participation did not create a financial burden. The amount was kept modest to avoid coercion or undue influence, in

line with ethical guidelines for research involving vulnerable populations (Tri-Council Policy Statement, 2010).

Potential participants were provided with the information sheet required to make an informed decision about their participation in the interview (Appendix F). This essential information included the purpose of the study, the identity of the researcher, a description of the study place, the anticipated duration of the interview, and an overview of the procedures involved in the study. Participants were informed of their roles and responsibilities within the study. Adequate time was given for participants to read the consent, absorb the information, and ask questions or express concerns as needed. Additionally, participants were informed about the dissemination plan including how the research findings will be shared through academic publications and presentations to advance societal knowledge.

Participants were engaged in the research only after they demonstrated an understanding of what their participation entailed and signed the consent form. Each participant was offered a copy of the consent form along with a list of professional psychological resources (Appendix G) to access if they needed them after the interview. Participants were explicitly assured that their decision to participate, or not, would have no impact on the services they received from Immigrants community organization. At the start of both the individual interviews and the focus group discussion, participants were reminded that they could withdraw from the process at any time without penalty. They were also informed that they were under no obligation to disclose any information that may cause them to feel uncomfortable.

4.3.3 Psychological Wellbeing and Safeguarding

The participants, survivors of IPV, were recognized as a vulnerable population due to their experiences of abuse and potential exposure to psychological and emotional distress.

Vulnerability in this context refers to the state of susceptibility to experiencing psychological harm, emotional distress or spiritual risks (Adger, 2006; Tomm-Bonde, 2012). Ethical safeguards were implemented to protect participants' wellbeing throughout the study. The participants were clearly reminded of their rights, including the options to skip any questions, take brake or withdraw from the interview or focus group discussion at anytime without any consequences. During each session, careful attention was paid to participants' verbal and non-verbal responses (Merry et al., 2016). Any signs of distress or discomfort were monitored closely, and the interview was paused or redirected when necessary to ensure that participants felt safe and supported. I ensured that both the interview and focus group discussion questions were conveyed in a supportive, non-judgmental approach and ensured that they were free from any blaming expressions or stigmatizing language. Care was taken to foster a safe and respectful environment that encouraged open expression. Participants' reactions were met with empathy, active listening, and validation, allowing them to articulate their experiences without fear of judgment. Throughout the process, I remained sensitive to emotional cues and responded with compassion and acknowledgment. Each session concluded on a positive and affirming note, with participants' contributions and feelings explicitly recognized and validated, reinforcing their agency and the value of their narratives (Btoush & Campbell, 2009).

In the event of severe emotional distress, a contingency plan was in place for immediate referral to the therapeutic counsellor on-site (in the crisis department). Should such a situation have arisen, the participant would have been accompanied to a separate, private room where their needs could be addressed in a safe and supportive manner. However, this plan was not activated, as no participant required this immediate intervention. It is important to note that existing research has consistently demonstrated that survivors of IPV are typically not retraumatized by

participation in qualitative research. On the contrary, many participants have reported benefits from the opportunity to share their experiences with a compassionate and empathetic listener (Griffin et al., 2003; Hamberger et al., 2020; Hlavka et al., 2007; Overstreet, Okuyan & Fisher, 2018). In this study, participants confirmed that the value of speaking openly outweighed any emotional discomfort, and many expressed a sense of learning and empowerment through their involvement.

4.3.4 Confidentiality and Anonymity

To ensure participant confidentiality, all data were de-identified, and each participant was assigned a participant identification number. Identifying details were omitted or altered to protect privacy, while maintaining data integrity. All audio-recordings and transcripts were encrypted, and password protected (Creswell & Creswell, 2017). Confidentiality measures included:

- Secure data storage – All interview recordings and transcripts were stored on a password-protected, encrypted USB driver.
- Restricted access – Only the academic supervisor and I had access to raw data.
- Anonymization in reporting – No real names or personal identifiers were used in transcripts, analysis, or publications.

It is also important to note that the quotes from participants were not linked to any identifiers or pseudonyms. This decision, made in consultation with my thesis supervisor and informed by a thorough review of the literature, was grounded in strong ethical and methodological rationale. Participants were assured from the outset that their quotes would remain anonymous, ensuring that no reader could trace them back to an individual or reconstruct their full narrative. This measure was essential to creating a safe environment where participants could share their experiences openly and honestly, without fear, stress, or hesitation, particularly

given the cultural stigma surrounding IPV (Berg, 2004; Hellmuth & Leonard, 2013). Safeguarding participant anonymity and minimizing potential risks are central to ethical research practices, especially when dealing with sensitive topics (Ansell et al., 2023; Sieber, 1992). Moreover, avoiding pseudonyms or identifiers helps preserve the integrity of the data, reduces potential analytical bias, and prevents the emergence of hierarchies among responses, in which certain voices may be perceived as more significant (Hardesty, Haselschwerdt, & Crossman, 2019). Finally, assigning numbers to participants can unintentionally depersonalize their narratives, reducing complex, lived experiences to mere data points (Btoush & Campbell, 2009).

4.4 Setting, Sampling, and Procedures

4.4.1 Study Setting

Immigrants community organization was selected as the research site due to its role as a leading support organization for immigrant women experiencing IPV. As a community-based organization, it provides a range of services, including crisis intervention, counselling, and advocacy, making it an appropriate setting for participant recruitment.

This organization helps the immigrant women in various way. Some of her services include supporting IPV survivors and providing culturally responsive interventions. This organization works collaboratively to address the needs of immigrant women, helping them navigate safety and support systems. Participants for this study were recruited through this organization. This organization also offers a safe space for the interviews.

To protect the safety, privacy, and dignity of the women supported by the organization, which operates in Ottawa, its name has been intentionally anonymized in this thesis. The organization serves immigrant women experiencing IPV, and disclosing its identity could unintentionally compromise the confidentiality of survivors, especially in cases where abusers

reside in the same community. Anonymity also helps protect survivors from potential stigma, retaliation, or social repercussions associated with seeking IPV-related support. In addition, ethical standards in research involving vulnerable populations require the protection of both individuals and the organization that serve them, particularly when dealing with sensitive topics. By keeping the organization's name confidential, the emphasis remains on the women's experiences and the broader systemic issues they face, rather than on the institution itself(Sabri, Lee & Saha, 2022).

4.4.2 Sampling Strategy

A purposeful sampling strategy was employed to identify and recruit participants who had direct experiences of IPV during the perinatal period (Patton, 2002). Purposeful sampling is a non-probability approach where participants are selected based on specific characteristics that align with the study's focus. In this case, collaboration with the existing workers at Immigrants community organization informed the purposeful sampling approach. The counselors, who had direct experience working with MEIW affected by IPV, provided critical insights that informed the participant selection process. Their input helped identify key characteristics and contextual factors to consider when developing the sampling criteria. Collaborating with the counselors enabled me to refine the criteria to ensure a diverse and representative sample of MEIW who could offer meaningful perspectives on IPV. In addition, the counselors' identification of potential participation barriers informed a recruitment strategy that balanced feasibility with ethical consideration of participants' circumstances. These barriers may include, but are not limited to issues such as availability, transportation and childcare needs.

While purposive sampling was the primary approach, convenience sampling also played a role, as participation was limited to women who were already receiving services at Immigrants

community organization, were available for interviews, and met the study's eligibility criteria (Polit & Beck, 2012). In addition, snowball sampling was used, allowing existing participants to refer others who met the inclusion criteria (Creswell & Poth, 2018). While snowball sampling was employed in this research, it was approached with great caution given the sensitivity of the topic. Some participants expressed an interest in referring close friends who might also meet the inclusion criteria. In these cases, I made it clear to participants that any sharing of study information should be done carefully in order to prioritize their friends' safety, privacy, and comfort. I emphasized that participation had to be entirely voluntary and that they should not pressure anyone to take part.

4.4.2.1 Inclusion Criteria

The criteria for being invited to participate in the study were as follows:

- Immigrant women from Middle Eastern backgrounds;
- Having experienced IPV during the perinatal period;
- 18 years old or older;
- Attends at the Immigrants community organization;
- Speaks English;
- Lives in the Ottawa.

In this study, immigrant women are defined as "persons residing in Canada, who were born outside of Canada, excluding temporary foreign workers, Canadian citizens born outside of Canada and those with student or working visas" (Canada Statistics, 2010).

4.4.3 Recruitment Process

Participants were recruited directly through Immigrants community organization using an English-language recruitment poster (Appendix H). The organization was purposefully selected

based on its trusted presence within the community, the availability of safe and accessible spaces, and its established policies for maintaining confidentiality and safety. Additionally, their willingness to provide a crisis or therapeutic counsellor during sessions and daycare, if needed, further supported the suitability of the organization. The recruitment poster was designed to capture attention quickly and convey the study purpose concisely. It clearly indicated the title of the study, the aim of the study, the voluntary nature of participation, and the contact information for my supervisor and me.

The poster was displayed following the ethics approval from the University of Ottawa, Research Ethics Boards (REBs) and after obtaining the required permissions from the organization. I worked closely with crisis workers at the Immigrants community organization and met with them individually to inform them about the nature and inclusion criteria of the study, to agree on how confidentiality would be maintained, and to explain the data collection logistics. To foster a non-extractive approach, I discussed ways to support the Immigrants community organization beyond the study, including providing research findings that could inform improvements for services.

Once ethics approval and the organization approval letters were obtained, the crisis counsellors at this community-based organization distributed the recruitment posters. Also, the poster was left at the front desk so that more potential participants could see and read them when attending service sessions and directly contact me. When individuals contacted me, I provided them with detailed information about the study (including its purpose, confidentiality, and participation requirements), answered their questions, and clarified any concerns. After reviewing this information, those who remained interested confirmed their willingness to participate. Once they confirmed interest, participants were provided with the Participant

Information Sheet for Interview (Appendix F). As in most qualitative research, the data collection and analysis processes were running simultaneously in this study, so data analysis began after the first interview (Denzin, 2012).

4.4.4 Sample Characteristics

A total of 20 MEIW participated in the study. Their demographic characteristics are summarised in Table 4.2.

Table 4.2. Characteristics of the Sample

Demographic Features	Number of participants	Percentage
Age		
18-24	*2*	*10%*
25-29	*7*	*35%*
30-34	*5*	*25%*
35-39	*4*	*20%*
40-45	*2*	*10%*
Country of origin		
Palestine	*4*	*20%*
Syria	*4*	*20%*
Lebanon	*3*	*15%*
Jordan	*2*	*10%*
Turkey	*2*	*10%*
Egypt	*1*	*5%*
Yemen	*1*	*5%*
Iraq	*1*	*5%*
Iran	*1*	*5%*
Saudi Arabia	*1*	*5%*
Number of children		
0-2	*7*	*35%*
2-4	*11*	*55%*
4+	*2*	*10%*
Marital status		
Married	*12*	*60%*
Divorced	*4*	*20%*
Separated	*3*	*15%*
Widowed	*1*	*5%*
Religion		
Muslim	*16*	*80%*
Christian	*3*	*15%*
Prefer not to say	*1*	*5%*

Demographic Features	Number of participants	Percentage
Education		
Elementary school grade or less	*5*	*25%*
High school	*9*	*45%*
Undergraduate	*5*	*25%*
Graduate	*1*	*5%*
Employment status		
Employed	*7*	*35%*
Unemployed	*13*	*65%*

Note. A value of "0" under Number of Children indicates that the participant is currently pregnant or planning to become pregnant.

These characteristics illustrate the diversity of MEIW accessing IPV support services in Ottawa, reinforcing the study's case boundaries while capturing a range of lived experiences. Although participants came from diverse backgrounds, the case remains well-bounded by its focus on those seeking IPV services at the Immigrants community organization during the perinatal period. This diversity enables an intersectional analysis of how structural, cultural, and institutional factors shape IPV experiences within a clearly defined social context.

4.4.5 Data Saturation (Sufficiency and thick description)

While Stake (1995) does not explicitly use the term data saturation in his discussion of the instrumental case study, his work emphasizes the importance of achieving data sufficiency and providing thick descriptions that capture the complexity of the case. In broader qualitative research, data saturation refers to the point at which no new themes or insights emerge from data collection, suggesting that additional interviews are unlikely to contribute further understanding and can also indicate that data sufficiency was achieved (Fusch & Ness, 2015; Noble & Heale, 2019). For this study, recruitment continued until data saturation occurred when no new information was obtained from the themes of the interviews (Creswell & Poth, 2018). In this study, saturation was reached after 15 interviews, as at this stage subsequent interviews repeated patterns already identified.

Although thematic saturation was reached after 15 interviews, a total of 20 interviews were conducted to ensure comprehensive coverage and to confirm that no new themes or information emerged. The additional five interviews aimed to enhance the robustness of the dataset and to account for the possibility that certain perspectives or experiences may not have been fully represented in the initial sample of 15 participants (Hennink & Kaiser, 2022). This approach strengthened the reliability and depth of the findings, recognizing that saturation is often difficult to predict precisely and that additional interviews can provide greater confidence in the thoroughness of the thematic analysis (Weller et al., 2018).

Data saturation was used to determine the target sample size as the study was ongoing. Rigour in qualitative research, including instrumental case study, can only be obtained when rich, thick and in-depth information is collected. Data saturation is not about the number of participants but more about the depth of the data (Fusch & Ness, 2015). Guest, Bunce & Johnson, stated that data saturation might be reached by as little as six interviews (2006). Though, it is better to think of data in terms of rich (high quality) and thick (high quantity) rather than the size of the sample by itself (Gentles et al., 2015; Tran, Nguyen & Fisher, 2016).

It is important to note that the sample size of 20 participants was sufficient to capture a diverse range of perspectives and experiences. Prior qualitative research on IPV has demonstrated that such a sample size is adequate for generating rich in-depth narratives (Green & Thorogood, 2009; Guest, Bunce & Johnson, 2006). Although qualitative research emphasizes data quality, an appropriately sized sample also enhances the comprehensiveness of the findings by reflecting the nuances of participants' experiences.

4.4.6 A Note on Sample Size

While qualitative research does not aim for statistical generalizability, an adequately sized sample in case study research ensures data sufficiency and supports a rich, contextualized understanding of the phenomenon within its specific setting (Baker & Edwards, 2012; Creswell & Poth, 2018).

- 6–12 interviews may achieve 97% saturation (Guest, Bunce & Johnson, 2006);
- 14–25 interviews are often suitable for qualitative theses (Charmaz, 2006);
- 20 interviews is a common threshold where few new insights emerge (Green & Thorogood, 2009).

Based on these considerations, a sample of 20 participants was deemed sufficient to ensure comprehensive coverage and depth of understanding of IPV experience MEIW within the context of this case study.

4.5. Study Procedures

Once the participants accepted to take part in the study, they contacted me to schedule a mutually convenient time for the interview and completion of the demographic questionnaire. Interviews were conducted in a private and safe meeting space with respect to physical distancing measures in place in accordance with COVID-19 public health guidelines at the time. All in-person interviews were conducted with appropriate safety measures in place, including mask-wearing, physical distancing, and hand hygiene. At the beginning of each session, I reviewed and explained the informed consent form to the participant in the interview, who was then asked to sign it (See Appendix D). Following this, the participant completed the sociodemographic questionnaire (Appendix I).

The interview officially began after the demographic questionnaire. At the conclusion of each interview, I expressed gratitude to the participants and provided them with a $20 Walmart gift card as a token of appreciation. A list of professional psychological resources was also shared to ensure participants had access to help in case the interview process evoked emotional distress (Appendix G). Additionally, I offered participants the opportunity to meet with the on-site therapeutic counsellor if immediate support was needed.

4.6 Data Collection

In this section, I present four interrelated methods of data collection: (1) a brief sociodemographic questionnaire, (2) an in-depth semi-structured interview, (3) reflexive field notes, and (4) a focus group discussion. Together, these methods provided a comprehensive and nuanced understanding of MEIW's experiences of IPV during the perinatal period.

4.6.1 Sociodemographic Questionnaire

At the beginning of each data collection session, participants completed a sociodemographic questionnaire (Appendix I). Completion of the sociodemographic questionnaire took approximately 5 to 10 minutes. The first part of the questionnaire includes seven questions that gathering key background information about the participants' age, education level, employment status, ethnicity, religion, marital status, and other contextual factors relevant to their IPV experiences. These characteristics were chosen because they may impact the women's experience of IPV.

The second part of the questionnaire included six questions related to the participant's relationship history, such as "How long have you been with this husband?" and "How long have you been in an abusive relationship?" The third and final section consisted of one open-ended question asking, "What factors do you think contributed to the IPV problem during your

perinatal period?" This question invited participants to reflect on their personal experiences; for example, one participant responded, "I think having a baby girl was the reason for IPV." The purpose of this questionnaire was to provide contextual background for understanding each participant's narrative and to assist in describing the overall study sample. It was developed based on existing literature and knowledge of IPV among MEIW. The questionnaire responses were not included in the thematic analysis because they were primarily quantitative and designed to capture structured background information. Their purpose was to supplement the qualitative data by familiarizing the researcher with each participant's profile rather than to generate interpretive themes.

4.6.2 Semi-structured Interviews (guide)

Following completion of the sociodemographic questionnaire, participants engaged in an in-depth, semi-structured interview to explore MEIW's experiences of IPV during the perinatal period. This method was chosen for its ability to elicit rich, nuanced narratives, ensuring that participants' voices and perspectives remained central to the research. The interview process was designed to be participant-centred, offering a safe and confidential environment in which women could share their experiences. The semi-structured format also allowed for flexibility, enabling participants to guide the conversation according to their comfort levels and personal priorities.

This method served as the primary form of data collection and was conducted with 20 participants. Semi-structured interviews offered an interactive and flexible format, allowing for the collection of rich, qualitative data (Wengraf, 2011). An in-depth interview is defined as "a qualitative research technique that is used to conduct detailed interviews with a small number of participants," with the aim "to get detailed information that sheds light on an individual's perspective, experiences, feelings, and the derived meaning about a particular topic or issue"

(Rutledge & Hogg, 2020, p. 1). In this study, each interview lasted approximately one hour, was audio-recorded, and was conducted in a private room and safe space to ensure confidentiality and participant comfort.

The interviews were guided by an interview guide (see Appendix J), developed based on the study's research questions, case study framework, literature review, and theoretical foundations including intersectionality and the social-ecological model. Intersectionality informed the wording of questions to ensure that participants' experiences were situated within overlapping social identities and power structures. For example, questions such as "How do you think your identity as an immigrant woman impacts your IPV experience?", "Have you experienced discrimination related to your race, culture, or religion?", and "How did your language skills or immigration status affect your ability to seek help?" were designed to elicit how gender, culture, migration status, and systemic inequities shape IPV experiences and MEIW's responses. The SEM informed the overall structure and layering of the interview guide. Questions at the individual level (e.g., "How do you define relationship violence?") explored personal experiences and understanding. Relational-level questions (e.g., "Tell me about the relationship between you and your husband/ex-husband" and "Can you talk about your family's role in your IPV experience?") examined intimate partner and family dynamics. Community-level questions (e.g., "Cultural norms that put you at greater risk?") explored access to and interactions with community supports. Societal-level questions (e.g., "Do you think cultural norms, immigration policy, or discrimination affected your IPV experience or your decisions to seek help?") examined broader structural influences.

The interviews lasted approximately one hour, were audio-recorded, and were conducted in a private room at the immigrants community organization, except in cases where remote

interviews were necessary; in total, four interviews were conducted remotely due to participant preference or public health considerations. In a few interviews, participants shifted from English to Arabic when discussing emotionally difficult topics. As the researcher shared the participants' native language, this enhanced rapport, data richness, and the ability to clarify meanings.

The interview guide was structured into seven content sections, each designed to explore different dimensions of participants' experiences with IPV during the perinatal period. The first part of the interview guide included three questions, aimed at understanding the participant's background, such as general questions like, "Can you tell me about yourself?". The second part contains five questions focusing on the women's understanding of IPV and its associated factors such as "How do you define relationship violence or intimate relationship violence?". This allowed participants to reflect on and articulate their experiences and discuss their perspectives of IPV. The third part contains four questions focusing exclusively on the participant's help-seeking behaviours, including whether the participant found any services or strategies helpful in their efforts to flee IPV such as community services. The fourth part, which has twelve questions, explores the risk factors and causes of IPV. The fifth part, included six questions, explored the impact of IPV during the perinatal period on the participant, her children and infant. The sixth part consisted of three questions designed to assess the participants' perceptions of the interview process. At this stage, participants were asked how they felt about the interview, whether they found the questions clear and respectful, and if they had any suggestions for improving future interviews. The final section, containing four questions, offers an opportunity for the participants to provide other comments and to reflect on their feelings and experience of participating in this study.

The semi-structured format was deemed most appropriate for the study, as it ensured that important research questions were addressed while allowing for participants' perspectives to be revealed and emerged through open-ended discussions (Britten, 2006). Using this approach enabled me to follow up on significant details and insights shared by the participants and pose additional questions relevant to the issues raised. I also employed probing techniques to explore participants' views and to clarify meaning where necessary. As data collection progressed and preliminary analysis began, interview questions were continuously assessed and evaluated to confirm the questions were presented in a way that were relevant to the research core focus and that they were clearly understood by the interviewees. No modifications were necessary, as the original questions continued to elicit rich and meaningful responses (Miles & Huberman, 2014).

Sixteen interviews were conducted face-to-face at the immigrants community organization at a mutually agreeable time. Conducting in-person interviews proved beneficial, as it allowed for the observation of non-verbal cues, the development of rapport with participants as well as to maintain safety for the participants (Britten, 2006). The in-person interviews were scheduled during school hours, and participants were offered free on-site childcare provided by the immigrants community organization. This arrangement ensured that their younger children were cared for, which helped maintain privacy, reduce interruptions, and create a more comfortable and focused environment for the interviews. For face-to-face interviews, one participant preferred to meet in a public location close to her residence. A safety assessment was conducted prior to the meeting to ensure a secure environment. For participants interviewed at immigrants community organization, private meeting rooms were arranged to accommodate the interviews. At the end of each interview, participants were asked for their consent to be recontacted for a brief follow-up conversation. In line with a critical theoretical approach, this

follow-up was an opportunity for collaborative reflection and co-construction of meaning, allowing participants to clarify, expand, or challenge the researcher's interpretations of their narratives. (see Appendix L).

Due to logistical constraints, six of the participants were interviewed via telephone. These participants were unable to leave their homes due to illnesses like COVID-19 or cultural and linguistic comfort with remote interviews. The safety for these participants was assessed before calling them. All six participants were interviewed by telephone and their abuser had no contact with them and no access to them.

During the interviews, three participants initially responded in English but switched to Arabic as they began to share more sensitive and emotionally charged experiences. These participants struggled to express the complexity of their trauma in English and instead used a mix of Arabic and English throughout the interviews. As a native Arabic speaker, I was able to establish rapport and mutual understanding by using shared vocabulary and cultural references. This linguistic alignment allowed participants to feel more comfortable and supported, enabling them to express their experiences more openly and in greater depth.

Allowing participants to speak in their native language, particularly during moments of distress, enriched the quality of the data and enhanced the authenticity of their narratives. To ensure accurate interpretation of Arabic terms used during the interviews, I adopted two approaches: in some cases, I clarified meanings with participants during the conversation, enabling immediate understanding and follow-up; in other instances, I waited until the end of the interview to verify meanings so as not to disrupt the flow of dialogue.

During data analysis, I used line-by-line coding rather than word-for-word translation to better capture contextual meaning. A back-to-back translation approach, translating from Arabic

to English and then verifying the translation, was employed to minimize bias and preserve meaning (Squires,2009). This process improved the accuracy and quality of the translated data.

Ultimately, by using both Arabic and English, I engaged in translating, "the process of making meaning, shaping experiences, gaining understanding and knowledge through the use of two languages" (Lewis, Jones, & Baker, 2012, p. 641). Throughout the processes of transcription, translation, and analysis, I moved fluidly between the two languages (Srivastava, 2006), which enhanced the accuracy and depth of interpretation.

4.6.3 Reflexive Field Notes

This section acknowledges my role as a researcher in shaping the interview process and emphasizes the significance of the researcher's presence in qualitative research. As the sole interviewer and researcher, I played a crucial role in establishing trust, ensuring a safe and supportive space for participants, and navigating the emotional and ethical complexities of discussing IPV. Reflexive field notes were maintained throughout the study to record contextual insights, emotional cues, and non-verbal expressions during the interviews. These notes supported the interview data and helped the researcher reflect on their positionality, emotional engagement, and any emerging ethical concerns. While not thematically analyzed, these notes enhanced transparency and trustworthiness in the qualitative research process by serving as a record of researcher reflexivity.

I observed the participants' behaviour, emotional responses, and any signs of tension, anxiety, and irritability during the interviews and recorded these observations in the field notes for later reflection. These non-verbal observations helped me to remain fully engaged with the participants and evaluate their readiness to continue with the questions. For example,

> This participant appeared anxious at the beginning of the interview, often fidgeting with her hands. Her voice was soft and low pitch, and she avoided eye contact. As the interview progressed, she became more comfortable, especially when talking about her family. However, moments of emotional difficulty were obvious when recounting specific incidents of abuse, as her voice broke, and tears welled in her eyes.

For this participant, I allowed additional time for her to respond the questions and provided a supportive and non-judgmental space, enabling her to share her experiences at her own pace. Another example was:

> This participant expressed frustration about the lack of culturally responsive resources. She gestured while speaking which indicated strong emotions about her experiences with service providers.

The reflexive field notes provided free space to document the observations, emerging findings, concerns and methodological issues throughout the study (Creswell & Poth, 2018; Stake, 1995). The aim of using field notes is to support reflexivity and to contribute in developing an in-depth understanding of IPV. They served as a reflective tool to evaluate what worked well and what could be improved during the research process. As Dewey (1916) asserted, learning occurs through reflection on experience, and these notes helped embed that reflective practice throughout the study. These field notes were kept in a locked cabinet in my thesis supervisor's office. While they were not included in the thematic analysis, they offered critical insights into the researcher’s positionality and engagement with the data. For example, one entry noted, “As a researcher, I found myself deeply immersed in these women’s stories. However, I need to remain mindful of maintaining professional boundaries while empathizing

with their experiences". Another stated, "It was evident that creating a safe space allowed participants to express themselves openly". The notes were not coded for thematic analysis; rather, they served as a reflexive space for the researcher to capture ongoing insights into the data. Their presence and role in the study are acknowledged here for the sake of transparency, in alignment with the quality criteria outlined later in this thesis.

4.6.4 Focus Group Discussion

While the focus group discussion was mainly conducted for member checking and result validating purposes, it also served as a data collection method by generating additional insights, clarifications, and reflections from participants in response to the preliminary themes (Bloor, 2001; Finch & Lewis, 2003). This collective dialogue not only confirmed the credibility of the results but also deepened the understanding of participants' lived experiences. Further details about the focus group discussion are provided in the following section.

4.7 Data Analysis

Thematic analysis is particularly appropriate for this study as it enables the researcher to explore specific phenomena, experiences, perspectives, thoughts, and behaviours across the dataset (Nowell et al., 2017). Braun and Clarke (2006)'s six-step framework was used to guide the qualitative data thematic analysis. A theme is a pattern in the information that describes and organizes the possible observations, or interpretations of phenomena identified in the data. This process includes six phases: (1) familiarizing with the data; (2) generating initial codes; (3) developing a coding tree to guide the coding of transcripts; (4) identifying themes; (5) reviewing, defining and naming themes; 6) interpreting the narratives and stories; to produce the research report, which is a concise, coherent, logical, and non-repetitive account supported by vivid examples (Braun and Clarke). They describe thematic analysis as a method that is "rich in detail"

(p. 78) which provides core analytical skills applicable to various qualitative approaches. As discussed further below, themes were identified based on recurring patterns in participants' narratives and represent shared commonalities related to the research questions (Braun, Clarke & Rance, 2014).

During the analysis, I used the word ‘code’ to describe the smallest unit of the analysis. It represents a specific concept or idea identified in the data such as love or help-seeking. ‘Subtheme’ was used to group related codes and highlight an emerging trend. I employed ‘theme’ to describe the broader insights that emerged from multiple subthemes. These themes intend to capture the main ideas found in the data and represent significant aspects of the research topic. Several prominent themes emerged to reflect the core aspects of participants' experiences. However, during deeper engagement with the data, a number of cross-cutting themes emerged that spanned across multiple core themes. These cross-cutting themes were not confined to one particular domain of experience. Rather, they surfaced throughout participants' narratives, intersecting with and enriching the main thematic categories. These themes were interpreted not only as recurring patterns but as expressions of the bounded case, that is, the shared social, cultural, and systemic context shaping MEIW’s experiences of IPV during the perinatal period (Stake, 1995). While the findings are presented as themes in the results chapter, the cross-cutting themes were explored in the discussion chapter to highlight their integrative significance and to illustrate how they illuminate broader systemic and structural dynamics within this case. Their recurrence across individual stories underscores their centrality to understanding the complexity of the case and contributes to a holistic portrayal of the lived realities of MEIW experiencing IPV during the perinatal period.

4.7.1 Data Management and Coding Process

To ensure that data remained organized and manageable, all participant information was systematically stored in a secure, password-protected Microsoft Excel database (Merriam, 2009). This system facilitated efficient data retrieval, editing, and analysis (Patton, 2002). Data analysis was iterative and reflexive. Initial codes were compared across interviews, and patterns were examined to ensure coherence and consistency. The coding process condensed the raw data to elements relevant to the research question, facilitating a focused and more meaningful thematic analysis (Green et al., 2007).

Throughout the analysis, I engaged in ongoing reflexivity, critically considering how personal perspectives and prior experiences might influence data interpretation. The data analysis was conducted collaboratively with my thesis supervisor, who contributed to various aspects of the analysis, including refining, coding categories (i.e., clusters of related codes that organize data), reviewing themes (i.e., overarching patterns of meaning that address the research questions), and providing feedback on interpretation.

This collaborative process enhanced the rigor and comprehensiveness of the analysis. Also, the regular discussions with the academic supervisor helped ensure that themes remained grounded in the data rather than pre-existing assumptions (Nowell et al., 2017). This study followed Braun and Clarke's (2006) six-step approach to thematic analysis, which provides a systematic and iterative process for analyzing qualitative data:

1. **Familiarization with the data**: I transcribed all interviews verbatim and repeatedly listened to the recordings while reading the transcripts to fully immerse in the data. Multiple readings of the transcripts facilitated an in-depth understanding of participants' experiences.

2. **Generating initial codes**: Initial open coding was conducted manually. Each segment of text related to IPV experiences, challenges, and help-seeking behaviours was coded based on meaning and relevance to the research questions.
3. **Searching for themes**: Coded data were examined for patterns and connections, leading to the grouping of codes into categories, sub-themes and overarching themes. These categories were identified inductively from the data.
4. **Reviewing themes**: Identified themes were refined and reorganized to ensure they accurately reflected participants' narratives. Relevant data extracts were re-examined to confirm that themes were well-supported by the dataset.
5. **Defining and naming themes** – Themes were clearly defined to capture the core aspects of IPV experiences during the perinatal period. Each theme was carefully labelled to reflect its meaning and relevance to the research.
6. **Writing up the analysis**: The results were structured to highlight participants' voices, using direct quotations and narrative summaries to illustrate key themes.

The final themes identified in this study are presented in Chapter Five, where they are described in detail with direct quotations and contextual analysis. The cutting themes, that spanned across multiple core themes, were presented in the discussion chapter.

4.7.2 Scope of Data Analysis

Although multiple data sources were collected to enhance depth and credibility, not all were included in the formal thematic analysis. The primary dataset comprised 20 semi-structured interviews, which provided the richest and most comprehensive narratives addressing the research questions. Reflexive field notes, the focus group discussion, and the sociodemographic questionnaire were used to support triangulation, contextualize participants' accounts, and

enhance credibility rather than to generate additional themes. To keep participants' voices central, only interview data were thematically coded. Field notes, the questionnaire, and the discussion group informed interpretation and reflexivity but were not used to derive new themes. This decision was guided by the study's focus on capturing in-depth, first-person narratives of experience. The interviews provided the richest and most direct accounts of participants' meanings related to IPV during the perinatal period. In contrast, the field notes and discussion group data served supplementary purposes offering contextual insight, supporting analytic reflexivity, and validating themes but lacked the same narrative depth or consistency required for primary coding.

4.8 Methodological Rigor

The concept of trustworthiness in qualitative research aims to ensure that the research's findings are "worth paying attention to" (Lincoln & Guba, 1985, p. 290). This study adheres to Lincoln and Guba's (1985) criteria for establishing methodological rigour in the context of qualitative research. The four criteria are: credibility, dependability, confirmability and transferability. Each criterion is described below, along with the specific techniques employed in this study to address it.

These criteria were employed to enhance the transparency and rigor of the research process. This decision reflects a realistic approach that acknowledges the value of established qualitative data trustworthiness while also engaging reflexively with the data. Given the nature of this study, these criteria offer accessible standards for demonstrating research quality to diverse audiences, including public, healthcare providers and policymakers. At the same time, the principles of reflexivity, transparency, and coherence as advocated by Braun and Clarke were actively upheld throughout the analytic process.

I recognize that my close connection to this topic shapes how I see and interpret the data. Rather than treating this influence as a limitation, I approached it as an important interpretive resource. I engaged in ongoing reflexive journaling, discussed emerging insights with my supervisor, and consistently returned to participants' narratives to guide my analysis. This process allowed my experiences to contribute meaningfully to the interpretive lens while ensuring that the perspectives of MEIW remained central.

4.8.1 Credibility

Credibility refers to the effort to establish confidence in the accuracy and truthfulness of the data and the interpretation of its meaning at the time of data collection (Lincoln & Guba, 1985). Shenton (2004) states that "investigators must attempt to demonstrate that a true picture of the phenomenon under scrutiny is being presented" (p. 66). In this study, credibility was enhanced through persistent observation, reflexive journal and FDG, all of which contributed to ensuring that the participants' perspectives were authentically and accurately represented.

4.8.1.1 Persistent Observation and Reflexive Inquiry

During the interviews, I employed persistent observation as a strategy to enhance the credibility of this study. This involved using reflective follow-up questions to probe each participant's responses, which deepen the understanding of IPV and captured the nuances of each woman's various experiences and expressions. Examples of such reflective prompts included, "Can you explain more what you mean by…" or "Tell me more about what you just said."

At the analysis stage, I engaged in a continuous internal reflexive dialogue to ensure the credibility of the findings. Reflective questions included:

- Does the data accurately represent the information the participants provided?

- Do the results mirror the IPV experiences and backgrounds of the participants? Can the results create an in-depth understanding of IPV?
- Do the explanations and interpretations justify the description given by the participants?

Credibility was further honed through researcher self-awareness and reflexivity (Elo et al., 2014; Koch, 1994). Following Koch (1994) recommendations, I maintained a reflexive journal throughout the study, documented ideas, insights and thoughts that emerged during each interview. These entries were regularly revisited during data collection and analysis to support critical self-reflection and self-awareness. Reflexivity was further embedded in the study during the data familiarisation phase, particularly, during the transcriptions of the interview recordings. At this stage, I posed reflective questions such as, "Did I manipulate the participant by any means during the interview?" This ongoing process of reflection helped to ensure the trustworthiness and integrity of the data analysis.

4.8.1.2 Member Checking

Member-checking is a process in which the study's findings are presented to participants for their feedback and validation (Varpio et al., 2017). Member checking was approached in this study as a dialogic and reflexive process and it was consistent with critical theory. Rather than seeking confirmation, it aimed to invite participants' reflections, clarifications, and reinterpretations of the preliminary findings, thereby redistributing interpretive authority and enhancing the collaborative construction of knowledge. This technique enhances credibility by reducing the likelihood of misrepresentation during the analysis process (Candela, 2019). In this context, misrepresentation may occur when participants' meanings, intentions, or contextual nuances are unintentionally altered during processes of translation, interpretation, or thematic

synthesis. In this study, the first form of participant engagement involved individual follow-up telephone calls with participants to discuss and reflect on preliminary interpretations of the data and to invite their insights, clarifications, and alternative perspectives (McKim, 2023). Consistent with the critical theoretical orientation and the interpretive nature of case study research, this process emphasized dialogue and collaborative meaning-making rather than verification, allowing participants to contribute to the evolving understanding of the case. The member-checking guide (see Appendix K) was used selectively in situations where participants preferred more structure or when unstructured dialogue was not feasible. The intent was not to impose control or limit participants' dialogic agency, but to provide a supportive framework that enabled participants to engage comfortably and meaningfully in the conversation. A total of twelve interviews were conducted with participants who had provided prior consent by completing the participant consent to be contacted by the research team (see Appendix L) and voluntarily chose to take part in this member checking process. Each follow up interview lasted approximailty10–15 minute. The second technique involved conducting a focus group discussion (Kitzinger, 2000). This focus group discussion consisted of community members who attended an IPV support group at immigrants community organization and featured six of the original interview participants. These participants were invited by crisis workers at the organization using the study's recruitment poster (Appendix H). The interested participants were given the participant information sheet to learn more about the focus group discussion (Appendix M). The focus group discussion guide (Appendix N) was designed to ensure the findings accurately reflected the experiences and perspectives of MEIW. Questions were developed based on key themes identified during data analysis, using open-ended formats to allow participants to validate and reflect on the results. This approach encouraged in-depth feedback and created space for

participants to discuss the relevance and applicability of the findings. To ensure alignment with the study's objectives, I collaborated with my thesis supervisor during the development of the discussion guide. The supervisor provided feedback on the wording of the questions to avoid leading questions and to ensure that the discussion remained participant-driven while staying aligned with the research objectives. The final version of the guide included questions that encouraged participants to reflect on the findings in relation to their personal experiences, and to confirm, refine, or expand upon the results. This structured approach of the guide supported the collection of meaningful and valid feedback from the participants.

The focus group discussion took place online via Zoom and included 10 participants. The session was guided by a structured focus group discussion guide (Appendix N) . It began with a presentation of the preliminary findings and interpretations followed by an open dialogue to assess whether the results resonated with participants' experiences and perspectives (Frith, 2000). Participants provided clarification on areas where there were minor misunderstandings or oversights in the interpretation of their experiences or perspectives existed.

The focus group discussion also facilitated collective reflection and validation, as participants were able to hear others affirming the findings, thereby adding credibility to the analysis (Freeman, 2006; Kruger et al., 2019). This shared agreement helped ensure that the themes resonated not only with individual participants but across the group as a whole. Additionally, this discussion enriched the data as participants expanded upon or deepened their original responses, providing richer, more nuanced insights. Feedback from this session with the community members was integrated into the coded transcripts to enhance the depth and accuracy of the analysis.

4.8.2 Dependability

Dependability refers to the stability of data under different circumstances and over time (Lincoln & Guba, 1985). In qualitative research, dependability is established by ensuring that the research design, data collection, and analysis process are systematic, well-documented, and logically traceable. This concept aligns with the Critical Theory paradigm, which emphasized transparency in methodological decision-making, rather than expecting identical findings in repeated studies, as would be expected in a positivist tradition (Elo et al., 2014; Thomas & Magilvy, 2011). As Shenton (2004) explains, dependability is achieved when the research process is clear enough that another researcher could follow the same steps and understand how decisions were made.

One way to enhance dependability is by employing an audit trail throughout the research process (Lincoln & Guba, 1985; Polit & Beck, 2012). An audit trail is defined as "the systematic documentation of material that allows an independent auditor of a qualitative study to draw conclusions about trustworthiness" (Polit & Beck, 2012, p. 720). For this study, an audit trial was maintained to provide a transparent rationale for decision making during the research design, data collections, data analysis and writing stages. The audit trail was examined by the thesis supervisor to ensure accuracy, accountability, and methodological integrity.

Dependability was further supported through the inclusion of key supplementary documents, such as the literature search strategy, the semi-structured interview guide, and the discussion guide used for the member checking group discussion (Appendix K). These supplementary materials reflect a consistent and transparent research process, demonstrating methodological coherence across all phases of the study (Bowen, 2009; Polit & Beck, 2012).

4.8.3 Transferability

Transferability refers to the extent to which a study's findings may be applicable to other similar contexts, settings, or groups (Lincoln & Guba, 1985). Rather than seeking generalizability, qualitative research emphasizes providing sufficient contextual detail to allow readers to determine whether the findings are relevant to their own settings (Payne& Williams, 2005). As Lincoln and Guba (1985) emphasize, it is the researcher's responsibility to provide sufficient contextual information to enable readers in making such transfer. In this study, transferability was supported through the use of direct participant quotes and the application of thick description in the results chapter. (Creswell & Poth, 2018). Providing a thick description of the participants' experiences and the research context enables readers to assess whether and how the findings may be meaningfully applied to similar populations or circumstances.

4.8.4 Confirmability

Confirmability refers to the degree to which the results of a study are representative of the collected data and shaped by the participants' responses rather than researcher bias, motivations, or assumptions (Lincoln & Guba, 1985). Shenton (2004) notes that, "researchers must take steps to demonstrate that findings emerge from the data and not their predispositions" (p. 63). In this study, along with credibility, confirmability is also addressed with an audit trail which documented the research process, including methodological decisions and analytical procedures. The detailed audit trail allows any reader to trace the course of the research step-by-step via the description of procedures and decisions made during the study. In addition, the audit trail confirms that the study's findings are the result of the participants' experiences and ideas rather than the researcher's opinions and preferences. The maintenance of a reflective journal further enhances confirmability and served as a tool for identifying and mitigating potential researcher

bias. By regularly reflecting on personal values, assumptions, and reactions throughout the research process, I ensured that the findings remained firmly rooted in the participants' lived experiences.

4.9 Summary of Chapter Four

This chapter outlines the research methods employed in this study, detailing the qualitative approach, case study methodology, and data collection and analysis procedures. The study utilizes an instrumental case study to examine IPV among MEIW during the perinatal period, with semi-structured interviews serving as the primary data collection method. This approach aligns with the study's critical and intersectional lens, allowing for an in-depth exploration of systemic barriers, social structures, and power dynamics shaping participants' experiences.

The chapter also describes the recruitment process, research setting, and sample characteristics, emphasizing the use of purposive and snowball sampling strategies used to identify participants receiving support from immigrants community organization. Ethical considerations, including informed consent, confidentiality, and participant wellbeing, were central to the research design, ensuring that the study adhered to principles of beneficence and voluntary participation. A rigorous thematic analysis was conducted following Braun and Clarke's (2006) six-step framework. To enhance trustworthiness, the study followed Lincoln and Guba's (1985) criteria for credibility, dependability, transferability, and confirmability. The following chapter presents the study's results, highlighting key themes and insights derived from participants' narratives.

Chapter Five: Results

5.1 Introduction

This chapter presents the results of the study, examining how MEIW in Ottawa define, experience, and respond to IPV during the perinatal period. The results reveal the nature and impact of IPV for perinatal MEIW at the individual, relational, community and system levels. The SEM informed the analysis of the data and therefore shapes these results, although its full application will occur in the discussion chapter (Chapter Six), where the results will be situated within the broader literature and theoretical insights. The focus in this chapter is on presenting a coherent account of the women's words, capturing their lived experiences and the complexity of IPV as described by them.

A thematic analysis approach (Braun & Clarke, 2006) underpins this chapter, ensuring that participants' voices remain central while grouping their narratives into meaningful major themes, sub-themes and categories. To support a clear presentation of the results, this hierarchy of analysis is summarized in Table 5.1, which outlines each major theme, sub-theme, and category, along with indicative quotes from participants. This table offers a snapshot of the data and orients the reader to the nature of each theme.

Table 0.1*. Summary of All Major Themes, Sub-Themes and Categories*

Major Theme	Sub-Theme and Categories	Indicative Quote
Defining IPV	Walking on Eggshells • Individual Experiences of Fear and Safety • Cultural Influences on Perceptions of Abuse	"I have never felt safe with him, all the time I was waiting for the attack" "I didn't speak up because I was taught that a good woman keeps the family together, no matter how much she suffers."
	Love as Control • Perceived Justifications for IPV	"Because he loves me too much and did not want me to talk to anybody else"

Major Theme	Sub-Theme and Categories	Indicative Quote
	• The Role of Cultural and Romantic Beliefs	" You are taught that love grows after marriage, even in hardship."
	A Psychological Trap • IPV as a Mental Health Issue • The Cycle of Abuse and Entrapment	"It is a mental problem. My husband is mentally sick. Sometimes, he is okay and sometimes he is aggressive." "It was always calm after a big storm, and I held onto that calm as if it meant things were getting better… but never"
	Compliance Through Violence • IPV as a Conflict Resolution Strategy • IPV as a Tool for Establishing Hierarchy	"My husband was using his hand to resolve any problem with me. He knew that I can not do anything when he hit me, but I will be silent and do whatever he wants" "He believed men should be on top and women should obey… he did the bad things so I will not forget this rule"
Forms of IPV	The Physical, Sexual and Financial Abuser • Physical Abuse • Sexual Abuse and Exploitation • Financial Abuse	"It took me several years to realize the extent of the sexual abuse my ex-partner put me through. He forced me to sleep with him and if I say no that's mean I am a bad woman. Today, I understand that his control over my sexuality was the background of his dominance in other parts of my life…his remains one of the deepest wounds that I still carry today, in my soul and my body" "Once in the nighttime, my in-laws and my husband all beat me, slapped me and dragged me. I escaped to a nearest gas station without money or anything"
	The Psychological Manipulator • Manipulation and Emotional Abuse • Surveillance, Isolation and Post-Separation Control	"I felt that the engagement gave him the power to control and abuse me…now, he is forcing me to get pregnant and I am not allowed to take contraceptive pills or other device" "He was comparing me with other women and constantly put me down…he would say you are fat, or you are so dumb" "He said that I do not deserve to be a part of this family and that I should be isolated like people who has COVID 19…at that time, I felt my heart like the pressure cooker that will explode"
	The Immigration-Based Exploiter • Legal and Residency Threats • Cultural Stereotypes and Isolation	"As I told you, I am not Canadian yet and I do not have paper yet…he is acting bad with me because I do not have these papers…he told me if I reported him, he would take my kids and send me back home…if that happened it will be the end of my world…so, I have not report him and will continue to live with him…maybe when I become Canadian, I can leave him"
	Impact At the Centre: Health and Wellbeing of MEIW	"I cut myself off from my family and I cut myself from all of my friends…and for years, I just stayed at home…because I couldn't face the world, and I did not have

Major Theme	Sub-Theme and Categories	Indicative Quote
IPV Impact	• Physical Health • Mental Health • Maternal Health • Reproductive Health	the power to meet people…he made me lose the trust on myself…abuse made me very reclusive" " I had some injuries on my body ..look it is blue now"
	Ripples of Impact: The children of MEIW • Emotional and Behavioural Challenges • Social Integration Issues • Intergenerational Transmission	"I tried to realize it. At the beginning, I did not think that all of these fights will affect my kid while there was not a part of it. We even had these fights in our room even when he hit me. I tried by all means not to engage my kids in that. But I was really mistaken. My daughter came to me and was very scared of what was happening. she felt knots were getting tighter on her stomach as the time passed. This brought great sadness to me because I wasn't able to protect my Self and my family." "My child behaviour is a bit aggressive with his peers. I believe it is because he saw these aggressive behaviours before when I was married"
	Wider Circles of Impact: Community and Systems • Social Isolation • Systemic Strain • Community Cohesion	"It is disheartening to know that a lot of young people are brought up by their parents in households that violence is a norm, they leave with such a deep psychological and social wound that our schools and the general society bears the brunt" "My entire family suffers, and I really see how this transferred to my community. I experience these effects of violence on myself in my workplace. I feel that I am having withdrawal symptoms. So, I usually stay alone and not make relationships with my colleagues"
IPV Vulnerabilities and Help Seeking Behaviours	Cultural and Linguistic Barriers • Cultural Expectations and Gender Norms • Language as a Barrier • Community Perception and Face-Saving	"Staying with him and tolerating all of his bad behaviours was not my choice. I was forced to stay with him because if a woman goes for a divorce, it is only her fault. The people believe that you are a bad woman. They will not even give you the chance to talk about what happened…there are many unheard stories" "Being a woman is enough to be abused and undervalued … Just because I am a woman, I can not confront him and ask him why you did this to me? As a woman I was taught through my childhood that men are above us" "I wanted to call for help, but I didn't know the words to explain what was happening. Even when I tried, they couldn't understand me, and I felt completely trapped."
	Sociocultural and Economic Precarity • Barriers to Employment and Autonomy	"My partner came to my work to embarrass me and caused me to lose my job. His aggression worsened after that because I became very dependent on him for money" … "Poverty is what causes it…. The hardships in our life bring out violence."

Major Theme	Sub-Theme and Categories	Indicative Quote
	• Sociocultural Oppression	"I could not understand why I remained stuck for so long. It took me long time to figure out how and where to seek help."
	Racial Discrimination • Institutional Racism • Immigration-Driven Marginalization	The first time I wanted to escape, I could not find any shelter to go to. The second time, I went to a shelter and there were no women like me, all are white people and speak English only. I felt alone and I could not deal with the women there as I felt that I am different and not welcomed in there.
Coping strategies	Practical Solutions: Problem-Focused Strategies • Seeking Safety and Legal Support • Professional Guidance and Advocacy • Building Independence	" I managed to put a safety plan for us to leave if something bad happen" "I was writing in my diary everything because if I decided to call the police, I have all the evidence" "When I realized that he is abusing me with some tactics that I know and others that I do not know, I decided to improve myself, learn English and work."
	Personal Investment: Emotion-Focused Strategies • Spiritual and Emotional Resilience • Self-Care and Distraction Techniques • Seeking Social Support	"I just try to focus on myself and my kids. I bought many skin care products last month and I started to take care of myself." "I have gone through hell in my life … I left him with a hope that things will change and be better. I wanted to work I wanted to meet friends and adjusted in this new country." "I pray to God for help, and I go to mosque. I cry in front of him [God], he knows everything I am going through. I do not need to tell him anything. I ask God to show me the path. I will say God help me, help me, help my kids."

5.2 Defining IPV

This major theme addresses the study's objective to "Describe how Middle Eastern immigrant women define intimate partner violence. It encompasses four sub-themes, and eight categories sets out how MEIW during the perinatal period make sense of IPV for themselves (see Table 5.1). It captures the sociocultural and structural factors that impact their understanding. The

stories told by the participants indicate that the prevalence of patriarchal values makes it harder for women to recognize or challenge IPV. Structural barriers, including migration-related stressors and systemic inequities, further compounded these perceptions, obscuring the boundaries between acceptable and abusive behaviours.

The results show that participants' perceptions of IPV are shaped by cultural norms, gender roles, and social expectations within their communities. While some women recognised and labelled abusive behaviours, others internalised cultural narratives that framed abuse as a private matter or a wife's failure to meet societal expectations. By addressing these definitions, this major theme provides insight into the ways MEIW conceptualise IPV and how these perceptions influence their ability to respond to or resist abuse.

5.2.1 Walking on Eggshells

This sub-theme explores how participants conceptualized and defined IPV through their experiences of constant vigilance and fear. Rather than viewing IPV solely as physical harm, many women described it as a pervasive condition that shaped the rhythm of everyday life. Their metaphors of "walking on eggshells" reveal how they understood IPV as an ongoing atmosphere of tension and control, where even minor actions or words could trigger conflict. However, what constitutes "IPV" was not always uniformly defined, participants' interpretations were often shaped by cultural expectations and personal experiences rather than formal definitions.

The analysis also indicates that sociocultural norms and expectations both amplified their fear and normalized IPV. This created a sense of cognitive dissonance about the reality of their situation and reduced the likelihood of them seeking help. Patriarchal ideals about marriage and family honour further overlapped with their individual circumstances. The categories in this sub-

theme focus first on participants' individual experiences of fear and safety, before considering how cultural factors shape their perceptions and responses to IPV.

5.2.1.1 Individual Experiences of Fear and Safety.

Participants described the impact of IPV on their sense of personal safety. They explained that fear and vigilance are a part of their daily lives. A participant stated:

> Living with abuse on a daily basis is something not many women can tolerate. Imagine how do you feel when your life is at grave danger every day. A picture is waking you up each day with the thought that it could be your last...I have never felt safe with him, all the time I was waiting for the attack…I was walking on eggshells all the time.

The deliberate nature of the abuse was a recurring theme. Women described their abusers' actions as intentional and calculated, leaving no room for misinterpretation. One woman expressed that her life was filled with constant danger, and it was only after she left her abuser that she regained a sense of safety, she recounted:

> This is what IPV means to me, waiting the harm…I was feeling safe in a park or in a mall rather than being with him, IPV is more dangerous than Covid and more painful than death. It is like a cancer that affects all your body. It is worse than war.

The women who saw the abuse as purposeful and deliberate were often left with existential questions about their partners' reasons for enacting abuse. This included the question of why their abuser chose to remain in the marriage. One participant articulated this tension:

> He was very aggressive and every time he hit me; he meant it. He just wanted to hurt me. He just wanted me to suffer…. I was questioning myself all the

time, why did he marry me if he does not want me and does not love me ? I had to run for my life multiple times when I was living with him.

Being able to see and name harm was an empowering act for some MEIW during the perinatal period. However, it did not alleviate feelings of self-doubt about why the abuse was happening. This reflects the psychological complexity of IPV. These conflicting emotions reveal the ways in which IPV erodes not only a woman's physical safety but also her sense of self and understanding of intimate relationships.

5.2.1.2 Cultural Influences on Perceptions of Abuse.

This category describes how cultural norms and values influenced participants' perceptions of IPV, particularly their experiences of fear and insecurity. For many women, the act of "walking on eggshells" extended beyond the immediate relationship and was shaped by broader cultural and societal factors that both normalized and obscured IPV. These influences amplified the women's sense of danger and restricted their ability to respond specifically during the perinatal period

Some participants described the emotional and psychological toll of living under constant control during the perinatal period, which was often justified by cultural expectations surrounding the man's role and gender norms within relationships. Their reflections conveyed how coercive behaviours infiltrated daily life, producing feelings of pain, confusion, and helplessness. One participant explained: "It was like controlling me with no reason…All the time and everywhere…this hurt me the most…he did not know how to be a good husband… only how to show that he was the man, the one in charge of everything" Her words capture the distress of enduring arbitrary domination and the moral disappointment that accompanies a partner's failure to uphold values of care and respect within marriage. Similarly, another participant stated: "I

know that he is my husband and head of the house but that does not give him the excuse to hit me or ruin my life like that." Together, these narratives demonstrate how women defined IPV not only as physical harm but as a broader violation of dignity, fairness, and emotional security, rejecting cultural norms that normalize male control or justify violence within marriage.

Some statements highlight the tension between the women's rejection of violence and the cultural narratives that position men as dominant figures within intimate relationships such as "I know he is the man and should lead the house, but that doesn't mean he owns me. A husband should protect, not control or hurt his wife or his kids" Participants shared that the decision to leave an abusive partner was often perceived as bringing shame upon their families or communities, reflecting cultural teachings internalized since childhood. These cultural and patriarchal norms made it more difficult for participants to cope with their internal sense of injustice. This illustrates how cultural factors intensify the psychological burden of IPV for MEIW. As one participant stated : "I knew it was not okay, but leaving felt impossible. People would say, 'Be patient, he's your husband.' I felt trapped between doing what was right for me and for my kids and what my culture expects from a good wife and good mother."

Cultural expectations of obedience and family cohesion often intersected with explicit threats from abusers, further intensifying the women's fear and sense of entrapment. For some participants, these threats were deeply intertwined with their perceptions of IPV, as abusers used both cultural and personal vulnerabilities to exert control. One woman described how her abuser leveraged the threat of separation from her children:

> Once in our living room while we were discussing an issue about the kids' school, he stood up and pinned me by my neck, started choking me against the wall. Because he wanted me to shut up … Well, this was not the first time to

> threaten me with my kids and this was not the only way to threaten me. Sometimes he was threatening me to send me back to my country. He told me that he will take my kids away if I think about calling the police.

Another participant said:

> He threatened me if I did not leave the house, he will make me leave the world…you know I cannot define the IPV as an experience…it is a trauma…it is a nightmare. I was so scared and until now I feel so scared when I remember him.

For some participants, their understanding of IPV was further informed by intergenerational experiences of abuse within their families of origin. One woman drew comparisons between her mother's prolonged experience of IPV and her own:

> My mother felt insecure for the whole of her life. For 40 years she was insecure. She died and she did not feel safe…I did not have that power to tolerate. I could not continue my life with him while I am expecting to die every day because of him.

Together, these reflections illustrate how fear, a lack of security, and cultural expectations intertwine to shape MEIW's lived experiences of IPV. The constant state of vigilance described by participants reflects not only their internalisation of abuse but also the external pressures that normalize or obscure it. These dynamics create a precarious foundation for understanding IPV, where cultural values and personal vulnerabilities merge to perpetuate further harm.

While fear and insecurity were central to the participants' experiences, another significant aspect of IPV emerged through perceptions of love and control. For many MEIW, the boundaries

between affection and domination were blurred, complicating their ability to recognize and resist abusive behaviour. The next sub-theme explores how IPV was rationalized or justified within the context of romantic love, shedding light on how love is used as both a justification for harm and a tool for control.

5.2.2 Love as Control

This sub-theme examines how perceptions of romantic love shaped participants' experiences and interpretations of IPV, reflecting the interplay between cultural, relational, and individual dynamics. These accounts align with the microsystem level of the SEM (Heise,1998), where beliefs and close relationships intersect to shape behaviours and perceptions. For some MEIW, IPV was reframed as an expression of misguided affection or protection, blurring the line between love and abuse. These perceptions, rooted in cultural and social norms, not only contributed to men's perpetration of IPV but also made it harder for women to recognise or escape abusive behaviours. The following categories explore these dynamics: Perceived Justifications for IPV, which examines how abuse was rationalised as protective or affectionate, and The Role of Cultural and Romantic Beliefs, which considers how ideals of love and marriage reinforced harmful power dynamics.

5.2.2.1. Perceived Justifications for IPV.

Among several participants, romantic love was perceived as the foundation of marital relationships, an ideal deeply embedded in cultural norms that often reinforce masculinity and gendered power structures. During the challenging period of migration, romantic love became even more significant, serving as an emotional anchor in the absence of familiar support systems. However, this reliance often obscured the realities of IPV and the inherent power imbalances within marriages.

Participants frequently expressed difficulty recognising IPV or acknowledging its impact, attributing abusive behaviours to their husbands' changing identities after migration. This reframing allowed women to separate their husbands' abusive actions from their core identities, attributing the violence to external pressures such as poverty, high costs of living, and limited opportunities. One participant explained: "I know this type of love will change soon to different types of love I believe that he is showing me his love in a different way". Controlling behaviours are interpreted as expressions of love. This makes it harder for MEIW to distinguish affection from abuse.

5.2.2.2. The Role of Cultural and Romantic Beliefs.

Romantic love and cultural beliefs were deeply intertwined in shaping MEIW's perceptions of IPV. Jealousy was frequently framed as a natural aspect of love, an uncontrollable emotion inherent to men, which justified controlling behaviours. One participant explained:

> He loves me so much and did not want me to talk with anybody…once, I did not listen to him and went to school, when I came back, he beat me so hard. It was the first time he did that, but he apologized and regretted doing this because he loves me.

For several women, controlling actions were perceived as attempts to protect them from Western influences that their partners believed could challenge traditional gender expectations or family values. Spouses employed coercive control under the pretence of safeguarding, rationalizing their maltreatment by invoking familial honour or purported moral integrity: "He did that because he just wanted to protect me from any problem.... you know we are new here, and I do not speak English very well so I may get in trouble without him." Another participant stated " He said he didn't want me to socialize with the wrong people or learn bad habits from

Canadian women…. Just to protect me you know.. He told me it's safer if I just stay home, that this country changes women and makes them forget who they are."

These quotes show that IPV acts are justified as protective measures, particularly in the context of migration. This context was reinforced by cultural expectations that prioritised male authority and family cohesion, further complicating women's ability to label IPV as abuse. By defining IPV through cultural beliefs and ideals of love, participants relied on collective knowledge and shared values to make sense of their experiences. In the following quote, family members actively participated in these interpretations, reframing acts of IPV as expressions of affection, marital duty, or moral responsibility, thereby normalizing the abuse. This collective framing profoundly influenced how women explained, evaluated, and navigated their circumstances within intimate relationships.

> Not far along, I knew that my husband was raping me…to me that was not rape because sex without the woman permission during the marriage is okay and legal in my country. When I told my sister that he is raping me, she laughed and said he did this because he loves you and his desire is strong for you. When I told my mother, she told me that what he did was his right and if I say no, the God will be upset with me. For years this was my belief too.

For some, the cyclical nature of IPV, marked by abuse, remorse, and temporary reconciliation, reinforced its perception as an extension of love. One participant reflected:

> I know that he loves me because every time he hit me or do something bad to me, he would come and apologize…he will be very sorry…at least he

> apologizes, and he wants to be better…he loves me and that's what makes him come back every time he hurts me.

Participants utilized collective harmful norms to actively negotiate the intersections of personal experiences, relational dynamics, and social ideals. These factors or aspects constrained the women's ability to label IPV as unacceptable while shaping their strategies for navigating or enduring abusive relationships.

5.2.3 A Psychological Trap

The psychological component of IPV appeared in two notable ways during the interviews. Firstly, several women described IPV as a feature or consequence of their partner's mental health issues. Secondly, participants described themselves as psychologically trapped by IPV due to threats and enforced dependency. These accounts reflect participants' efforts to make sense of their experiences by framing IPV as simultaneously a consequence of their abusers' psychological struggles and a dynamic that trapped them within abusive relationships.

The following categories explore these perspectives. IPV as a Mental Health Issue examines how participants attributed abusive behaviours to emotional or psychological struggles, while balancing recognition of their partners' challenges with the harm inflicted. The Cycle of Abuse and Entrapment focuses on the cumulative impact of abuse, detailing how cycles of harm and enforced dependency deepened participants' experiences of entrapment.

5.2.3.1. IPV as a Mental Health Issue.

In several accounts, participants framed IPV as stemming from underlying mental health issues, interpreting abusive behaviour as reflective of their partners' psychological struggles. This framing reflects the participants' efforts to rationalize their experiences and locate explanations

within a broader understanding of their partners' histories and behaviours. One participant linked her husband's aggression to his past trauma:

> He has a mental problem. I believe my husband is mentally sick. Yes, he has a mental illness…. Sometimes, he is okay and sometimes he is aggressive……. no, he is not okay but… I hate when he gets angry because he usually throws things on me, but occasionally hurts me...You know he had many issues in his life, he was in a detain center for 7 years, they punished him for things he did not do. He saw the death with his eyes, and they tortured him for long time. They made him crazy.

Such a quote highlights how the participant sought to contextualize IPV as the product of their partners' psychological instability or trauma. She also gave a structure that allowed for the IPV to happen. While this framing provides a way to make sense of abusive behaviour, it also shifts attention away from the agency and responsibility of the abuser. Another participant commented:

> I am thinking the abuse is like a mental illness. You are abusive that means you are sick…I think my ex was off. He was not okay. He was like the sick people in a movie…He needed a treatment…it was not only like illness, but it is something inside him that made him abusive…yes violence is illness. You are abusive…you are sick.

These narratives reflect a tension between recognizing abuse as a deliberate act and framing it as a consequence of mental illness. While participants' accounts revealed a nuanced understanding of how psychological struggles can shape behaviour, they also highlight a potential risk: reducing IPV to a symptom of mental illness can obscure its structural and

relational dimensions, including power dynamics and gendered inequalities. In the second quote, the participant highlights the cyclical nature of abuse, explaining it as something beyond her control and attributing it to "something inside him that made him abusive."

Similarly, one participant described IPV as a progressive mental issue with compounding consequences:

> When I remember what happened to me with him…I feel that he was mentally not okay. Violence is like a disease…it spreads, affects everyone around it, and if left untreated, it worsens with time

This account underscores the cumulative harm of IPV, illustrating how it extends beyond isolated incidents to affect the broader relational and social context. However, framing IPV as comparable to a disease may unintentionally diminish the accountability of the perpetrator by suggesting that abusive behaviour is a mental condition. This highlights the need for critical engagement with how mental health narratives are applied to IPV, particularly when they risk absolving the responsibility of the abusive partner.

5.2.3.2. The Cycle of Abuse and Entrapment.

This category explores how participants conceptualised IPV as a cycle of violence, reconciliation, and dependency, reinforcing a sense of emotional entrapment. At a personal level, participants reflected on the emotional toll of living within the cycle of abuse, characterised by recurring violence followed by apologies and temporary reconciliation.

One participant encapsulated the personal aspect of this dynamic, describing the relationship as a psychological trap: "When I was with my husband, I was feeling trapped and overwhelmed. Our relationship was the trap, and I was the prey."

Another participant highlighted the complexities of navigating abuse while balancing societal expectations and parental responsibilities:

> I cannot really explain what abuse means to me. But I feel that I am in cage. If I stay with him, people will accuse me of failing to protect my kids from violence and he will continue abusing me. But if I leave and left my kids behind, I will be accused by abandoning them and being a bad mother. If I decide to take my kids with me, where shall I go with three kids? There is no win in my situation. I am now trapped.

This sense of entrapment was further reinforced by the cyclical nature of IPV, as described by another participant:

> I am trapped. We are okay today, tomorrow we will have a fight and he will hit me, and after tomorrow he will apologize and we will continue our life like that ...every time, I want to leave he will come and apologize to me then I forgive him …When I feel that he is angry, I will know that he is stressed and he will hit me so I will try to avoid him but sometimes the accident will happen then he will feel sorry of what he has done.

This participant's account aligns with the established cycle of abuse, encompassing tension-building, crisis, and reconciliation phases. The tension-building stage involves the abuser's rising frustration, prompting the victim to comply or avoid conflict. This is followed by the crisis phase of physical abuse and the honeymoon phase of apologies and promises of change. Such cycles perpetuate fear, hope, and dependency, creating significant barriers to escape.

These accounts highlight how IPV is entrenched at the intersection of personal, cultural, and societal forces. The sense of being "trapped" stems not only from internal struggles but also from external pressures like community expectations. This dynamic becomes even more complex when IPV is perceived as functional within marriage. For some participants, IPV was framed as a means of conflict resolution, a way to silence disputes and maintain relational order.

5.2.4 Compliance through Violence

This sub-theme explores how participants define IPV as part of a broader discourse of control, where different forms of IPV were used to enforce obedience and sustain patriarchal authority. Participants described IPV as both a coercive strategy to resolve conflict and a means to maintain hierarchical power relations, reflecting gendered norms that normalize domination and silence women's agency. The following categories explore these dynamics. IPV as a Conflict Resolution Strategy examines how participants perceived physical violence as a means to address disputes or enforce abusers' authority in family settings. IPV as a Tool for Establishing Hierarchy focuses on how violence reinforced patriarchal power structures, maintaining men's dominance and curtailing women's agency within intimate and familial relationships.

5.2.4.1. IPV as a Conflict Resolution Strategy.

For several participants, IPV was framed as a coercive strategy to manage disputes within their relationships. Physical violence was described as replacing constructive communication, creating an environment where fear suppressed resistance and enforced compliance. One participant explained how her husband's use of violence ensured that her objections were silenced:

> My husband was abusing me just to keep the peace and stop any larger problems from happening in our relationship…. I felt the abuse was a way to

> resolve conflicts between us… it was not the greatest way to resolve conflicts, but it was working for him.

This account reflects how IPV was perceived as a functional, albeit harmful, method to avoid larger disputes by forcing compliance. However, this framing normalized violence as a way of resolving conflicts, reinforcing the silencing effect of IPV. Another participant highlighted how IPV was used to suppress autonomy, sharing how her husband resorted to violence to ensure control:

> My husband was using his hand to resolve any problem with me. He knew that I cannot do anything when he hit me, but I will be silent and do whatever he wants. Once I asked him that I wanted to learn driving so I can take the kids to school or go shopping. He refused and I insisted. So, it ended up by beating me badly. After that, I have never asked him to drive again.

This narrative underscores how IPV curtailed women's autonomy, as the fear of escalation discouraged further resistance. The participant's decision to abandon her request exemplifies the pervasive silencing effect of IPV.

5.2.4.2. IPV as a Tool for Establishing Hierarchy.

Beyond its use in conflict resolution, participants described IPV as a mechanism for asserting dominance and reinforcing hierarchical power dynamics within the family. Violence was employed not only to silence women but also to establish their subordinate status within the household.

Parenting practices were a significant area where IPV was used to reinforce these hierarchical dynamics. One participant shared how her husband used violence to invalidate her authority as a mother and assert his dominance:

> Once I was talking with my child and telling him do not to hit back in the school. My husband got angry and told my son no do not listen to your mother and that he has to hit back. Then he started blaming me that I wanted my son to be soft and to be a victim. I tried to argue with him then he came and slapped me multiple times and stated that I do not have an opinion in raising my kids and I am not allowed to raise them this way. Since then, I only talk with my kids about these issues when my husband is not at home.

This account reveals how IPV operated to undermine the participant's parenting decisions and reinforce her husband's authority within the family. The violence she experienced was not solely about resolving disagreements but about maintaining hierarchical control, ensuring that her role remained subordinate.

In a migration context, this dynamic becomes even more complex. The participant's actions, limiting discussions with her children to private moments, highlight how IPV silences women and reshapes family dynamics. Participants faced compounded challenges in asserting their autonomy, yet some also found ways to reclaim a sense of control within restrictive circumstances

These narratives demonstrate how IPV functions as a mechanism for enforcing compliance and asserting dominance within familial relationships. By leveraging physical violence, abusers reinforce traditional gender roles, curtail women's autonomy, and perpetuate cycles of control and subjugation.

5.3 Forms of IPV

This theme, which explores the various forms of IPV, addresses the study's overall purpose of exploring how MEIW experience IPV during the perinatal period in Ottawa and supports the

objective of describing how immigrant women define IPV within their lived contexts. It includes three sub-themes, and seven categories explores the diverse and intersecting ways IPV manifests in the lives of MEIW, highlighting the complexity of their experiences. Participants described various forms of abuse, including physical, sexual, emotional, financial, and immigration-related exploitation, demonstrating how abusers employed multiple strategies to exert control and maintain power. These forms of abuse were often interconnected, with cultural and systemic factors compounding their impact.

By focusing on the specific manifestations of IPV, this major theme underscores how different forms of abuse intersect with participants' cultural and relational contexts. For example, financial abuse was frequently tied to systemic barriers, while emotional manipulation leveraged cultural norms to reinforce control.

5.3.1 The Physical, Sexual and Financial Abuser

This sub-theme explores the intersecting forms of abuse experienced by participants, highlighting the physical, sexual, and financial dimensions of IPV. Participants' narratives reveal how abusers used physical violence, sexual coercion, and financial control as tools to dominate and restrict their autonomy. The following categories examine the distinct dynamics of these forms of abuse. The first explores Physical Abuse, where abusers employed violence as both punishment and a demonstration of power. The second focuses on Sexual Abuse, detailing participants' experiences of coercion and violation, often framed within marital expectations. The final category, Financial Abuse, highlights the use of economic control to undermine independence and deepen dependence on the abuser.

5.3.1.1. Physical Abuse.

Several participants described the physical aggression they experienced within their relationships. Physical violence emerged as the most frequently discussed form of abuse in the interviews. This prominence may reflect the participants' understanding of IPV as being primarily physical, potentially indicating a lack of awareness of other forms of abuse. Some participants related how physical abuse is often easier to recognize because it produces immediate and visible effects, both for victims and witnesses.

Participants reported various forms of physical abuse, including punching, hitting, strangling, slapping, hair-pulling, and biting. Many women described how physical abuse escalated over time. A participant described the physical and emotional toll of escalating violence:

> The problem was with him hitting, slapping and kicking me. He has never done that in front of the kids. It when we were alone. The most hurting thing was slapping me on the face. When he slaps me, I feel that I am not in the world. Last time he slapped me I fainted, and I had a headache for three days after. He slaps, kicks, bites…anything can really hurt he will do. Pulls my hair, pinches me or pushes me. You cannot imagine how I felt after each incident… I will be in pain and shock…sometimes I could not cry because I am not realizing what happened to me.

Physical violence during pregnancy and the postpartum period was a recurring theme, with several participants highlighting how the frequency and severity of abuse increased during these times. One of the participants shared a traumatic experience where she faced sexual assault

during pregnancy as well as physical violence, including hair-pulling and being forcefully pushed onto the bed. Another participant shared:

> When I was three months pregnant, he kicked me on my stomach, and I lost the baby. I did not have any problem with my pregnancy before that kick…just because he wanted me to make him food while I was praying. I buried my baby with my own hands, and he never asked where the baby was.

Physical violence during pregnancy was often framed as especially concerning for participants, as it not only harmed them but also caused significant risks to their unborn children. One woman explained:

> He hit me on my tummy when I was pregnant. He called his mother and told her that I was on the ground and that I needed to go to hospital. His mother and his sister-in-law came and took me to the hospital. They told me not to tell the doctor about what happened. They said that the kid's society would take the child from me at birth if they knew about the abuse happening in the house. So, I did not tell the nurses. You know I am used to his rude words, but I am mostly worried about the hitting and pushing.

This participant expressed how family interference and fears of child protection services discouraged her from seeking help, further entrenching her in an unsafe environment. She added that while she had grown accustomed to verbal abuse, the physical violence during pregnancy caused her significant worry, particularly about the potential for miscarriage or other harm to her baby.

5.3.1.2. Sexual Abuse.

Several participants described experiences of sexual abuse in their relationships, revealing how it intertwined with emotional manipulation and broader systemic challenges. Influences on the specific experiences of sexual abuse faced by MEIW include cultural norms that position men as dominant within domestic hierarchies, the isolation of women from support networks, and structural issues such as inadequate access to culturally sensitive services. At the relational level, emotional coercion, and reproductive control further complicate women's ability to recognise, resist or escape sexual abuse, particularly during the perinatal period.

One participant recounted her partner's relentless use of emotional manipulation to pressure her into unwanted sexual acts:

> …like a nightmare sex that he'd make us do. I would be tired or busy and simply I did not want to do it…then he would just shame me into it. He would just tell me "You don't want to do this for me…you do not like me or you like somebody else...doesn't a girl want to please her husband?' or sometimes he would force me to talk dirty to him. I told him that I am just not comfortable doing that…he would scream at me. It was very stressful…he was always time telling me that I am not normal because I do not want to do sex with him, and he makes me questioning my normalcy.

For other women, the fear of escalating conflict or further abuse forced them to comply with their abusers' demands. As one participant explained:

> he would start yelling at me and would say "do you not love me?" or '"do you not want me?"' to manipulate me so we would always end up doing it…to stop

> these types of conversation because it was never something I enjoyed doing at that moment.

These narratives highlight how emotional manipulation became a mechanism to assert dominance in intimate relationships, diminishing participants' agency, and autonomy.

Another participant recounted the extreme consequences of reproductive coercion, revealing her efforts to reclaim some autonomy over her body: “My little son wasn’t planned…I was forced to have sex with him. He forced me to get pregnant too.”

In an attempt to resist this control, she secretly sought medical intervention, requesting that the doctor conceal her use of an IUD: “I told the doctor “Will he feel it? Please cut the string short because I do not want him to feel it”.

The perinatal period amplified these challenges, as participants faced heightened vulnerability to abuse and greater barriers to accessing support. Pregnancy often became a period of control and coercion, with women reporting forced pregnancies, restricted decision-making, and physical violence tied to their reproductive health.

5.3.1.3. Financial Abuse.

Participants described financial abuse as encompassing a range of controlling behaviours that eroded their autonomy and reinforced their dependence on their partners. This form of abuse manifested in various ways, including denial of access to household income, withholding financial information, monitoring expenditures, and exclusion from financial decision-making. Some participants also reported their husbands’ incurring debts in their names, further exacerbating their vulnerability and dependence. One participant described this dynamic:

> He used me for many years. I was working and I had a good pay, and he was working and getting better pay than me. But he was not giving me any money

> to spend on myself or on our kids. I was paying for everything. I was paying the mortgage, kid's allowances, their clothes and everything…he did not contribute to the house's expenses at all.

This example highlights a dual exploitation: outwardly, both spouses appear to be undertaking paid employment and contributing financially to the home, reflecting the social values of shared responsibility that reflect the Canadian context. Yet, behind closed doors, the participant's income was appropriated, violating both progressive and traditional expectations. This exploitation was concealed from the broader community, enabling the abuser to maintain a façade of cultural adherence while intensifying the participant's isolation and dependence.

Another participant shared how her husband framed his control over their finances as a supportive gesture, manipulating cultural expectations of the male-as-provider to justify his actions:

> He was telling me that "I know you are under a lot of stress right now so why don't you just let me take care of the finances and I will give you money each week to spend on what you need" …he was taking all of my money, and he had my credit card too.

By presenting his control as a means of alleviating stress, the participant's husband weaponised patriarchal norms to entrench financial dependence. This manipulation reinforced gendered power imbalances deeply embedded in Middle Eastern cultural contexts.

Participants also highlighted how financial abuse extended beyond controlling existing resources to actively obstructing women's efforts to acquire financial independence. One participant recounted:

> He did not allow me to learn English because he does not want me to get a job. Then, I tried to work in a Middle Eastern restaurant where everybody speaks Arabic, but he refused, and I could not do anything about it…he was worried if I worked and have money, I will take the kids and leave him. He was so scared.

These narratives emphasise that financial abuse is not merely about controlling money, but about systematically eroding autonomy. For many participants, financial independence was seen as the first step toward escaping IPV. However, abusers exploited cultural norms of male authority and systemic barriers, such as linguistic and employment challenges, making independence profoundly difficult to achieve. Importantly, all of this occurred behind closed doors, where the abuse remained hidden, and the voices of the women were silenced.

5.3.2 The Psychological Manipulator

This sub-theme examines the ways in which IPV manifested through psychological and emotional abuse. Participants described experiences of emotional abuse, surveillance, and retaliation, illustrating how abusers weaponised cultural norms, systemic barriers, and intimate knowledge of their vulnerabilities to maintain power.

The following categories explore these dynamics in detail. The first, Manipulation and Emotional Abuse, examines how verbal insults, reputation damage, and cultural expectations reinforced participants' isolation and dependence. The second, Surveillance, Isolation and Post-Separation Control, focuses on the strategies abusers used to limit participants' connections to support networks, and addresses how control persisted beyond the relationship by continuing to exert power through digital abuse, manipulation, and reputational harm.

5.3.2.1 Manipulation and Emotional Abuse.

This category explores how IPV manifested as manipulation and emotional abuse, reflecting abusers' deliberate efforts to control and undermine their partners. Participants described a range of emotionally abusive tactics, including reputation damage, verbal insults, and the use of cultural norms to reinforce dependency and prevent resistance. For MEIW, these experiences were often amplified by cultural expectations around honour and reputation, leaving them isolated and unable to seek support without fear of judgment or further harm. One participant recounted how her husband exploited these norms by publicly accusing her of infidelity:

> He totally damages me when he shouted loudly in our yard that I'm a bad woman who sleeps with other men, and all the neighbors could hear him, and he did know that everybody will hear him and that will affect me and break my heart.

This public humiliation served not only to tarnish the participant's standing but also to obscure the abuser's own misconduct, such as infidelity. These manipulative strategies exploited cultural expectations, leaving participants isolated within the relationship.

Verbal abuse was another tactic employed by abusers, often beginning early in the relationship and intensifying over time. Insults, swearing, and threats targeted participants' appearance, domestic abilities, and parenting skills. Many women reported feeling devalued and undermined by these constant attacks. One participant reflected:

> My husband used to swear at me or call me names such as donkey or cow. To be honest I do not care that he does that because these are only words but doing this in front of my kids was my main problem ... I feel my kids do not respect me anymore.

Participants highlighted how verbal abuse often escalated into physical violence, creating an environment of fear and vigilance. For some, verbal abuse became a warning sign of imminent harm, prompting strategies to avoid confrontation. One woman shared:

> My husband gets angry and yells at me over the littlest things. Is this verbal abuse? … Now, I used to his swearing and cursing and sometimes I ignore him. But if he gets very angry and swears a lot, I will leave the house for a while because he might attack me.

One participant reflected on her struggle to reconcile her faith with her husband's behaviour:

> You tell me what should I do as a Muslim woman? He always screams, swear and lose his mind I ask Allah at each prayer to make him better but he gets worse…sometimes he throws things on me…he says he swears at me because I am nagging on him all the time… but I tried to talk to him only to ask things for kids or for me.

The illusion of love also played a significant role in participants' experiences of manipulation. Abusers often masked their controlling behaviour as affection, leaving women unable to identify early warning signs of IPV. One participant described how she misinterpreted her husband's possessiveness:

> He was like a charm. Like the main actor in a movie, he was the prince that loves me. I was thinking his actions like obsession, jealousy and possessiveness as signs of love…but after a while all of these actions made me a prisoner. A prisoner who cannot break free. He was playing with my feelings…actually he was playing games with my heart and head. He was just

> using me for his own pleasure and told me whatever he thinks I need in order to stay with him

This manipulation often intensified after marriage, as participants became more reliant on their partners. Many women entered their relationships with hope that their partners would change, only to find that marriage provided further opportunities for control. One participant reflected on how her engagement marked the beginning of escalating abuse:

> I was in a love relationship and because of my bad luck I ended up getting engaged to the abuser. I was thinking if we get married, he will be better and he will stop bossing me around. I thought he will be less controlling about what I said or with whom I am talking. But as soon as we get married, the criticizing and blaming started…… I felt that the engagement gave him the power to abuse me.

The emotional abuse described by participants was intertwined with cultural expectations and systemic barriers, leaving many MEIW trapped in relationships where their autonomy was consistently undermined. For those in the perinatal period, the physical and emotional demands of caring for a newborn compounded their vulnerability, intensifying their reliance on their partners. For example, a participant stated : " I felt like I had no choice .. everyone expected me to stay and make it work, even when I was breaking inside. With the baby, I couldn't imagine how to leave or where to go". This intersection of cultural pressures, relational dynamics, and this life stage, left participants unable to access the resources or support needed to envision a way out of their abusive circumstances.

5.3.2.2 Surveillance, Isolation and Post-Separation Control

Surveillance and isolation were significant aspects of IPV, with abusers employing various strategies to limit participants' autonomy and sever their connections to the outside world. Participants described how their abusers confined them physically, restricted their movements, monitored their interactions, and denied them access to education or social networks. These tactics were framed as protective but served to deepen control and dependence.

One participant recounted how her husband used physical confinement and surveillance tools to enforce isolation:

> I am not able to go outside of the house door. He has a camera at the door. He also told me that I need not to contact my family because he does not like them. Sometimes I talk to my mother and sister, but this is hard because sometimes he uses it against me…he will say that I lied.

Many participants highlighted how digital surveillance was used to restrict their freedom and maintain control. Abusers monitored social media accounts, read private messages, and restricted participants' phone usage. One participant reflected on how her ex-husband justified his controlling behaviour:

> Nobody was allowed to come to my house, and I wasn't allowed to go anywhere. My ex-husband imprisoned me for a while, and to convince me of his good intention he told me, "It's out of too much love for you. You're so beautiful, if other men see you, they'll flirt with you".

This form of control extended to social isolation, where participants were cut off from their family, friends, and communities. Abusers often employed emotional manipulation to discourage participants from seeking support, creating a cycle of dependence. The perinatal

period further amplified the impact of surveillance and isolation for MEIW. Caring for an infant, combined with limited mobility and increased vulnerability, left many participants entirely reliant on their abusers. For example, a participant explained: “Everyone told me to focus on the baby and let him handle things, but that just gave him more control. I was stuck inside, alone, with no one to talk to.”, and another participant highlighted: “He used the baby as an excuse to keep me inside the house. He’d say, ‘You shouldn’t be taking the baby out,’ or ‘ your role is to take care of the baby only.’ I started believing that I am only good to stay home and take care of the baby, and soon I just stopped going anywhere.” This life stage deepened their emotional and physical constraints, as one participant reflected: “He just wanted to cut me off from other; he does not want me to talk to anyone…this is his only intention to be the boss of me.”

For some participants, isolation was so severe that it mirrored imprisonment. One woman explained, “I wasn’t allowed to go anywhere alone not even at the doorstep. The only time I could see my family was if he said so. I felt like a prisoner in my own home.” For some other participants, isolation created a sense of conditional freedom rather than complete imprisonment. One woman described the conditions of her confinement: “My husband was controlling me all the time. If I did something he does not want, he would physically abuse me. If I did whatever he wants, he would let me go to visit my family.”

Post-separation control also emerged as critical dimensions of IPV, with participants detailing how abusers restricted their autonomy during the relationship and maintained power after its end. One participant shared the extent of the harm her abuser inflicted after separation:

> As soon as we separated, and I took the kids with me because he was hitting them. He started to post stuff online about me…he created a fake Facebook page with my name, and he said that I became a lesbian. He posted many of

> my photos without my permission and my family found that…it was really a big problem for me.

This example illustrates how post-separation control often mirrored the patterns of abuse experienced during the relationship. In this case, the participant's ex-husband weaponized cultural and religious norms to cause reputational harm, knowing the stigma surrounding homosexuality in their community would lead to exclusion and scrutiny. Another participant described the rigid expectations and punishments imposed by her abuser:

> He was like a god. He will set the rules and if you break any, he will give you consequences. He will be like, do this and do that and if you say no, you will be punished.

For many MEIW, the cultural expectation of submission to male authority instilled the belief that control was both right and normal. As one participant reflected: "It is okay, I should listen to him and do whatever he wants. Since we were so young we learned that we need to listen to our husbands. It is their right that we respect their words."

At the same time, participants described how these dynamics stripped them of agency and reduced them to objects, leaving them unable to fully assert their autonomy, though some described fleeting glimmers of agency within these constraints.

This perception of control as both natural and oppressive created a form of cognitive dissonance that, for some women, persisted even after leaving the marriage. One participant illustrated this experience when she explained: "He was very controlling. I know that he is the man, and he should take control of everything in the house including me and the kids…it is just like I am a furniture piece." The emotional toll of these dynamics was significant, leaving

participants feeling isolated and constrained by fear of judgment or ostracism. One participant explained how this fear shaped her self-imposed isolation:

> I decided not to talk to anyone or have friends. I felt everybody will judge me…maybe shame was overwhelming me. I felt like if I talked about it, people would see me differently or judge me. Yes, he isolated me but the fear from how other will see me made me isolate myself.

The enduring nature of isolation and post-separation control highlights how abusers maintain dominance, both within relationships and long after they ended. For MEIW, the integration of cultural expectations and systemic limitations created significant obstacles to regaining autonomy. Even after separation, the legacies of control and fear continued to shape their lives, leaving participants to navigate the challenges of rebuilding their sense of agency in the face of ongoing social and emotional barriers.

5.3.3 The Immigration-Based Exploiter

Immigration-related abuse appeared throughout the data, uniquely shaping participants' MEIW experiences of IPV. Explicitly mentioned in half of the interviews, it intersects with every major theme in this chapter. To ensure this issue is clearly addressed, it has also been presented here as a short, discrete subtheme that examines how immigration status and processes were weaponized by abusers to create dependency and restrict autonomy.

Participants described how husbands exploited immigration processes, such as spousal sponsorship and legal documentation, as tools of control. Threats to cancel sponsorships, withhold documents, or report women to immigration authorities created fear and vulnerability. These tactics were especially impactful for participants with refugee or undocumented status, who faced limited options for securing residency and heightened precarity.

While immigration-related abuse does appear throughout the data corpus, this sub-theme focuses on it distinctly. The following categories explore these dynamics: Legal and Residency Threats, which examines the use of immigration processes to maintain control, and Cultural Stereotypes and Isolation, which considers how cultural norms reinforced dependency and isolation.

5.3.3.1 Legal and Residency Threats.

Participants revealed how abusers manipulated legal and residency processes to foster dependency and maintain control. These tactics included refusing to file immigration papers, threatening to withdraw sponsorship, and using immigration authorities as a means of coercion. Many women described their abusers as exploiting their lack of legal status to create fear and entrapment. One participant explained how her husband used her immigration documents to restrict her freedom:

> He was threatening me all the time that he withdraws my application and send me back to my country … he was telling me go back to [country name] so the soldiers will rape and kill me and that's what I deserve.

In some cases, participants acted as sponsors for their abusive partners, reversing the traditional power dynamic. Even in these scenarios, abusers exploited the sponsorship process to enforce compliance. One participant shared: "I lost my work and applied for welfare. People on welfare cannot sponsor their partners. Then he threatened me that if I could not continue the sponsorship, he will stop sleeping with me and he did. He knows that I love him and could not live without him." This example illustrates how sponsorship was subverted into a tool for manipulation, with abusers using threats of withdrawing intimacy to enforce control. While withdrawing or discontinuing sponsorship may legally fall within a sponsor's rights, using it as a

threat or tool of punishment constitutes a form of IPV related to immigration process. The participant highlighted how immigration status, financial dependency, and relational dynamics became entangled, increasing her vulnerability.

One participant's interview reflects the intersection of multiple forms of vulnerability. She mentions lack of knowledge, immigration status, language barriers, and dependency and how they overlapped to increase her vulnerability to IPV, stating:

> My application for permanent residency is still in process, but my husband is somewhat abusive. He knows I am unaware of the details of my immigration status and deeply anxious about my future since he is my sponsor. The issue is that I don't speak English well, and I have no idea where to begin seeking help.

These results underscore how immigration status is weaponized, creating barriers that made it difficult for participants to leave abusive relationships or access support systems.

5.3.3.2 Cultural Stereotypes and Isolation.

Participants described how cultural expectations and stereotypes intersected with immigration-related abuse, exacerbating their isolation and dependency. Abusers leverage societal norms that emphasize submission to male authority and prioritize family unity, framing control and coercion as aligned with cultural values.

This dynamic led to participants feeling trapped between cultural expectations and the realities of their abusive relationships. The fear of judgment from their communities often prevented them from seeking help or disclosing their experiences. These pressures were especially pronounced for MEIW with precarious immigration statuses, as cultural narratives around shame and honour intersected with legal vulnerabilities to deepen their isolation, as described here:

> In my culture, people believe the wife should stay no matter what, leaving is seen as shameful. But I also couldn't risk losing my status here. He used that against me. He'd say, 'If you tell anyone, I'll cancel your papers.' I felt trapped by both my community's judgment and the fear of being sent back.

These accounts highlight how abusers utilize cultural norms to legitimize control and reinforce participants' isolation. Many participants could not see a way out because they were being threatened with immigration policies and manipulated because of their culture. Therefore, abuse related to immigration is both a personal and a structural block to autonomy.

5.4 IPV Impact

This major theme addresses the study's objective "Describe the impact of IPV on women, their infants, other children, families, and society". This major theme analyses the complex effects of IPV on MEIW. The results show that IPV has physical, psychological, and systemic repercussions. IPV fundamentally undermines individual health and well-being, serving as a pivotal factor that influences children, families, communities, and larger societal frameworks. Participants reported the physical consequences, including injuries and chronic health issues, as well as the vulnerabilities and risks linked to pregnancy and motherhood, along with the lasting mental health impacts of IPV. The psychological effects included anxiety, depression, and a widespread sense of fear. The repercussions on children's emotional and social development are evident in the data, with participants indicating intergenerational cycles of harm. The data presented indicate that IPV strains public systems, undermines social cohesion, and perpetuates inequality at the societal level.

This section presents a structured examination of the impacts, starting with the immediate effects on health and well-being and subsequently extending to children and wider societal dynamics.

5.4.1 Impact at the Centre: MEIW's Health and Wellbeing

This sub-theme explores the impacts of IPV on the individual health and well-being of MEIW. These effects, centred on women's physical, mental, maternal, and reproductive health, serve as the starting point from which the consequences of IPV extend outward, influencing children, extended families, communities, and systemic structures, captured in later sub-themes. Participants provided detailed accounts of the physical toll of IPV, including injuries such as bruises, fractures, and chronic health conditions like hypertension and diabetes. Mental health challenges including anxiety, PTSD, and depression also appear. This indicates the significant emotional and psychological impact of IPV on survivors. They also indicated that IPV increased maternal vulnerabilities, resulting in negative outcomes such as miscarriage, preterm birth, and other complications during pregnancy and postpartum periods. This sub-theme investigates the effects of IPV on MEIW's health and well-being using three interrelated categories: physical health, maternal health, and mental health.

5.4.1.1 Physical Health.

Many participants described the direct physical impact of IPV, revealing a wide spectrum of injuries ranging from minor to severe. Minor injuries, such as scratches and bruises, were the most commonly reported. More severe outcomes, including fractures, head injuries, internal injuries, sore muscles, and broken teeth, were also shared. One participant shared: "My ex-husband was frequently slapping and pushing me. So, I had many bruises on my face and body."

Injuries to the head, neck, and face were among the most frequently reported, reflecting the abuser's use of hands or objects to cause harm since beating with an object often affects areas of the body that are at hand height.

These patterns indicate an intent to inflict highly visible and impactful injuries. Another participant shared the ongoing experience of sustaining repeated injuries:

> I had many bruises on my body. Some are faded and some are still new. He bit me last week. Now it is yellow and last week was blue. I am not sure if it will go completely.

Women also described significant injuries due to violence escalating, with one participant sharing:

> The other day during an argument over kids related topics, my husband grabbed me by the waist and twisted my arm behind my back. At that time, I heard something break, and it was my wrist bone.

The ongoing physical impact of IPV also came through in participants' accounts. Some connected the stress and trauma of abuse to the development of serious health conditions. For example, a participant stated, "My family doctor told me because I lived with an abusive husband for a long time, I developed hypertension because these problems affected my heart and vessels." And another stated "I think I had diabetes because of him. I lived with him for fifteen years in stress and fear. I often wonder if I hadn't married him, would I still have gotten diabetes."

Participants also described physical injuries requiring medical intervention, such as fractures and dental damage. One woman shared:

> Three years ago, my husband kicked me on my ankle because he was angry with me. It was not very hard, but I had too much pain and when the doctor saw my ankle, he asked me to do an X-ray, and it was broken, and last year, he slapped me on my face, and he broke one of my teeth.

Collectively, the results illustrate the diverse physical health outcomes experienced by MEIW as a result of IPV. These included soft tissue injuries (e.g., wounds, abrasions, and tears), orthopedic issues (e.g., fractures and chronic pain), sensory impairments (e.g., partial hearing loss), and chronic diseases (e.g., hypertension and diabetes).

5.4.1.2 Mental Health.

The study highlighted a significant association between IPV and the mental health of MEIW, with participants describing a wide range of mental health challenges. These included anxiety, stress, fear, insomnia, depression, and symptoms of post-traumatic stress disorder (PTSD). While many participants did not explicitly name their mental health conditions, their narratives revealed significant emotional distress. Most women sought support from social workers, counsellors, or support groups rather than formal healthcare systems, reflecting cultural and systemic barriers to accessing mental health services.

Anxiety was a recurring theme, with participants detailing how the constant unpredictability of IPV heightened their state of stress and hypervigilance. For many, the psychological trauma of IPV activated the body's fight-or-flight response, leading to persistent anxiety. One participant vividly captured this:

> I was always feeling myself on the edge, never knowing when he would attack me. I could not sleep, and every little noise would make my heart race. I was

> always feeling like that I am walking on a circus rope and that the fear never left me even when I was not around him.

This sense of unpredictability contributed to a pervasive fear of escalation. Another participant described waking each day with apprehension:

> The worst part of my experience was the constant fear of what will happen next. I would wake up every morning with a knot in my stomach, anxious about whether today be a good day or if I would say or do something that would fire him up.

For some women, this chronic anxiety eroded their self-trust and decision-making abilities. One participant reflected on how the abuser's constant criticism compounded her fear:

> He would yell and put me down for little things and it got to a point where I was scared to do anything at all. I became so anxious about making any mistakes. I stopped trusting my own decisions.

Over time, the impact of IPV on participants' mental health extended beyond the immediate abuse. Many women internalized the negative messages they received, leading to feelings of worthlessness and heightened vigilance even after leaving abusive relationships. As one participant explained:

> After many years of being told I was nothing and worthless, I started to believe that. I felt anxious all the time, even now, I am all the time anxious even around the people who care about me. I could not relax or feel safe anywhere and anytime. I am always expecting that something bad will happen to me.

The enduring nature of these experiences underscores the impact of IPV on anxiety among MEIW, where the emotional scars often persisted long after the abuse had ended.

Symptoms commonly associated with trauma appeared across the data collected for this study. Participants frequently described symptoms such as flashbacks, emotional distress, and withdrawal, which were strongly correlated with both psychological and physical IPV. One participant recounted how a routine event triggered memories of her abuse:

> I can tell you that I remembered all the abuse that I experienced, and it comes to me on different occasions. Once we were practicing lockdown at work and when the man started to knock on the door, I remembered what my ex-husband had done to me, and I started shaking and I almost fainted.

Another woman described the profound loss of self that accompanied her trauma and persisted after she left her abusive relationship:

> My sense of self is disappearing like I am falling into a hole of nothingness. I was only something in relation to him, and I am still feeling the same. I cannot feel that I am something important in this life.

These accounts illustrate the impact of the trauma symptoms experienced by women which included intrusive memories, emotional numbing, and hypervigilance. The emotional pain of past abuse often resurfaced in vivid, distressing ways:

> His voice is still in my head. I cannot get rid of these memories. I did not ask for all of what I've been through. And I definitely didn't want my mind to paint and repaint the pictures back in flashback forms.

Persistent sadness also emerged as a common consequence of IPV, with participants describing feelings of hopelessness, isolation, and despair. For many, the abuse drained their motivation and self-worth, leaving them unable to see a path to recovery. One participant

explained: “I used to feel like I had no reason to get out of bed or like no reason to being alive. He tore me down. I felt empty and had nothing left to give.”

The isolating nature of IPV often compounded these feelings, as another participant shared:

> He made me feel so isolated. I stopped talking to my family and friends because I did not want them to see how broken I was. I just had no more desire to speak with no one. I wanted to be alone.

These experiences underline the deep psychological toll of IPV on MEIW, where anxiety, trauma, and sadness intersected to create a cycle of emotional and mental distress. The results highlight the urgent need for accessible, culturally sensitive mental health support to address the complex needs of survivors.

Overall, the results presented in this sub-theme illuminate the extensive impact of IPV on the health and well-being of MEIW. Physical health outcomes ranged from minor injuries to chronic conditions like hypertension and diabetes, reflecting both the immediate and cumulative effects of abuse. Maternal health was particularly vulnerable, with participants describing IPV as a catalyst for complications such as miscarriage, preterm birth, and other adverse perinatal outcomes. Mental health challenges, including anxiety, trauma, sadness, emerged as a persistent and deeply entrenched consequence, often exacerbated by cultural stigma and systemic barriers to accessing support.

5.4.1.3 Maternal Health.

Participants reported various negative outcomes associated with pregnancy, labor, and neonatal health. One of the consequences described by participants was miscarriage, directly resulting from physical abuse. Miscarriage in this context refers to the loss of a pregnancy before the fetus

is viable, typically before the 20th week (Quenby et al. ,2021). A participant shared: “I was pregnant on my first three months and my husband physically abused me. and I only woke up at the hospital finding myself having a miscarriage.” This testimony underscores the direct physical harm inflicted during a period of heightened vulnerability. The participants frequently described the use of force, such as kicking or beating, that caused irreversible damage to their pregnancies. Another participant recounted: “I lost my baby because of him as he kicked me and beaten me with a stick”. These accounts underscore how violent assaults during pregnancy placed both women and their fetuses at serious risk. Participants reported that miscarriages resulted from being kicked or beaten with sticks, household objects, or fists. Another participant stated: “My ex-husband did not want any more kids, but I got pregnant by mistake. As soon as he knew, he started to treat me badly. Then, I lost the baby when he pushed me from the stairs.”

Premature rupture of membranes (PROM) was another significant complication reported by participants. PROM occurs when the amniotic sac breaks before labor begins, increasing risks of infection, preterm birth, and other complications (Lin et al.,2024). In some cases, PROM was linked to direct physical trauma, such as being pushed or falling. One participant recounted her experience: “He pushed me down the stairs when I was eight months pregnant. I remember falling on my belly, and suddenly my water broke. I ended up having my baby four weeks early.” This account highlights how IPV physically disrupts the natural course of pregnancy, endangering both mother and child. In other cases, PROM was associated with the immense stress caused by IPV. Another participant shared:

> Once I was pregnant and after we had a big argument, I felt I was very stressed and could not breathe. In the nighttime, my water broke, and, in the hospital, I had surgery to get the baby out. But he was not ready to come out.

These examples reflect the dual impact of physical and emotional trauma on maternal health. While direct violence often caused immediate physical harm, the chronic stress and anxiety resulting from IPV also contributed to adverse perinatal outcomes. The participants' accounts collectively underscore the extensive toll of IPV on maternal health. Miscarriage, PROM, and preterm birth were recurring themes, illustrating how IPV jeopardized not only the physical well-being of pregnant women but also the health of their unborn children.

support.

5.4.1.4 Reproductive Health.

Besides the impact of IPV on pregnancy and childbirth, participants described how IPV severely affected their reproductive health and autonomy. Reproductive coercion, where abusive partners exerted control over their wives' reproductive choices, emerged as the most common issue in this context. Reproductive coercion includes sabotage of birth control methods, forced pregnancies and interference with access to reproductive health care.

Reproductive coercion occupies a multifaceted position within the broader framework of IPV, as it can be understood simultaneously as a form of IPV, a tactic used to exert control, and a significant impact resulting from ongoing IPV. From one perspective, reproductive coercion involves behaviours such as pressuring a partner to become pregnant and controlling pregnancy outcomes which represents a direct and intentional approach to control and domination. These actions fall mainly within the definition and forms of IPV as they aim to exert power over a woman's bodily agency and reproductive choices. From another perspective, reproductive coercion can also emerge as a consequence of ongoing IPV. In abusive relationships, the collective impacts of emotional, physical and financial abuse can place MEIW in vulnerable positions where they are unable to negotiate reproductive decisions safely and freely. Under

these circumstances, reproductive coercion becomes an outcome of IPV reflecting the ripple impact of IPV on a MEIW's health and decision-making.

One participant mainly discussed the impact of IPV on her reproductive health by revealing that her abuser frequently interfered with her use of contraception by hiding birth control and asserting dominance over family planning decisions. She stated, “He would hide my pills. If I asked about it, he’d just say, ‘I’m the man and I decide when we have a baby.’”

Another participant reported menstrual irregularities and other gynecological problems that she attributed to the chronic stress resulting from IPV. While these disturbances are less visible than physical injuries, they significantly affect women’s physical and mental health. The participant stated: “During my two years of marriage, I was always stressed but when things got bad, my period would stop for two or three months. Then it would come back with sever pain that made me scream.”

Four participants disclosed that IPV contributed to long-term fertility challenges, either due to untreated infections, internal injuries or emotional distress. Furthermore, they stated that they were discouraged and actively prevented from seeking medical attention because their partners controlled their interactions with healthcare providers. One participant said “I had a lot of pain after he hit me there [pointing to her lower abdomen], but he refused to take me to a clinic. I still don’t know what happened to me.” Another participant disclosed: “ I tried to get pregnant when I was with him. There wasn’t any physical issue for either of us, but I think it didn’t happen because I wasn’t okay mentally.”

Two participants disclosed that untreated sexually transmitted infections (STIs) associated with partners’ infidelity were other consequences of IPV. One participant said “ I swear he cheated a lot and when I got an infection, I was scared to go to the clinic and it was not

easy for me to go. You know, I didn't know how to explain it in English… Ammm, I felt that the doctor will think that I am a dirty woman." In this quote, the woman highlighted the stigma surrounding sexual health, along with language barriers and immigration concerns which prevented her from accessing timely care. This narrative highlights a broader pattern of restricted access to reproductive health services as a result of stigma around STI. This pattern influenced by IPV and compounded by linguistic barriers and fear of judgment and stigma.

Another participant attempted to seek help from a doctor but was not successful "I wanted to get checked because I was always in pain down there, but he would always come with me to the clinic and talk for me. I felt invisible." These stories underscore the intersectional vulnerabilities that shape reproductive health experiences for MEIW experiencing IPV. Reproductive health was not only affected by direct physical and sexual violence but also by fear and systemic barriers to care as well as the lack of autonomy by the women.

Overall, the results presented in this sub-theme illuminate the extensive impact of IPV on the health and well-being of MEIW. Physical health outcomes ranged from minor injuries to chronic conditions like hypertension and diabetes, reflecting both the immediate and cumulative effects of abuse. Mental health challenges, including anxiety, trauma, and sadness, emerged as a persistent and deeply entrenched consequence, often exacerbated by stigma and systemic barriers to accessing support. Maternal health was particularly vulnerable, with participants describing IPV as a catalyst for complications such as miscarriage, preterm birth, and other adverse perinatal outcomes. In addition, reproductive health was significantly compromised, with participants reporting menstrual irregularities, untreated infections, and fertility challenges.

Together, these categories highlight a need for targeted interventions that address the physical, maternal, and psychological dimensions of IPV. Survivors require holistic and

culturally attuned care that not only treats immediate injuries but also mitigates long-term health risks, provides specialized maternal health support, and offers accessible mental health resources.

5.4.2 Ripples of Impact: The Children of MEIW

The effects of IPV extend beyond the immediate experiences of MEIW, sending ripples outward to deeply influence their children's lives. While this study focuses on the perinatal period, participants' reflections also revealed how the effects of IPV during pregnancy and early motherhood continued to shape their children's emotional and social development later in life. These accounts illustrate the enduring impact of perinatal IPV, suggesting that exposure during this developmental period can have long-term consequences that persist into childhood and beyond. These ripples manifest as emotional instability, social challenges, and the potential for intergenerational patterns of harmful relational dynamics. Participants described how their children struggled with mood swings, anxiety, and behavioural difficulties, often linked to the unpredictable and volatile nature of their home environments. Some children faced social integration issues, finding it difficult to develop meaningful connections with peers or navigate relationships outside the home. Participants also expressed fears that their children's exposure to IPV might normalise abuse, perpetuating cycles of violence into adulthood.

Despite these challenges, many participants found it difficult to openly discuss the impact of IPV on their children due to fears of custody loss, guilt, and cultural pressures. These barriers may have contributed to underreporting or minimization of this issue. The effects of IPV on children are explored through three categories: Emotional and Behavioural Challenges, Social Integration Issues, and Intergenerational Transmission.

5.4.2.1 Emotional and Behavioural Challenges.

Participants described how their children's exposure to IPV made them vulnerable to significant emotional and behavioural challenges. These impacts were evident in mood swings, anxiety, and difficulties in school or social settings, reflecting the pervasive influence of living in a volatile home environment.

One participant highlighted the unpredictability in her son's emotions, linking his erratic behaviour to the instability they experienced:

> I noticed my son started having these unpredictable mood swings after when I was living with my ex-husband. One minute he was happy, and the next, he'd explode in anger for no reason. He was always like he's afraid something bad will happen again.

Another mother shared her concerns about her daughter's anxiety, which became so overwhelming that it affected her ability to concentrate at school:

> My daughter was always very anxious. She was always asking me if I was okay, constantly worrying about me even when things seemed normal and quiet. It got to the point where she couldn't focus at school because she was so anxious about what might happen at home.

Such narratives reveal the emotional toll of IPV on children, whose heightened anxiety and fear often stemmed from the unpredictability of their home lives. For some children, this led to patterns of hypervigilance, always anticipating the next moment of conflict.

Participants frequently described how sudden outbursts from the abuser created confusion and fear in their children. As one woman noted:

> The constant mood changes confused the kids. One moment, he'd hug them and tell them he loved them, and next, he'd slam doors and scare them to tears. They never felt safe at home.

This emotional instability often left children struggling to regulate their own feelings, as seen in these two accounts, "My child was very moody. He would be happy now and very upset in 2 minutes. I think he seemed worried and scared about what was happening at home." Similarly, another participant said, "Mood swing was the most noticeable impact on my kids. They are always on the edge and cannot have a state of mind."

These reports illustrate how children may internalize the dynamics of an abusive household, leading to persistent fear, difficulty trusting others, and emotional dysregulation. Over time, some children may begin to mirror their fathers' behaviors, adopt similar patterns of anger or withdrawal, which reflects how exposure to violence can normalize such responses in the next generation. Exposure to IPV created a home environment where children were constantly on edge, unable to find stability or emotional safety. Examining these challenges, it becomes clear that children's psychological well-being is deeply intertwined with the trauma of IPV, necessitating targeted interventions to address their unique needs.

5.4.2.2 Social Integration Issues.

Participants expressed concerns about the social development of their children, describing how the instability and fear created by IPV left lasting effects on their ability to form relationships and navigate social settings. One participant highlighted her son's struggles with social skills:

> My son barely talks to other kids. He doesn't know how to make friends, and I think it's because he saw too much at home. It's like he doesn't know how to deal with people, and that worries me. I am very worried.

For children exposed to IPV, the home environment was often marked by unpredictability and fear, which disrupted their sense of security and ability to trust others. One participant recounted how her children reacted to their father's volatile outbursts:

> My kids would get so scared when he started yelling out of nowhere. My youngest would hide under the bed, and my oldest would cry and beg him to stop. They never knew if he'd be calm or explode.

A participant stated: "My daughter is grown now, but she still doesn't trust people easily. What she saw at home stayed with her, it didn't end when we left.". Another participant stated: " Even now that my son is a teenager, he still gets anxious and angry very quickly. It's like he's still living in that fear, even though we left years ago." She also further explained "Now that my boy is older, I sometimes see him talk to his girlfriend the way his father talked to me. It scares me like the cycle is starting all over again."

These narratives reveal how growing up in an abusive household not only heightened children's fears but also hindered their ability to engage socially. Participants connected the constant exposure to aggression and instability inside the home to problems interacting with peers outside the home, making it difficult for them to form meaningful relationships. Such results underscore the impact of IPV on children's social development. Participants shared that these challenges often persisted into adolescence and beyond, emphasizing the need for early and ongoing interventions to help children rebuild their confidence and social skills after being exposed to IPV.

5.4.2.3 Intergenerational Transmission.

Participants frequently expressed concerns about the long-term impact of IPV exposure on their children, fearing that it might perpetuate an intergenerational cycle of violence. One participant reflected on how her son was beginning to mimic the abusive behaviour of his father:

> I am worried that my son will grow up thinking it is okay to treat women like this. He is young, but I can already see how he is starting to mimic his father's behaviour, and that scares me.

For some, the fear extended to their daughters, who they worried might internalize harmful dynamics as normal. As one mother explained:

> My daughter has seen too much. She says she'll never let a man treat her the way her father treated me, but I cannot help but wonder if, deep down, she believes this is normal. I'm afraid that when she's older, she'll end up in a similar situation because it's what she knows.

These reflections underscore how exposure to IPV can shape children's perceptions of relationships, potentially normalizing abuse and perpetuating destructive patterns into adulthood. This account not only reflects the participant's fear that her daughter may experience the cycle of abuse but also reveals a deep sense of guilt for exposing her to such experiences. Feelings of guilt and self-blame were common among participants, underscoring the emotional toll of IPV that extends beyond the immediate experience of violence.

Overall, the results in this sub-theme illustrate the impact of IPV on children, encompassing emotional instability, challenges with social integration, and the risk of perpetuating harmful relational patterns into adulthood. Participants described how the

unpredictable and volatile environment created by IPV contributed to their children's heightened fear, difficulty trusting others, and challenges in forming healthy relationships.

The narratives also reveal the potential for intergenerational transmission of IPV, as children may internalise abusive behaviours or accept harmful dynamics as normal. These results underscore the urgent need for interventions tailored to the unique experiences of children exposed to IPV. Such measures must address emotional and behavioural challenges, rebuild social skills, and break the cycle of intergenerational violence.

5.4.3 Wider Circles of Impact: Community and Systems

This sub-theme explores the broader societal consequences of IPV, moving beyond the immediate impact on MEIW to examine how the effects extend outward to communities and systems. While IPV begins at the centre with the survivor, its influence extends in wider circles, shaping social relationships, community dynamics, and societal infrastructure.

The narratives shared by participants illustrate how IPV disrupts community cohesion, perpetuates cycles of violence, and places pressure on critical resources like law enforcement, social services, and healthcare systems. For immigrant women, these challenges are compounded by cultural displacement and barriers to integration, further isolating them from the communities they strive to join.

Through three interconnected categories, Social Isolation, Systemic Strain and Community Cohesion, this sub-theme demonstrates that IPV is not an individual or private issue. Its far-reaching consequences challenge the social fabric of community safety, equity, and well-being.

5.4.3.1. Social Isolation.

Several participants described how IPV extends beyond the individual, creating far-reaching consequences that affect communities and society as a whole. Notably, one participant discussed how IPV exacerbates inequality and social exclusion, particularly among marginalised groups such as MEIW. This dynamic perpetuates cycles of disadvantage and hinders overall community well-being and safety.

One participant articulated the isolating nature of IPV in the context of her identity as an immigrant woman:

> You know IPV isolated me from my community and this community. Add to that as an immigrant woman, I already felt like I didn't belong, but the violence isolated me even more. It's hard to feel like part of the community when you're constantly living in fear and dealing with all these other struggles.

The participant referred to her family and other connections in her country to " my community" and she used "this community" to refer to her neighbour and friends in Canada. This account underscores how IPV compounds existing vulnerabilities. For MEIW, the intersection of cultural displacement and domestic violence creates a dual burden that deepens their isolation.

This experience highlights how IPV not only damages individual well-being but also obstructs opportunities for integration and participation in broader society. The intersection of cultural adaptation and IPV presents unique challenges that isolate MEIW from the communities they are striving to join, further perpetuating marginalization and exclusion.

5.4.3.2. Systemic Strain.

Participants emphasised how IPV imposes significant pressure on public resources, including law enforcement, social services, and healthcare systems. These reflections underscore the systemic impact of IPV, extending its consequences beyond individuals to broader societal structures.

One participant described her repeated interactions with law enforcement and the toll such cases take on the system:

> It was a very hard experience. I was feeling very overwhelmed, and I was also overwhelming everybody around me. I call the police every time we had a fight. The police were always involved in our situation. I cannot imagine how many women would call like me as they worried about their life. This is for real must be draining for the system.

Similarly, another participant detailed her repeated reliance on social services, highlighting the strain on already stretched resources as well as the inadequacy of the system infrastructure:

> I've been in and out of social services including shelter, legal aid, and many more and it feels like every time I go back, the resources are stretched thin. There are so many women like me needing support because of the violence in their homes.

These accounts illustrate how IPV not only disrupts individual lives but also places a heavy burden on essential community services. The increasing demand on law enforcement, shelters, legal aid, and other support systems reflects the far-reaching impact of IPV on societal infrastructure.

5.4.3.3. Community Cohesion.

Participants' accounts provide insight into how IPV undermines social cohesion, perpetuating cycles of violence that extend across generations and erode communal well-being. One participant reflected on how the effects of IPV ripple through families and communities, manifesting in children's behaviours and perpetuating intergenerational harm. She said, "Violence doesn't just stop at one person or one case. It spreads, and I see it in the way children in abused families behave at playgrounds and with their friends. It's like a cycle that no one can break."

For immigrant women, IPV can further exacerbate feelings of alienation and impede their ability to contribute meaningfully to their adopted communities. As one participant explained:

> When you come to Canada, it is very obvious that you need to work and to do something with your life. But my husband abandoned me from doing anything. I feel that I am not contributing to Canada. I am very tired of thinking this way. I want to be a good citizen, but my husband is not allowing me.

Participants articulated the far-reaching societal implications of IPV, framing it as not merely a private issue but a structural challenge that compromises the safety and cohesion of entire communities. This sentiment was powerfully conveyed by one participant: "I want everybody to live in a safe community."

The results reveal that IPV contributes to social inequality, particularly among marginalised groups such as MEIW, further excluding women from full participation in society. This exclusion not only hinders individual recovery but also disrupts community well-being and societal harmony.

Overall, this sub-theme illustrates how the effects of IPV extend far beyond individuals, disrupting community cohesion, straining public systems, and perpetuating cycles of violence and marginalization. Participants' accounts reveal how IPV isolates MEIW, compounding the challenges of cultural displacement and creating barriers to meaningful community participation. This dual burden highlights the social exclusion experienced by survivors. IPV also imposes significant pressure on public resources, including law enforcement, social services, and healthcare systems, reflecting its systemic cost to society. Finally, IPV erodes community cohesion by fostering cycles of violence that ripple through families and neighbourhoods, limiting opportunities for healing and safety.

5.5 IPV Vulnerabilities and Help Seeking Behaviours

This theme addresses the study's objective to "Describe the factors influencing IPV during the perinatal period" and relates to the objective of "Identify culturally and contextually responsive interventions and strategies to support MEIW experiencing IPV during this time." This major theme examines how MEIW's experiences of IPV are shaped by intersecting vulnerabilities and the barriers they face when seeking help. Participants described how cultural norms, economic pressures, and systemic discrimination heightened their susceptibility to abuse while limiting their capacity to access support or assert independence. These vulnerabilities often intersected, reinforcing cycles of dependency, and increasing the risk of IPV.

Cultural norms and patriarchal gender roles and expectations around family unity, frequently normalised or obscured abuse, making it difficult for participants to recognise their experiences as IPV. Economic precarity, coupled with migration-related vulnerabilities, further constrained women's agency, while systemic barriers, such as discrimination, inadequate services, and language difficulties, deepened their isolation. This major theme highlights the

complex interplay of cultural, economic, and structural forces in shaping IPV vulnerabilities and help-seeking behaviours.

5.5.1 Cultural and Linguistic Vulnerabilities and Responses

This sub-theme explores the cultural and linguistic barriers that shape MEIW's experiences of IPV and their ability to seek help. These challenges are deeply rooted in gender norms, expectations of family unity, and the socio-linguistic isolation that often accompanies migration. The participants' narratives reveal how cultural pressures reinforce silence, while linguistic limitations create significant obstacles in accessing services and asserting agency. The results are organised into three categories: Cultural Expectations and Gender Norms, Language as a Barrier and Facilitator, and Community Perception and Face-Saving. These categories illustrate the interplay between cultural and linguistic factors, highlighting the barriers to support and the strategies MEIW employ to navigate their circumstances.

5.5.1.1 Cultural Expectations and Gender Norms.

Cultural and religious beliefs, particularly those tied to gender roles, influence the experiences of MEIW with IPV and their responses to it. These beliefs are rooted in patriarchal traditions that establish a strict hierarchy where men hold authority and women are expected to obey. This dynamic is often portrayed as the natural order, making it difficult for women to challenge abusive behaviours. One participant shared:

> Since I was very young, I was taught to obey my father then obey my husband. No matter if he abuses me, it is okay. I remember that my mother was telling me all the time, that I have to listen to my husband and that I should not go above him. I mean I should be always at a lower level than him in home and in the community.

This testimony captures the cultural pressure on women to conform to traditional gender roles, even in the face of violence. Such norms render IPV invisible by framing male dominance as acceptable and expected. Another participant reflected on this belief: “Men believe they are more superior than women.”

This perception creates an environment where abuse is normalised, and women are conditioned to endure it to align with societal expectations.

Beyond the issue of male dominance, cultural beliefs in collectivism and the emphasis on "face-saving" further entrench women in abusive relationships. Collectivism prioritises the preservation of family reputation over individual well-being, pressuring women to remain in harmful situations to avoid community shame. One participant explained:

> I am not happy with my husband, and I will never be. I always live in fear so how can I be happy in this relationship. I still live with him because if I get divorced in this community, people will talk about me; people will whisper that I have a bad character that’s why my husband has divorced me.

This fear of judgment and ostracism prevents many women from seeking help or leaving their marriages. The cultural emphasis on family harmony and reputation often silences women’s experiences, forcing them to prioritise the community's perception over their own safety. Another participant shared: “Women like me are afraid to tell their friends or families about their martial problems because when you do that your friend will broadcast it and when you walk in your neighbourhood you just see people staring at you.”

The stigma surrounding divorce is particularly severe in these communities. Women described it as a social failure, with blame often placed squarely on them rather than on their abusive partners. As one participant observed:

> It is complicated to get a divorce in this community. You will be the content for everyone to talk about you. Nobody will say that you left because of an abusive husband. Everybody will say why you did not stay with him; he will change. But the reality is he will never change.

Cultural norms around male entitlement further exacerbate IPV, particularly regarding infidelity. Several participants highlighted how societal acceptance of male infidelity reinforced their abuse. One woman recounted:

> Once, I found a woman in my house with my husband. When I asked him about her, he said that she is his classmate. Then, when I got upset about it and asked him not to do it again. He started to abuse me. All types of abuse, slapping… stalking yeah, all types …. It is okay for the man to be disloyal because he is a man.

Others described the emotional toll of enduring infidelity, compounded by further psychological abuse. As one participant explained:

> When he comes home, I could not talk to him, he was in a different world. He would ask me to be quiet and I felt by talking with him I am ruining his outside joy that he got from the other woman. …he may slap me if I ask him about his relationship with other women.

Religious and cultural norms also frequently grant men control over women's bodies, including decisions around sexual activity and contraception. This dynamic often leads to unintended pregnancies, which some women described as a tool of further abuse. One participant noted:

> We believe power is granted to men over women…The man can swear, hit and discipline his wife, actually, everybody in our country knows that discipline from this kind is supported by our religion.

However, other participants recognized that religious teachings could be interpreted to promote respect and equality, highlighting the complexity of religion's role in IPV. These differing interpretations underscore how religious beliefs can either reinforce or challenge abusive dynamics, depending on their application.

For many MEIW, cultural and religious expectations create a cycle of subordination and silence. Women are socialized to endure abuse in the name of family unity, community reputation, and traditional gender roles. These deeply entrenched norms not only perpetuate IPV but also discourage women from seeking help, trapping them in harmful relationships and reinforcing their vulnerability.

5.5.1.2 Language as a Barrier and Facilitator

Language represents a critical factor in the IPV vulnerabilities and help-seeking behaviours of MEIW. For many participants, limited English proficiency created significant challenges, restricting their ability to access resources, articulate their needs, and achieve independence in a new environment. These barriers exacerbate the risks of IPV by fostering dependency on abusive partners and making it difficult to seek help.

Participants highlighted how a lack of English proficiency impeded their access to essential services and constrained their opportunities for self-sufficiency. One participant explained the intersecting challenges of language, caregiving, and employment: "I have three kids which makes it hard for me to learn English or get a job. I tried many times to learn English,

but my husband said I need to raise my kids first then I can study…if I have a job, he will not treat me like this."

This quote demonstrates the complex ways in which language barriers are both a result of and a tool for control in IPV dynamics. Husbands, in some cases, withheld support for language education to perpetuate economic dependency and restrict their wives' autonomy. For many women, the inability to speak English also created obstacles in seeking help from emergency services or service providers. Language barriers left women feeling isolated and unable to communicate their experiences effectively. One participant reflected on her struggle to contact law enforcement: "I could not call for help. I did not know what say in English…the police told me that I can call them anytime if my husband abused me, but I did not know how to call them or what to say".

This sentiment was echoed by other participants who described their frustration and fear in situations where their limited English proficiency left them vulnerable. The challenge of navigating legal and social support systems without adequate language skills not only delayed their ability to escape abuse but also reinforced their feelings of helplessness.

Language barriers also prevented MEIW from fully understanding their rights and protections under Canadian law. Without access to accurate information about their legal status or available resources, women remained trapped in abusive situations. Participants discussed the broader implications of these barriers, particularly how they limited their access to employment and financial independence, which are crucial for escaping abusive relationships. The inability to secure stable work due to language deficiencies left women dependent on their partners. This dependency not only increased their vulnerability to IPV but also perpetuated a cycle of control and abuse. One participant described her challenges in seeking employment: "I tried to apply for

many jobs, but no one called me back. I think if I have a job, my husband will not be able to abuse me".

The lack of English proficiency also created logistical difficulties in accessing services such as shelters, counseling, or legal aid. Women reported feeling unwelcome or misunderstood when trying to seek help, which often discouraged further attempts. One participant shared: "I never did imagine that there are organizations to help people in my situations. I often felt this loneliness since I was thinking that I am the only one that was going through this".

While language barriers are a significant source of vulnerability, some participants highlighted how improving their English skills became a pathway to empowerment and independence. For those who were able to access language education, learning English opened up opportunities for employment and social integration, which, in turn, helped them regain a sense of agency. One woman reflected on her decision to focus on improving her language skills as a means of breaking free from her abusive relationship: "When I realized that he is abusing me with some tactics that I know and others that I do not know, I decided to improve myself, learn English and work". This highlights the dual role language can play as both a barrier and a facilitator in the context of IPV vulnerabilities. For MEIW, learning English is not merely about communication; it represents a critical step towards self-reliance and safety.

However, even for those who managed to improve their language skills, systemic barriers remained. Participants described how the requirement for Canadian work experience, coupled with limited language proficiency, made it difficult to secure meaningful employment. These challenges underscored the need for targeted interventions that address both language education and employment opportunities for immigrant women.

In conclusion, language barriers significantly shape the IPV vulnerabilities and help-seeking behaviours of MEIW. Limited English proficiency not only restricts access to resources and services but also reinforces dependency on abusive partners, perpetuating cycles of control and isolation. However, for those who can overcome these barriers, language acquisition offers a pathway to empowerment and independence. The dual role of language as both a barrier and a facilitator highlight the importance of culturally and linguistically responsive services to support MEIW in navigating these challenges.

5.5.1.3 Community Perception and Face-Saving.

The significance of community perception and the cultural practice of face-saving emerged as a substantial factor in how MEIW experience IPV and decide whether to seek help. Collectivist cultural norms often impose expectations that prioritize family reputation and communal harmony over individual well-being, leading to immense pressure on women to endure abusive relationships silently. For many participants, this dynamic compounded their vulnerabilities and served as a barrier to seeking external support. One participant described how the fear of gossip and judgment within her community influenced her decision to stay in an abusive marriage:

> In my culture, people don't talk about these things. If a woman leaves her husband, no one asks what she went through, they just assume she failed as a wife. I knew if I left him, the community would start gossiping, and it would bring shame to my family back home and here. My mother would be blamed, and people would say I'm dishonouring my family. I felt like I had to choose between protecting myself and protecting my family's reputation. So, I stayed quiet, even when the abuse got worse. I didn't feel like I had the right to speak

> out, because in their eyes, keeping the family together was more important than my safety.

This quote encapsulates the concept of a ‘double fear’ experienced by many participants, both the fear of IPV and the fear of divorce-induced social ostracism. Divorce in this cultural context is often perceived not as a consequence of abuse but as a woman's moral failing, absolving the abuser of responsibility. Such perceptions further entrap women in harmful relationships by linking their self-worth to their ability to maintain a marriage.

The cultural emphasis on face-saving discourages women from publicly acknowledging IPV, framing it as a private matter that should remain within the household. As one participant recounted: “They say that conflicts between people who share the same bed remain in there”. This cultural norm perpetuates silence around IPV, leaving women with limited avenues for support. Participants frequently expressed that disclosing their experiences could result in social humiliation, loss of community support, or blame for their marital problems.

The practice of maintaining familial and community reputation often comes at the cost of personal safety and well-being. Women are expected to tolerate abuse to preserve the family unit and avoid bringing shame to themselves or their extended families. Collectivist values place a high premium on harmony and stability, which discourages women from seeking help or leaving abusive relationships. One participant explained the societal pressure to remain patient despite enduring IPV: “Marriage is seen as a communal affair, and women are told to maintain harmony to support the family’s status and reputation. Men know their wives will tolerate the abuse because of this”.

These cultural norms also intersect with gender roles, reinforcing women's subordinate position and limiting their options for escape. Another participant reflected on how these expectations are internalized, shaping her response to IPV:

> It is complicated to get a divorce in this community. You will be content for everyone to talk about you. Nobody will say that you left because of an abusive husband. Everybody will say, 'Why didn't you stay with him? He will change.' But the reality is, he will never change.

The participant's reflection underscores how community narratives often dismiss the abuse, focusing instead on the woman's perceived failure to maintain her marriage. This creates a toxic environment where women are discouraged from prioritizing their safety over societal expectations. In this context, the community functions as a source of surveillance. The fear of stigma and social exclusion limits women's willingness to seek help, highlighting the absence of nonjudgmental social support networks.

In addition to cultural pressures, some participants described the ways in which their experiences of IPV were further exacerbated by expectations tied to motherhood. The idea that women must sacrifice for the sake of their children reinforces their decision to stay in abusive relationships. One participant shared: "If I escaped, he would take my kids, and when I go back to my country, my family will blame me. That's why I thought about escaping many times, but I could not."

In such cases, women weigh the risks of leaving against the fear of losing their children or facing judgment from both their families and their communities. The role of face-saving is also evident in how IPV survivors navigate social spaces within immigrant communities. Many participants reported feeling trapped in close-knit social circles where their actions were closely

monitored and judged by members of their immediate networks such as family and friends. The fear of exclusion or gossip often discouraged women from seeking support from community organizations or public services. Furthermore, some women even described being reported to their husbands by family members, friends, or others within their cultural or religious communities when they attempted to reach out for help. This surveillance reinforced their isolation and limited their ability to seek support which deepens the cycle of control and silence. For example, a participant stated: " I trusted someone from our community…. A friend of mine, and told her what was happening. A few days later, my husband knew everything from her husband. He said, 'So now you're talking about me behind my back?' it was very difficult night…"

Despite these challenges, some women recognized the detrimental impact of these cultural norms and began to challenge them. However, this process often required significant effort and came with considerable risks. The complex interplay of cultural expectations, community perception, and face-saving creates a uniquely challenging landscape for MEIW navigating IPV, underscoring the need for culturally sensitive interventions that address these barriers while respecting women's lived realities.

5.5.2 Sociocultural and Economic Precarity

This sub-theme examines the intersecting sociocultural and economic factors that compound MEIW's vulnerabilities to IPV and hinder their help-seeking efforts. Participants shared how financial dependency, social isolation, and systemic inequities deepened their reliance on abusers and limited their pathways to autonomy. The data reveal how economic precarity intertwines with cultural oppression to exacerbate the risks of IPV and perpetuate cycles of abuse. The discussion is presented in two categories: Barriers to Employment and

Autonomy and Sociocultural Oppression. These categories unpack the systemic and relational dynamics that reinforce economic dependency and sociocultural vulnerability, ultimately constraining participants' ability to seek safety and independence.

5.5.2.1 Barriers to Employment and Autonomy.

Barriers to employment and autonomy emerged as a recurring theme in the experiences of MEIW, revealing how these obstacles heightened their vulnerability to IPV. Participants shared the significant challenges they faced in achieving financial independence and personal agency due to systemic, cultural, and interpersonal factors, all of which perpetuated cycles of dependency and abuse. Employment was identified as a critical pathway to reducing IPV, yet many women described how their attempts to work were hindered by their partners. One participant recalled: "We had many arguments around my work. He got very angry as I want to work. He asked me like this "Do you want to be the man of the house!" So, I could not work, and I was forced to stayed with him."

This underscores how some male partners employed traditional gender norms to limit women's employment opportunities, further entrenching their financial reliance and reducing their autonomy. These restrictions not only reinforced dependency but also served to isolate women, depriving them of opportunities to engage socially or access external support.

For women who had secure jobs, their employment was often disrupted by their partners' controlling behaviours. One woman recounted:

> My partner came to my work multiple times. He would come only because he wanted to cause trouble. One time he came and told me to leave work and go home with him. When I left with him without my boss's permission, my boss got very angry and I was not allowed to come back to work, and I was fired.

> After that incident, his aggressive behaviour increased, and I could not tolerate it, so I called the police on him.

The participant's experience illustrates how partners' interference extended beyond the home, undermining women's ability to maintain employment and increasing their isolation. Beyond the immediate financial impact of job loss, such disruptions also had cascading effects on women's confidence and psychological wellbeing. Losing employment not only stripped them of financial independence but also impacted their sense of self-worth, further deepening their vulnerability to abuse. Two quotes mainly reflected these experiences. A participant stated: " As soon as I see a job post and want to apply, he will start making problems and would say you need to take care of your kids, I can not deal with them and other things like that." . Another participant said: " He used to hide my bus pass or make me late on purpose so I would get in trouble with my manager and it worked. When I finally lost the job, he said it was my fault for not being responsible enough and he was happy about it.. I can not tell you how losing that job made me feel… just completely worthless."

Childcare also posed a significant barrier for many participants, further complicating their efforts to work. One woman explained: "I did not trust leaving my child with my husband and I could not find a daycare for her…I wanted to make sure that my child is safe".

This lack of accessible and reliable childcare prevented women from seeking or sustaining employment, reinforcing their financial dependence on their partners. The unavailability of culturally sensitive childcare options, in particular, compounded the issue, as women often faced additional concerns about language barriers, cultural differences, and the stigma of leaving children in non-familial care. These systemic failures to provide adequate

support not only limited women's economic opportunities but also forced them to remain reliant on abusive partners.

Poverty and economic dependency were frequently cited as factors that amplified the intensity of IPV. Participants described how financial control and deprivation were used as tools of abuse. One woman shared:

> He takes hold of all the money we receive from the government. If he wants, he can make the kids starving and that's all to give me hard time…in September, I did not have the money to buy school supplies for my kids and when I asked him for some support, he swear at me and threatened that he will come and break my face.

This demonstrates how financial abuse extended to decisions about basic household needs, exacerbating women's sense of powerlessness. Economic hardship was described as a pervasive issue, with participants linking poverty directly to IPV. Several women expressed this sentiment succinctly, stating, "poverty is what causes it," and "hardships bring out violence." For many MEIW, the lack of financial resources and employment opportunities created an environment where abuse could thrive, as their options for escape were severely limited.

The interplay between financial dependency and IPV extended beyond economic control to include reproductive coercion. One participant explained how the lack of autonomy over her reproductive health further entrenched her vulnerability:

> My husband was very abusive. I could not think of anything, only my life. I was worried all the time about what will happen in the following day with him……I did not even have the time to think about taking contraception as I

> was really overwhelmed with his actions…. Then I got pregnant again and life became as a nightmare.

The participant's experience highlights how economic dependency and lack of control over personal decisions combined to deepen the cycle of abuse. The cascading effects of limited autonomy over reproductive health often further entrenched women in situations of financial precarity and emotional distress.

For some women, these barriers began early in life, shaped by cultural and systemic inequities. One participant reflected:

> I was fourteen years old when I got married. I did not have many life experiences, and my husband thought that he needed to support me all the time. For him it was support and at the beginning I was viewing this as support too. But later I understood these behaviours were not kind of support.

The participant's narrative points to how early dependency was framed as care but evolved into a mechanism of control, limiting her ability to assert independence. For many young women in arranged marriages, early experiences of dependency set the foundation for lifelong cycles of economic and emotional vulnerability.

In conclusion, barriers to employment and autonomy deeply shaped the lived experiences of MEIW, compounding their vulnerability to IPV. Cultural expectations, systemic inequities, and controlling behaviours by partners converged to restrict their opportunities for independence. While employment and financial security offered a potential avenue to reduce IPV, these women faced immense challenges in achieving these goals. Their narratives underscore the urgent need for targeted interventions that address childcare access, economic empowerment, and culturally sensitive employment support to break the cycle of dependency and abuse.

5.5.2.2 Sociocultural Oppression.

The narratives of MEIW reveal how economic dependence, and structural vulnerabilities intersect to entrench their experiences of IPV. These vulnerabilities, shaped by cultural expectations, systemic inequities, and a lack of access to resources, create environments where abuse thrives, and autonomy is severely constrained.

Participants frequently reflected on their lack of awareness regarding what constituted abuse and their limited understanding of their rights. One participant described her initial unawareness of abusive behaviours:

> I did not know that if he sleeps with me without my permission that [it is] considered rape…I did not know if he swears at me then he is verbally abusing me or when he pushes me [it] means he is physically abusing me. Maybe you cannot believe it, but this was the truth.

This gap in knowledge underscores how structural vulnerabilities, such as limited exposure to legal protections or culturally sensitive education about abuse, amplified women's dependency on abusive partners. Without this awareness, many women remained unable to identify or challenge the violence they endured, perpetuating cycles of control and coercion. The absence of targeted education and outreach programs tailored to immigrant communities exacerbates this issue, leaving women ill-equipped to navigate the complexities of IPV or seek support. Legal systems also often failed to provide meaningful assistance, further entrenching women in these situations.

For others, deeply rooted cultural narratives on submission and family unity further shaped their experiences of dependency. One participant described the lack of personal choice in her marriage:

> Imagine a woman did not have a voice during her marriage, how can she advocate for herself during this marriage? There is no love in this relationship and no consent from the beginning so the lack of personal choice will offer a good environment for IPV. I was expected to be submissive and obey all of my husband's orders. He felt that he was the boss of me and that he needed to control me and sometimes through violence.

Age disparities in arranged marriages were another significant factor contributing to structural vulnerability. One participant recounted:

> My marriage was an arranged thing. I did not see him before the engagement. The gap age between us was 20 years. He was very handsome but after the marriage, he became like a monster. I think we did not have anything in common because of the age difference so this [made] him abusive.

Such significant age gaps exacerbated power imbalances, leaving younger women more susceptible to coercive control. These relationships were often framed as protective or supportive, but this dynamic typically masked mechanisms of control and dependency. Many women described how cultural norms positioned their husbands as authority figures and providers, effectively stripping them of autonomy and reinforcing cycles of economic and emotional reliance.

Reproductive coercion also emerged as a key mechanism through which abusers-maintained control. One participant described how pregnancy intensified her abuse:

> Many people think when you get pregnant, it means you are safe but for me it was the opposite. He was very bad with me at all times. The worst period was during my pregnancy itself. Being only fifteen years old, my age became a

> reason to abuse me. He saw me as too young and incapable of handling the pregnancy responsibilities, so he started to abuse me.

Another participant explained: "I was not really aware about the number of contraception methods that we have here in Canada. The pregnancy just happened, and my husband did not want it, so I believe this was one reason for the abuse."

These accounts illustrate how limited knowledge of reproductive health and family planning intersected with cultural expectations, leaving women trapped in cycles of economic dependence and abuse. Pregnancy, often viewed culturally as a stabilising force in marriage, instead became a source of increased violence and control.

5.5.3 Racial Discrimination

This sub-theme focuses on the pervasive impact of racial discrimination on MEIW's experiences of IPV, and their interactions with institutional and community support systems. This finding directly relates to the study's purpose of understanding barriers to help-seeking among MEIW and it is directly addressing the one of study's main objectives on barriers to accessing support for IPV. Participants highlighted how systemic biases, rooted in stereotypes and a lack of cultural competency, compounded their vulnerability and eroded trust in key services. These experiences reveal how racial discrimination creates an additional layer of marginalization, making it harder for women to access resources and escape abusive environments. The results for this sub-theme are explored through two categories: Institutional Racism and Immigration-Driven Marginalization. Together, these categories capture the systemic inequities that deepen MEIW's dependency on abusers and limit their access to meaningful support.

5.5.3.1 Institutional Racism.

Institutional racism emerged as a pervasive factor in the experiences of MEIW, shaping their interactions with critical services and reinforcing cycles of marginalization and dependency. Participants described how systemic discrimination rooted in stereotypes and a lack of cultural understanding, created significant barriers in healthcare, social services, housing, and education. These structural inequalities not only compounded their vulnerability to IPV but also fostered feelings of alienation and mistrust toward institutions. One participant shared her experience of seeking shelter:

> The first time I wanted to escape, I could not find any shelter to go to. The second time, I went to a shelter and there were no women like me, all are white people and speak English only. I felt alone and I could not deal with the women there as I felt that I am different and not welcomed in there.

This highlights how institutional spaces often fail to consider the cultural and linguistic needs of immigrant women. The absence of staff or peers who could relate to participants' backgrounds compounded their sense of alienation, reinforcing the perception that support systems were not designed with them in mind. Another participant recounted:

> I just did not feel comfortable to reach out to one organization for support because I learned that some staff members held negative stereotypes…you know when you need to think twice before you run for your safety. You would ask yourself shall I leave him and go to ask for help from these people.

This demonstrates how systemic biases discourage women from seeking help in the future, as the fear of judgment and rejection outweighs the potential benefits of engaging with support systems.

The visible markers of identity, such as wearing a hijab, further exposed women to discriminatory treatment. One participant shared:

> I was afraid to go to a shelter because I wear a hijab. My friends told me stories about how women like us are judged, not just for being abused but for who we are. I didn't want to face that kind of treatment.

This account underscores how the intersection of cultural and religious identity made women feel hyper-visible in settings that were supposed to provide safety and support. For many, the fear of mistreatment acted as a significant deterrent to accessing services, leaving them isolated in abusive environments.

Healthcare systems perpetuated institutional racism, with many participants describing interactions that left them feeling dismissed or stereotyped. One participant explained:

> During COVID-19, I accessed mental health counselling online. However, I felt the counsellor had some biases against my race or appearance and that make me very hesitant to return or seek help. Actually, that affected me as I started to tolerate my husband behaviours without thinking of seeking help anymore…I just do not need any more problems or bad feelings in my life.

Another participant expressed a similar fear regarding the punitive potential of social services: "The scary thing was that I thought if I told someone, they would have social services straight after having the baby and then they would take the baby away from me."

These examples highlight how implicit biases among healthcare and social service providers make women reluctant to seek help even in critical situations. Such negative interactions reinforce cycles of tolerance for IPV, as women feel increasingly unsupported by the

systems meant to protect them. Furthermore, law enforcement interactions were similarly fraught with bias. One participant recounted:

> When I called the police for help, they questioned me more than they did my husband. I felt like they thought I was the troublemaker just because I'm Middle Eastern. They asked me if I was aggressive. I think they did not believe me…by doing this, I decided not to call the police again as I got scared then based on that I was tolerating the IPV until I got divorce.

This narrative illustrates how systemic discrimination within law enforcement not only failed to provide necessary protection but actively discouraged women from seeking help. The participant's fear of further judgment or disbelief left her feeling trapped, illustrating how institutional inequities exacerbate IPV.

Housing services also reflected systemic biases. One participant described her experience of seeking accommodation after leaving her abusive partner: "I couldn't find a place to stay after I left him. People didn't want to rent to someone with my background, especially a single woman with kids."

This account highlights how the intersection of racial and gender biases compounded the already significant challenges of leaving an abusive relationship. The reluctance of landlords to rent to immigrant women further limited their options for safety and independence. Another participant recounted a friend's experience:

> My friend told me that when she went to a shelter here, they found that no one speaks Arabic, and some workers were giving her attitude and cold reactions, and this behaviour was not the same for everyone. So, she felt that because she wears hijab as that was the only unique thing she had.

These testimonies underscore how systemic discrimination across multiple institutions creates a hostile environment for MEIW. Women often felt that their needs and identities were overlooked or disregarded, leaving them with limited avenues for support.

The cumulative impact of these experiences extends beyond individual incidents of discrimination. For many MEIW, the recurring patterns of dismissal, scrutiny, and neglect across institutions created a pervasive sense of alienation. This dynamic not only leaves women isolated but also entrenches their dependency on abusive partners, as institutional racism cuts off alternative pathways to safety and independence.

5.5.3.2 Immigration-Driven Marginalization.

While some aspects of this theme may appear to overlap with previously identified factors, this section focuses specifically on how immigration experiences uniquely shape MEIW's vulnerability to IPV. Highlighting this dimension is critical, as it contextualizes other barriers within the broader realities of migration and adaptation to the host country. For MEIW, immigration status and associated challenges posed significant risks that compounded their vulnerability to IPV. Participants described how systemic barriers tied to immigration, such as visa restrictions, language limitations, and cultural isolation, created environments where abuse could thrive. These risks often intersected with institutional racism and cultural narratives, further marginalising women and limiting their access to support.

This highlights how immigration policies and legal dependencies became tools of coercion, with abusers exploiting women's precarious legal standing to assert control. The fear of deportation was compounded by a lack of understanding about legal protections, creating situations where many women felt unable to seek help or advocate for themselves. Another

participant recounted the threat made by her partner: “He said the police wouldn’t care because they think Middle Eastern women just accept this kind of treatment”.

Fear of institutional bias against immigrants compounded these challenges, as women internalised feelings of vulnerability and distrust toward authorities. Cultural stigma surrounding IPV further exacerbated these risks. One participant explained:

> You know, violence is bad. If you experience violence in your home, then the people will think you are not good and that’s you have a problem. When I asked my friends if they want to participate in this study, they said “Oh no, that’s not me” …they are afraid that I judge them or talk about them badly or other people to judge them.

The stigma associated with IPV discouraged MEIW from disclosing their experiences or seeking support, as they feared judgment from both their communities and mainstream institutions in the host country. For MEIW, this fear was intensified by social isolation, language barriers, and uncertainty about how authorities in the host country might perceive them. Many felt that disclosure could lead to shame within their ethnic communities or jeopardize their family’s stability in Canada. This fear was compounded by internalised blame, as one participant expressed: “I was a failure [after coming to Canada] I could not keep the family unit. It was not his mistake only. I was a part of it too and I thought it was my fault.”. Another participant echoed these feelings: “As soon as we enter Canada, I started to feel ashamed and believed I deserved the abuse because I couldn't keep him happy. I was convinced that if I were a better wife, this wouldn't happen.” Such internalised guilt emerging after migration was further shaped by cultural narratives that emphasise women’s responsibility for maintaining family harmony within the host country.

Language and cultural barriers intensified these challenges. Many participants reported difficulty navigating public systems due to linguistic limitations. This isolation was compounded by cultural pressures to maintain privacy and avoid bringing shame upon the family. One participant recounted:

> I've never talked to people about it. I just cannot. It feels really shameful. The violence is something common, so many of my friend are the same of me…everyone gets beaten by their husband…you know they will judge me and say you do not know how to deal with him, and you are not patient.

For some, this stigma was reinforced by societal expectations that IPV was a private matter or a failing on the part of the wife. One participant shared: "I was such a bad wife at the beginning, I could not tolerate the abuse, but others can and they complete their life nicely."

Abusers often leveraged fears of racism and xenophobia to maintain control, further isolating women. One participant explained:

> My husband was telling me that if you go out to study or to work, I may encounter people who are racists. They may pull my hijab or hurt me. I was not able to go outside as I was scared to face these situations.

Such manipulation exploited both the real and perceived risks of discrimination in public spaces, reinforcing women's dependency on their abusers while deterring them from seeking autonomy or external support. The cumulative impact of these immigration-related risks, cultural stigma, and systemic barriers left many women feeling powerless and invisible. The recurring patterns of marginalization and discrimination created a pervasive cycle of dependency and vulnerability.

5.6 Coping strategies

This theme addresses the study's objective to " Identify IPV interventions and strategies that are culturally and contextually responsive to the needs of MEIW experiencing IPV during the perinatal period." This major theme examines the coping strategies adopted by MEIW to navigate the challenges of IPV. Participants described employing two main types of coping strategies: problem-focused and emotion-focused. Problem-focused strategies aimed at directly addressing external stressors, such as seeking safety, legal or professional support, and building independence, reflect resilience and resourcefulness. In contrast, emotion-focused strategies, which included spiritual practices, self-care, distraction techniques, and seeking social support, were designed to manage the emotional toll of IPV, offering relief and temporary stability.

While problem-focused coping is often tied to resilience and long-term functioning, emotion-focused strategies were more immediate and adaptive in managing participants' emotional responses to IPV. These approaches illustrate the diverse ways in which participants sought to endure and survive within a highly distressing environment. Importantly, these sub-themes are not presented as judgmental, but instead, reflect the wide spectrum of strategies employed by participants based on their circumstances.

The results are structured into two sub-themes: Practical Solutions: Problem-Focused Strategies, and Personal Investment: Emotion-Focused Coping, which are further divided into six categories (Table 5.1) that encapsulate the strategies participants used to navigate IPV.

5.6.1 Practical Solutions: Problem-Focused Strategies

This sub-theme examines the practical, problem-focused coping strategies employed by MEIW to address IPV. These strategies involved direct actions aimed at managing or altering the external stressors contributing to abuse. Participants highlighted efforts such as seeking safety,

accessing legal and professional support, and working towards financial independence. While these approaches were empowering, they also came with significant risks and challenges, reflecting the complexity of problem-focused coping in this context. The findings are structured into three categories: Seeking Safety and Legal Support, Professional Guidance and Advocacy, and Building Independence.

5.6.1.1 Seeking Safety and Legal Support.

For many participants, taking action to secure safety was an essential step in addressing IPV. Safety planning, reporting abuse to authorities, and finding shelter were recurring strategies. These actions were often driven by a need to protect themselves and their children, though they frequently involved navigating significant fears and risks. One participant shared the pivotal moment when she recognised the need to escape:

> At my first perinatal appointment, I did not say anything about my husband abuse. However, when he started to threaten me to kill me if I say anything, I got so scared and told the nurse everything. I felt he has something new; I felt that he would kill me even if I did not report him. It was the time to escape and run away.

Reporting IPV to the police was often described as a last resort, taken only after other coping mechanisms had failed. Another participant explained her decision-making process:

> Reporting him to the police was not easy for me. It was the last option for me. I tried everything with him before reporting. I ignored him many times, I left the house many times, once I apologized for him while he abused me, but nothing worked.

These narratives highlight the tension between the desire for safety and the significant risks participants associated with seeking legal support, including potential retaliation.

5.6.1.2 Professional Guidance and Advocacy

Participants emphasised the importance of seeking help from professionals, such as healthcare providers, lawyers, social workers, and counsellors, in order to navigate the complexities of IPV. These professionals provided vital assistance, from understanding legal rights to accessing community resources and addressing emotional needs. One participant described her experience of seeking legal advice:

> I called the women organization and asked for help. I did not want to report him to police at all, I just wanted to know my rights in Canada so I can plan for my life with him especially I have kids…. I know if I reported him to police, he would divorce me, and we will never go back together so I did not report him.

For others, engaging with professionals marked a turning point in recognising the severity of their situations and accessing specialised support. One participant recounted her decision to move forward without her husband: “When I ran outside of the house, I decided to put everything behind my back. I was caring for my kids only. I did not need him, and I did not want him in my life again”. These examples illustrate how professional guidance empowered participants to make informed decisions and take steps towards regaining control of their lives.

5.6.1.3 Building Independence

Achieving financial independence emerged as a critical coping strategy for participants, enabling them to reduce their reliance on abusive partners and gain autonomy. However, systemic barriers, such as caregiving responsibilities, limited job opportunities, and cultural expectations,

often made this path challenging. One participant reflected on how financial dependence heightened her vulnerability:

> I could not find a job for five years. I was asking myself every time he hurts me, if I was working can he do this to me? and the answer was absolutely no because he knew that I would leave him as soon as I got money and could rent a house and live on my own.

For many, the strain of balancing work and caregiving responsibilities proved overwhelming. One participant shared her experience:

> I was so happy when I got my registration as a practical nurse here in Canada and I could find a good job. But I found that they wanted me to workday and night shifts so I could not accommodate my need to take care of my kids… having no job makes me very weak and unable to protect myself form my husband.

These accounts underscore how financial independence was both a goal and a significant challenge for participants. While it represented a pathway to safety, systemic and personal barriers often complicated efforts to achieve it.

Problem-focused coping strategies provided participants with actionable pathways to address IPV, centring on immediate safety, professional guidance, and financial independence. These strategies were often initiated during critical moments when the risks of remaining in abusive relationships outweighed the fears of seeking help. However, the complexities of these coping mechanisms, including fears of retaliation and systemic obstacles, underscored the challenges inherent in breaking free from IPV.

The next sub-theme, explores how participants managed the emotional toll of IPV, focusing on strategies aimed at regulating their internal responses to abuse.

5.6.2 Personal Investment: Emotion-Focused Strategies

Emotion-focused coping involves using strategies to manage or regulate the emotions that arise from stressful situations such as IPV. These inward-facing approaches, including practices like prayer, meditation, and self-care, aim to reduce internal emotional distress rather than addressing external stressors directly. Participants reported that emotion-focused coping was often their front-line response to IPV, helping them endure the challenging circumstances they faced. Three categories are included in emotion-focused strategies: spiritual and emotional resilience, self-care and distraction techniques, and seeking social support.

5.6.2.1 Spiritual and Emotional Resilience

During interviews, participants described various emotional coping strategies they used to endure IPV, revealing their resilience in navigating a highly distressing and challenging environment. The data indicate a range of responses, reflecting how different choices are shaped by participants' emotional states and circumstances. These strategies, reported during interviews, provide critical insights into how participants managed and regulated their emotional distress amidst IPV. The following are some of these strategies:

- Expressing emotions through crying: Participants described this as a form of emotional release, helping them process overwhelming feelings.
- Seeking advice from friends or social media: This strategy often provided comfort and a sense of connection, even if it did not resolve underlying issues.
- Praying and practicing spirituality: Many participants turned to religious practices to find hope and emotional support, maintaining a sense of control amidst chaos.

- Engaging in self-care: small acts of self-care, such as focusing on skincare or physical appearance, helped participants reclaim a sense of autonomy and self-worth.
- Distracting themselves: Activities like spending time with children, engaging in hobbies, or visiting friends provided temporary relief from stress.

These strategies often empowered participants, allowing them to manage their emotions and sustain themselves through difficult times. Religious and spiritual practices, in particular, played a significant role in fostering resilience. One participant shared:

> I just pray and ask God to help me. Sometimes I would pray and cry for the whole night. I believe God will help me. I ask God every day to change my life and guide my husband to the right path.

Other Coping Strategies might include:

- Retaliating: Fighting back physically or verbally was often a response to anger but frequently escalated the abuse or resulted in further harm.
- Staying silent and accepting the situation: While this approach sometimes avoided immediate conflict, it often perpetuated cycles of abuse and emotional isolation.
- Apologising: Participants described apologising for the abuser’s behaviour as a way to defuse tension, which reinforced patterns of control.
- Gambling: Gambling as a distraction reflected the emotional toll of IPV but introduced financial strain and feelings of guilt.
- Using substances: Some women turned to substances to numb emotional pain, risking dependency and additional challenges.
- Avoiding confrontation: Although temporarily effective, avoidance left deeper issues unresolved and perpetuated participants' vulnerabilities.

These strategies highlight the intense emotional distress participants experienced and the limited resources they had to address it. While they sometimes provided momentary relief or defused tension, they often reinforced participants' entrapment or introduced new risks.

These results suggest that first set of strategies like spirituality, seeking advice, and self-care were important in helping participants maintain hope and emotional stability. These approaches provided participants with tools to focus on their well-being and regain some sense of agency. However, their limited capacity to address the underlying causes of abuse often meant that relief was temporary. In contrast, the second set of strategies such as gambling, substance use, and avoidance reflected participants' constrained circumstances and emotional distress. These behaviours, while often aimed at survival.

5.6.2.2. Self-Care and Distraction Techniques

Self-care and distraction techniques emerged as prominent coping mechanisms for participants, reflecting women's efforts to alleviate the emotional toll of IPV. These strategies, which were frequently discussed during interviews, offered participants moments of relief and a sense of control amidst their challenging circumstances. For MEIW, these practices often intersect with cultural expectations and personal resilience, highlighting the ways they navigated their complex realities.

Participants described engaging in self-care practices, such as focusing on skincare or pursuing small cosmetic procedures, as acts of self-nurturing that helped them reclaim a sense of autonomy and confidence. These activities provided a tangible way to counter the emotional degradation caused by IPV. As one participant shared: "I just try to focus on myself and my kids. I bought many skincare products and started to take care of myself. I feel better when I look in the mirror and see I am still beautiful."

In addition to self-care, physical activities and social interactions were highlighted as restorative practices. Exercise, meditation, and spending time with friends not only offered distraction but also reinforced emotional stability. One participant explained how these strategies helped her manage the immediate impacts of her partner's abuse: “When he starts, I will just ignore him and leave the place. Sometimes I do meditation or go to the gym next to my house. I sometimes go to the coffee shop with my friends.” For participants navigating IPV during the perinatal period, self-care and distraction often involved caring for their children or seeking support from trusted community members. These activities served two purposes: they made sure that their children were safe and healthy, and provided them with a chance to connect and relax. One person said: “When he gets angry, I take my kids and go to a park or our neighbor's house.”

Digital distractions were also a big part of how the individuals dealt with their problems. Many women who were being abused used their phones to play games to escape their minds. Unfortunately, this helped for a short time but sometimes led to problematic habits like gambling. One person said: “I found myself on playing some games. Sometimes I gamble on these games. But it is okay. I just distract myself, and this is how I can continue with him.”

Whilst MEIW can benefit from self-care and distraction techniques, many described only temporary relief from these practices. This shows how important it is for women to have support systems that are easy to reach, and culturally responsive to help survivors move from coping to long-term recovery.

5.6.2.3 Seeking Social Support

Participants said that getting social support was a big part of how they dealt with the mental health effects of IPV. Many women turned to their families, friends, and online communities for help and support. These could be social media sites like Facebook or WhatsApp groups. Even

though these interactions did not always lead to useful answers, they did provide emotional support and approval. Many of the woman found comfort in talking about their experiences with trusted family members or online anonymously, even if they did not directly address the abuse. As one person put it: “I sometimes feel better after talking about my problems with my mother. I sometimes post online and ask for advice about how to deal with my husband's abuse”. Systemic and cultural barriers, on the other hand, often made social help less useful. One participant explained that she could not tell healthcare workers about her situation because she was afraid of being judged:

> I doubted that I would receive a service without judgment. I was very careful not to discuss what was going on in my life with my gynecologist. It made things worse and left me feeling even more alone…I was trapped in a cycle I couldn't escape.

This narrative highlights how the stigma impacts the MEIW’s ability to seek help, particularly within healthcare settings, compounded participants’ feelings of isolation and limited their ability to seek help. Cultural norms played a significant role in participants’ decisions to stay in abusive relationships. One woman explained:

> Every time I talk with my friends, they would say it is okay and you must accept it to keep your life and protect your kids, or they would say you need to tolerate it as all men do the same. If I escaped, he would take my kids, and when I go back to my country, my family will blame me. That’s why I thought about escaping many times, but I could not.

These data show how cultural standards, family duties, and systemic problems interact. Many of the women were afraid of losing their children or being shunned by friends and family.

They were stuck in cycles of IPV because their network of support often reinforced cultural stories of sacrifice and endurance.

5.6 Conclusion

This chapter reports the results on the experience of IPV among MEIW during their perinatal period. Organised around five major themes, the results show how IPV manifests individually while being influenced by broader cultural and systemic factors during the perinatal period.

Participants' narratives reveal that IPV is not only an individual experience but also a socially situated phenomenon, shaped by patriarchal norms, cultural expectations, and systemic inequities. From the pervasive fear and control described in Defining IPV to the intersecting forms of abuse captured in Forms of IPV.

The consequences of IPV extend beyond the MEIW to children, families, and communities. This disrupts the MEIW's and children's health and well-being and social cohesion. Furthermore, the challenges participants faced in seeking help highlight significant barriers tied to cultural stigma, economic precarity, and systemic discrimination. Despite these adversities, the resilience demonstrated in Coping Strategies underscores participants' resourcefulness in navigating and resisting IPV.

Together, these results contribute to a deeper understanding of IPV as experienced by MEIW during the perinatal period. By centring participants' voices and examining IPV through the social-ecological lens, this chapter lays the groundwork for the discussion chapter, where the research questions will be answered, and the implications of these results will be explored within broader theoretical and policy contexts.

Chapter 6: Discussion of Key Findings

This chapter discusses the research findings and situates them within the context of existing literature. It compares and contrasts the findings of this study with previous studies and highlights the major contributions of this study to the fields of IPV, MEIW and nursing. The chapter is organized into eight sections. The first section provides an overview of the research and research questions. The subsequent sections synthesize and interpret the key findings, present the study's implications. and explains the study's strengths and limitations. Lastly, the conclusion emphasizes the need for intersectional, culturally safe, and systemic approaches to break the silence around perinatal IPV and support MEIW and their families.

6.1. Introduction

There is a scarcity of qualitative research examining the experiences of MEIW with IPV during the perinatal period. To address this gap, the present study employed in-depth interviews to gain deeper insights into individual experiences among these women, providing rich and in-depth description of these experiences. The aim of this study was to explore the experiences of IPV among MEIW living in Ottawa during the perinatal period. This study employed an instrumental case study to examine the MEIW's understanding of IPV, the factors influencing IPV during the perinatal period, and the perceived impact of IPV on themselves, their children, their family, and the broader society. This study is calling for culturally responsive interventions to address the IPV within this context. A thematic analysis of twenty interviews was conducted to explore and answer the research questions of how MEIW experience IPV during the perinatal period.

The data analysis led to five overarching themes and 16 subthemes. The main themes include: Defining IPV, Forms of IPV, IPV Impact, IPV Vulnerabilities and Help Seeking Behaviours, and IPV Coping Strategies. These findings are crucial for understanding the

experiences of MEIW and highlighting critical factors that disproportionately affect the well-being of the MEIW and their children, yet remain under researched within this population. In the next section, I will discuss the following four cross-cutting themes generated from the study findings: (1) Wounds Without Words: Navigating the Silence of Perinatal IPV, (2) Maps Not Drawn: Immigrant Women Navigating Unfamiliar Systems Alone (Integration of Immigrant Women and Support Systems in the Host Country), (3) Trauma Passed Through Blood and Memory (Intergenerational Trauma), and (4) A Glimmer of Hope: On the Pathway to Empowerment and Independence**.**

Cross cutting themes are the themes that emerged across multiple domains of participants' experiences and intersect with several of the key thematic categories. Cross-cutting themes capture broader patterns and linkages within the data, often reflecting deeply embedded issues that cut across different aspects of the study's results (Braun & Clarke, 2006; Nowell et al., 2017). These cross-cutting themes were identified as underlying patterns that run through and connect the five main themes of the result chapter**,** Defining IPV, Forms of IPV, IPV Impact, IPV Vulnerabilities and Help-Seeking Behaviours, and IPV Coping Strategies**,** emerged from the study findings. Together, these cross-cutting insights demonstrate how the key findings are interrelated and offer a more comprehensive understanding of the unique experiences of MEIW living in the Ottawa during the perinatal period.

The order in which these cross-cutting themes are presented reflects a narrative and experiential flow that mirrors participants' lived experiences. The first theme, Wounds Without Words: The Silence of Perinatal IPV, sets the foundation by revealing how IPV often begins in secrecy and silence particularly during the perinatal period. This is followed by, Maps Not Drawn: Navigating Unfamiliar Systems Alone, which captures the isolation and confusion

MEIW faced as they attempted to seek help within unfamiliar and new social, legal, and healthcare systems. The third theme, Trauma Passed Through Blood and Memory, builds on this by illustrating how the unresolved trauma of IPV echoes across generations, impacting MEIW, their children and the community. Finally, A Glimmer of Hope: On the Pathway to Empowerment and Independence, offers a forward-looking perspective, illuminating participants' resilience and the gradual steps they took toward healing and autonomy. This thematic order not only appreciates the complexity of their experiences but also offers a coherent and compassionate structure through which their voices can be heard and understood.

6.2. Wounds Without Words: Navigating the Silence of Perinatal IPV

This theme captures how the unspoken and normalized nature of IPV as revealed in Theme 1 (Defining IPV) and Theme 2 (Forms of IPV) may render many women's experiences invisible. In addition, this overarching theme emerged from Theme 5 (Coping strategies) as the silence surrounding IPV during the perinatal period does not signify the absence of IPV but rather reflects a strategic form of coping and survival shaped by cultural expectations, stigma, and systemic inequities. Viewed through the lens of critical theory, the silence surrounding MEIW's experiences of IPV during the perinatal period may reflect structural power imbalances including patriarchal norms and immigration issues that suppress MEIW's voices and normalize endurance as a moral expectation of motherhood. An Intersectional perspective further reveals that this silence is shaped by the overlapping influences of gender, culture, migration status, and language, which together create compounded vulnerabilities and limit access to support. The SEM helps situate these intersecting factors across multiple levels from individual fear and interpersonal control to community stigma and systemic inequities showing that silence is a coping strategy operating at individual, relational, community, and structural levels.

While this study set out to explore IPV in the perinatal period, participants rarely framed their experiences explicitly in relation to pregnancy or the postpartum period. Instead, they spoke more broadly about IPV and its impact on their lives, without always distinguishing how the perinatal period shaped these experiences. This raises important questions about how IPV is perceived and narrated, particularly within Middle Eastern immigrant communities, and suggests that perinatal IPV may be overlooked rather than absent in these narratives. This finding highlights potential gaps in awareness, discourse, or disclosure regarding the intersection of IPV and the perinatal experiences. This limitation underscores the need to further investigate how IPV manifests and is understood during this critical period, as well as the broader systemic and cultural factors that may impact women's willingness or ability to discuss it.

This section addresses the limited explicit discussion of the perinatal period in participants' narratives by adapting a multi-faceted approach. First, the findings will be reframed in relation to perinatal IPV, underlining instances where IPV may have existed, but not directly linked to perinatal IPV experiences. Second, the current literature will be employed to contextualize implicit perinatal IPV experiences, offering a broader understanding of how IPV manifests during this important period and why it may not always explicitly be discussed by participants. Lastly, the underlying reasons for this absence will be explored. This section will look closely at the cultural, systemic and other personal factors that contribute to the women's inability to discuss IPV within the perinatal context. Using this approach, this section will uncover the hidden dimensions of IPV during the perinatal period, and it will provide a deeper analytical perspective on its importance.

One of the most compelling findings of this study was the silence surrounding MEIW's experiences of IPV during the perinatal period. While participants openly shared experiences

around IPV, they often described these stories as if they occurred outside the perinatal period, even when the abuse clearly happened during the perinatal period. This unintentional distancing implies that the perinatal period is socially and emotionally framed as a time that must remain ideal, psychologically intact and unaffected by trauma or physical abuse, even when that is far from reality. This finding brings to attention the critical but overlooked issue of IPV during the perinatal period. IPV during the perinatal period is not only underreported in services and policies but also is often unrecognized and unspoken by survivors themselves.

The current literature consistently demonstrates that the perinatal period is a time of heightened vulnerability to IPV, with some women experiencing IPV for the first time during pregnancy, and others facing escalation in abusive behaviours during or after childbirth (Devries et al. 2023; Lévesque et al., 2022; O'Doherty, et al. 2015). Yet, this period is often overlooked in both research and practice, particularly for immigrant women (Gagnon et al. 2017). Existing studies indicate that cultural expectations of motherhood, combined with language barriers, systemic racism, and immigration status instability, often silence women's disclosures during this period (Amin et al., 2024; Liu & Proulx, 2023; Sanchez et al., 2022). However, what remains underexplored in the current literature, is how this silence is internalized by the survivors themselves and how that can help in preserving the sense of belonging and stability. Furthermore, the literature often overlooks how immigrant women may intentionally remain silent as a protective measure not only to avoid escalating IPV but also to shield their children from being taken away by either the abusive partner or child protection authorities (Bloom et al., 2021).

This study's findings show how MEIW disconnect IPV from the perinatal context, even when these incidents occurred specifically during pregnancy or early parenting. This silence

manifest in the absence of disclosure to healthcare providers. This finding adds an important dimension to the literature as it explains how IPV is both present and hidden during the perinatal period, not because it is uncommon, but because it is an acceptable part of being a good mother in context.

The current literature has acknowledged that many immigrant women do not disclose IPV during their lifetime (Sabri, Lee, & Saha, 2022; Park et al., 2021). However, less is known about the underlying mechanisms and cultural echoes behind this silence. This study contributes to filling that gap by illuminating how deeply embedded cultural and social norms, along with systemic, interpersonal, and emotional pressures, shape MEIW's capacity and willingness to disclose IPV. It uncovers the complex interplay between cultural ties, fear of stigma, and institutional mistrust that often silence their suffering.

For many participants, cultural expectations of motherhood, family preservation, and gender roles might create a moral obligation to experience IPV quietly rather than expose it publicly, as disclosure was perceived as dishonoring the family or threatening marital stability. These beliefs were reinforced by immigration-related vulnerabilities, such as language barriers, loss of extended support networks, and dependence on partners for financial or legal security, which limited women's access to healthcare and social services. Institutional mistrust and fear from stigma or discrimination further compounded this silence participants feared that police, social workers, or healthcare professionals might not understand their cultural background or could separate them from their children. On an emotional level, women might internalize these cultural and systemic pressures as shame, guilt, and self-blame, which diminished their confidence and reinforced a pattern of self-silencing. Together, these intersecting forces reveal

that women's silence is not a reflection of passivity or acceptance, but it might be a strategic and protective response shaped by overlapping cultural, emotional, and structural constraints.

This silence is not the result of a single factor, but rather the outcome of multiple overlapping factors operating across different levels of the (SEM). During the interviews, the participants discussed how the abuser's presence, financial dependency, and psychological manipulation restricted their ability to disclose. Being censored by the perpetrator was mentioned in their interviews. This study also reveals that silence functions as a survival strategy, serving as a conscious or unconscious coping mechanism employed by individuals to protect themselves from further harm or conflict. What is often perceived by service providers as an obstacle may, in fact, be a deliberate protective response by those experiencing distress. For many women, it enables them to sustain a sense of control, to preserve cultural expectations of motherhood, and to protect their children from systems (Children Aid Society, shelters, etc.) they do not trust. In these instances, silence is not merely reluctance to disclose, but a deliberate protective recontextualization of IPV away from the perinatal period, thus maintaining the illusion of safety in one of the most vulnerable periods of their lives.

This research sheds light on the perinatal period as a critical window for interventions and it emphasizes that overlooking this period represents a significant missed opportunity. Healthcare providers, policymakers and researchers should shed light on the perinatal period and reframe it not only as a time of excitement and transitions, but as a significant time for interventions (supporting, prevention, healing and trauma and violence informed care). Naming and acknowledging IPV during this time are not an attack on motherhood, it is a protective measure that safeguards the well-being of both mothers and their infants.

By employing the intersectional lens, this research brings to light that the silence observed during the perinatal period in the study is not merely personal but rather that it is structural. MEIW, who are marginalized, non-English speakers, unfamiliar with legal and immigration issues, experience a form of "compounded silencing" where multiple systems of the SEM overlap to make disclosure both dangerous and futile. For example, the individual factors which are related to MEIW's emotions and expectations to be a "strong immigrant mother" could overlap with community and societal factors such as stigma around IPV, fears of children protection services, and the risk of deportation. This overlapping burden produces a form of protective denial, where MEIW choose silence to retain control and family cohesion. This study also highlighted that responses from informal support systems may reinforce silencing due to individual and community normalization of IPV. From a critical theoretical perspective, breaking this silence requires more than individual empowerment, it calls for transformative, community-driven approaches that challenge the structural roots of MEIW's oppression. Interventions which are culturally responsive and led by community organizations, religious leaders, and societal institutions can serve as entry points for dialogue and change, provided they amplify survivors' voices rather than speak for them and critically question the norms and power relations that sustain silence. In this way, culturally grounded initiatives become not only acceptable but also emancipatory to foster collective awareness and shift power toward the MEIW. Developing care models that prioritize maternal autonomy during the perinatal period is crucial step toward breaking the silence that frequently characterizes this vulnerable time. These models of care must go beyond improving existing systems to redefine how care itself is structured and delivered. Empowering MEIW to voice their experiences requires a redistribution of power shifting authority from institutional frameworks to women's lived realities. Relationship-based, trauma

and violence -informed perinatal care, as illustrated by Hinton et al. (2022), offers a pathway toward this transformation. In such a model, care becomes a collaborative and culturally grounded practice, where home visits by trusted midwives replace hierarchical clinic encounters, and perinatal interventions are co-created with women rather than imposed upon them, ultimately challenging the systems that have historically silenced their voices.

These interventions are grounded in trust, relational continuity and cultural awareness and tended to unfold stories rather than treat bodies. These settings open a door through which MEIW especially who are experience IPV, precarity of migration and the weight of motherhood, might feel safe enough to speak and be heard. In such a setting, silence may no longer used as a coping mechanism to a starting point for healing and empowerment.

6.3. Maps Not Drawn: Immigrant Women Navigating Unfamiliar Systems Alone
(Integration of Immigrant Women and Support Systems in the Host Country)

Linked to Theme 4 (IPV Vulnerabilities and Help-Seeking), this overarching theme highlights how language barriers, racism, and immigration precarity hinder access to formal support systems, leaving women isolated, disoriented, and without guidance in navigating safety and care. Interpreted through critical theory, MEIW's difficulties navigating unfamiliar systems reflect structural power imbalances embedded within immigration, health, and social systems that reproduce exclusion and dependency. Intersectionality clarifies that these barriers are intensified by the overlap of gender, race, language, and motherhood, creating layered vulnerabilities that most mainstream interventions fail to recognize or address. The SEM helps situate these intersecting forces across individual, interpersonal, community, and societal levels, illustrating how isolation and marginalization are sustained through multilevel interactions.

The integration of MEIW into their new country is a multifaceted process shaped by social, economic, legal, and cultural systems. It is well-documented that immigrant women particularly those who are racialized (such as MEIW), linguistically isolated or survivors of IPV, face unique and intersecting barriers to successful integration (Salami et al., 2020). These barriers include limited access to language services, unstable immigration status, unemployment, and social isolation. Structural racism and cultural differences further hinder their ability to access health, legal, and social supports (Bachem et al, 2024). When IPV is superimposed on these challenges, the risks of marginalization and social exclusion are further intensified.

The current literature on social integration for immigrant women emphasizes the importance of coordination efforts across different areas (such as immigration, housing, health, legal aid, education, and employment) to support immigrant women's full participation in society (Crawford, 2023; Sethi, 2013; Stick, Schimmele, Karpinski & Arsenault 2024; Thurston et al., 2014). Nevertheless, much of this research focuses on general immigrant experiences and uses one-size-fits-all approach to immigrant women's integration. What remains underexplored is how integration systems must be adapted and tailored to meet the specific needs of MEIW affected by IPV, particularly during the perinatal period, a time when safety, identity transformation, social integration, and parenting intersect in complex and unique ways.

This study finding shows how the systemic exclusion from services and sociocultural participation may affect the women's perceptions of themselves as mothers and community members. Furthermore, this study draws attention to how children internalize and absorb the consequences of their mother's exclusion, thus reinforcing cycles of isolation and social exclusion.

Upon arrival in Ottawa, participants were met with unexpected challenges, including language barriers, cultural conflict, institutional racism, and IPV-related stigma, which contributed to feelings of marginalization and invisibility. This marginalization was intensified by siloed services that failed to acknowledge the intersection of their experiences and vulnerabilities. As a result, many withdrew from civic engagement, social participation, avoided accessing services, and internalized blame. These are conditions that profoundly influence their ability to raise their children with confidence and security in the host country. This study highlights that integration is not only about settlement services that the government may offer to immigrants; it is about emotional belonging, safety, and recognition.

Applying intersectionality reveals that MEIW's integration is shaped not only by their immigration status but by the overlap of language barriers, gender, race, class, racism, and motherhood. MEIW who are survivors of IPV experience additional silencing due to cultural norms that discourage speaking out or seeking help. These intersecting oppressions require service models that do not treat MEIW as a homogenous group but instead tailor supports to their diverse experiences. In the same context, the SEM (Heise,1998) can be used to create sustainable inclusion and prevent one-dimensional interventions by advocating for comprehensive approaches that address multiple levels of influences. This study highlights that integration is not only about the settlement services offered to immigrants, but also about fostering belonging, safety, and recognition. From an intersectional perspective, this finding points to critical areas of action that extend beyond service delivery, addressing structural inequities, strengthening culturally safe and trauma and violence-informed practices, and creating spaces that affirm MEIW's agency and belonging. These actions are essential within the SEM for promoting meaningful integration and supporting MEIW's empowerment in the host country.

This research contributes to ongoing efforts to strengthen capacity-building and foster integration across multiple levels to better serve MEIW. It advocates for multi-level interventions that enhance self-efficacy while addressing structural barriers shaping MEIW's IPV experiences. Grounded in Critical Theory, this approach challenges existing power imbalances by calling for culturally responsive programs that move beyond service delivery to empower women as agents of change. Participants' accounts of disempowerment underscore the need for interventions that not only support immediate safety but also promote systemic transformation through intersectional approach that integrate cultural dimensions of MEIW's experiences across all the levels of the SEM. These services should proceed at a pace aligned with each woman's comfort and readiness, unfolding gradually to allow MEIW to process information without feeling overwhelmed.

Utilizing established frameworks and research across the various tiers of the SEM(Heise,1998) can effectively enhance current interventions, ensuring that MEIW have equitable opportunities to integrate into the system. Drawing on Etowa and Adongo's (2007) work on culturally congruent care and the impact of everyday racism on marginalized women's health experiences, an individual-level intervention could involve culturally anchored perinatal empowerment sessions for MEIW women affected by IPV. While this intervention primarily targets change at the individual level, it holds the potential to foster broader community transformation by empowering individuals who, in turn, influence collective norms and social practices. These one-on-one or small-group sessions, facilitated by culturally trained nurses and social workers would provide a safe space for MEIW to explore their identities, share experiences, process trauma, and rebuild their sense of self as mothers. Grounded in Etowa and Adongo's emphasis on moving beyond cultural sensitivity toward true cultural congruence, these

sessions would validate MEIW's experiences of migration, motherhood, IPV, and systemic racism, while integrating culturally meaningful tools such as storytelling, faith-based affirmations, and empowerment narratives. This approach not only affirms the woman's strengths but also helps restore parenting confidence and emotional regulation, key factors in preventing the transmission of trauma to children. By empowering MEIW to regain their agency and rebuild trust in themselves and their cultural identities, this intervention symbolizes the principles of culturally safe, trauma and violence informed care and responds directly to the gaps identified in both the literature and this study's findings.

At the interpersonal and community levels, the loss of informal networks and support systems post-migration heightens isolation for these women. Some MEIW participants reported weakened resistance strength due to disconnection from family and community, indicating the need and value of trauma and violence informed support, parenting programs centered on emotional expression, and child-inclusive healing initiatives.

In Ottawa, there are some programs and organizations that have been instrumental in supporting the social integration of immigrant and refugee women by fostering one-on-one relationships between newcomers and local volunteers. Through informal mentorship and regular social interactions, programs help reduce isolation, improve language skills, and enhance cultural understanding. For example, the "Circle of Support" program, offered by a community center, provides home visits and workshops designed to help parents achieve their parenting goals. The program primarily supports newcomer Canadian parents and offers services in both English and Arabic. For many Middle Eastern immigrant mothers, this social support offers a crucial lifeline during their early resettlement period. However, while effective at promoting social connection and emotional support, the program does not address the deeper structural and systemic barriers

that many MEIW face, particularly in navigating complex systems such as immigration, child welfare, housing, and legal services. Implementing a culturally safe family partner program would be highly beneficial, pairing MEIW with culturally trained community liaisons and nurses. This program would not only offer practical guidance but also emotional support in navigating complex systems. As such this research proposes a new initiative, “The Safe Pathways” program is a multi-level intervention aimed at addressing the structural inequities that hinder MEIW’s access to safety, legal protection, and essential services.

This proposed government-funded program would embed legal and policy navigators within community health centers, shelters, hospitals and newcomer support agencies, with the goal of offering real-time support to MEIW navigating complex institutional systems related to immigration, child welfare, housing, and employment. These community-based nurses and social workers, who would be trained in trauma and violence informed, anti-racist, and gender-sensitive practices, would work collaboratively with legal advocates to ensure that MEIW receive legal protection from deportation, access to emergency housing, and support in maintaining custody of their children when experiencing IPV. This program would include a policy review component in which the program would work with different government organizations to identify discriminatory policies and call for intersectional frameworks that uphold the dignity and rights of MEIW.

While available navigation programs in Ottawa, such as immigrant liaison services, have demonstrated value in improving service access and reducing systemic barriers, they are often limited in scope, focusing primarily on helping individuals navigate systems like healthcare, employment, or social services. In contrast, my program offers a more comprehensive, trauma and violence informed, and culturally responsive approach tailored specifically for immigrant

women including MEIW and their children who have experienced IPV. Informed by intersectionality and the SEM, this program addresses not only practical barriers but also the emotional, psychological, and intergenerational impacts of trauma. Unlike standard navigation programs, it provides holistic support at multiple levels, individual, family, community, and system, by pairing MEIW mothers with culturally trained nurses and community liaisons. These partners offer not just logistical help, but sustained emotional support, cultural connection, and empowerment, helping families rebuild resistance, reduce isolation, and foster a sense of belonging. By integrating healing, family-centered care, and cultural safety, this program builds on the strengths of navigation models while addressing their key limitations.

6.4.Trauma Passed Through Blood and Memory (Intergenerational Trauma)

This overarching theme is linked to Theme 3 (IPV Impact) which demonstrates how IPV affects children and families. Interpreted through critical theory, the intergenerational transmission of trauma among MEIW reveals how structural inequities such as immigration policies, and patriarchal norms perpetuate cycles of violence and silence across generations. This lens highlights that trauma is not only psychological but socially and politically produced, sustained by power structures that limit MEIW's access to healing and agency. An Intersectional perspective further shows that gender, race, language, and immigration status intersect to intensify vulnerability, shaping how trauma is experienced, expressed, and passed on to children. The SEM helps situate these intersecting forces across individual, relational, community, and systemic levels, illustrating how IPV-related trauma operates within and between families as well as through broader institutions. Together, these frameworks reveal that breaking the cycle of intergenerational trauma requires interventions that address both personal healing and systemic transformation.

This study found that MEIW perceived the trauma caused by IPV not only as an individual burden but as a profound influence on their children's emotional and psychological wellbeing. Participants explained how witnessing or sensing IPV at home caused their children to become fearful, withdrawn, or anxious, and how this intergenerational trauma could continue to shape their lives in the future. This finding resonates with broader understandings of intergenerational trauma as discussed in the context of colonialism and Indigenous communities, where historical oppression and cultural disruption have lasting psychological and social effects across generations. Similarly, for MEIW, the trauma of IPV extends beyond the individual to reflect the deep emotional imprint of IPV, where unresolved trauma can manifest in children's future relationships as control, fear, or aggression, shaping family dynamics over time.

In this study, the intergenerational trauma is defined as the transmission of trauma effects from parents to children. The intergenerational trauma is a process that participants described through their observations of their children altered emotional development and diminished sense of security. This understanding aligns with established and official definitions in the literature, which describe intergenerational trauma as the psychological effects of trauma that are transferred from one generation to the next, often through parenting behaviours, family dynamics, and unresolved emotional distress (Danieli,1988; Resse et al.,2022). The intergenerational trauma emerged as a prominent aspect of the theme 'Impact of IPV' as women described how the IPV they endured affected their children's emotional development and sense of security.

This finding aligns with existing literature explaining the phenomenon of intergenerational trauma, which describes how the effects of trauma are transmitted from one generation to the next. Specifically, this study finding is consistent with existing literature that

indicates that children exposed to IPV are at higher risk for emotional and behavioural difficulties (Dvir et al., 2014; Sharma et al., 2024). While prior research has documented intergenerational trauma more generally, few studies have examined how abused immigrant mothers themselves interpret and narrate this transmission of trauma within the context of intersecting challenges such as migration stress, cultural conflict, and systemic racism (Guruge, Roche, & Catallo, 2012). By situating the women's narratives within their unique cultural and migration contexts, this study extends existing knowledge by demonstrating that the intergenerational trauma among MEIW was experienced not only as a psychological burden but also as a deeply emotional struggle marked by guilt and self-blame. These findings underscore the need for interventions that address not only safety and stability but also the emotional healing of mothers, helping them rebuild a sense of self-worth and break the cycle of guilt, trauma and violence.

These childhood experiences of IPV make these children violent themselves either as future victims or perpetrators (Fong et al., 2019). The research about the impact of the intergenerational trauma among the immigrant and racialized communities is less comprehensive (Williams, Lawrence, & Davis, 2022). These childhood experiences of IPV increase the risk that children may later become involved in violence themselves, either as victims or perpetrators (Fong, Hawes & Allen, 2019). A systematic review of risk and protective factors for externalizing problems in children exposed to IPV. While previous research, such as that by Williams, Lawrence, and Davis (2022), has examined the general impacts of intergenerational trauma in immigrant and racialized communities, this study builds on and extends that knowledge by specifically exploring how MEIW understand and describe the transmission of trauma to their children during the perinatal period. For example, this study highlights how the

culture may operate as a mediating force in the transmission of trauma, influencing both the meaning and manifestation of IPV within Middle Eastern immigrant families. For MEIW, cultural values surrounding motherhood, family unit, protection and silence can reinforce internalized shame and self-blame, which in turn limit open communication within the family. This silence may prevent mothers from processing their own trauma or discussing experiences of IPV with their children, allowing fear and anxiety to be absorbed indirectly through daily interactions. Over time, these unspoken emotional cues and coping patterns become may facilitate the intergenerational transmission of trauma through modeled behaviours, emotional withdrawal, and learned responses to conflict. By situating these insights within the context of migration-related stress and systemic barriers, this research provides a more nuanced understanding of how intergenerational trauma is experienced and perpetuated within this population.

Previous research has recognized intergenerational trauma related to IPV in immigrant families but has tended to focus on broad outcomes rather than the cumulative and intersecting factors, such as cultural conflict, racism, and migration-related stress, that shape how MEIW and their children experience this trauma (Ahmed & Mao, 2024; Aly & Johnson, 2023; Tastsoglou & Hudon, 2024). By investigating these interconnected influences through the voices of MEIW, this study offers a more nuanced understanding of the specific pathways through which IPV-related trauma impacts children in this community.

Furthermore, the findings reveal how structural barriers and stressors, including lack of culturally responsive services, limited social support and precarious immigration status, compound trauma at both the individual and relationship levels within the family unit. This research extends existing literature by explaining how these multi-layered factors interact over

time to influence not only the mental and emotional health of children but also their identity formation, trust in institutions, and sense of safety within their environments. These are the key pathways through which intergenerational trauma is transmitted and sustained.

The finding of this study, and in particular, the intersectionality reveals that the impact of IPV is not uniform; rather, it is aggravated at the intersections of systemic marginalization. For example, a Middle Eastern immigrant mother who is undocumented and does not speak English faces distinct barriers to reporting IPV or seeking access to mental health support for herself and her child. These intersecting vulnerabilities compound trauma limited opportunities for healing, thereby increasing the risk of transmitting intergenerational trauma. Notably, some participants also revealed that their own exposure to IPV began long before their current experiences, describing how they had witnessed violence in their families of origin, including abuse directed at their mothers, sisters, or themselves during childhood. This cycle of trauma, passed down through generations, further deepens the emotional and psychological impact on both survivors and their children.

To further contextualize the findings, the SEM (Heise, 1998) is employed to analyze how intergenerational trauma operates across different levels of influence. At the individual level, Middle Eastern immigrant children internalize the trauma of witnessing IPV through fear, anxiety, confusion, and emotional withdrawal. Although, the trauma at this level is often invisible but deeply embedded in their psychological development (Roberts et al., 2010). At the interpersonal level, the mother-child relationship can unintentionally serve as a conduit for trauma transmission, as the child may absorb the emotional impact of that IPV. While the participants attempted to shield their children emotionally, this may lead to emotional distance

and communication breakdowns, all fertile ground for the development of intergenerational trauma (Reese et al., 2022).

At the structural level, immigration policies and insecure immigration status, lack of housing stability, and mistrust of the healthcare system affect the family's ability to recover from IPV. Moreover, the fear of child protective services (CAS) involvement may lead MEIW to avoid or delay seeking help, further reinforcing cycles of silence and the development of intergenerational trauma (Innes et al., 2024). This study's conceptualization of intergenerational trauma highlights it as a layered trauma that is not only shaped by IPV but also sustained and amplified by structural barriers and systemic exclusion. Within the Middle Eastern families, the intergenerational trauma is not an inherited psychological condition or illness, but a socially and politically situated experience shaped by IPV, cultural norms and systemic marginalization in both their countries of origin and host societies. Ultimately, this research underscores the needs for multi-level intervention that is trauma and violence informed, culturally responsive, and structurally informed.

Structurally informed interventions are needed to support individual healing while also addressing the systemic conditions that produce and perpetuate trauma including poverty, discrimination, housing insecurity, and lack of access to culturally responsive services. Equally important is recognizing how cultural norms and expectation influence both the experience of trauma and the pathways to recovery. For example, implementing community-based mental health programs delivered by culturally trained providers, alongside policy reforms that improve access to affordable housing and social support for Middle Eastern immigrant families, can help address both immediate needs and broader structural inequities.

Research shows that integrating services across multiple levels, individual, family, community, and systems, within a single program enhances both engagement and long-term outcomes for populations affected by trauma and social exclusion (Castillo et al, 2019; Goodkind et al.,2017). For example, the Newcomer Health Program, delivered by The SHORE Centre in Waterloo, Ontario, is a comprehensive, multi-level initiative grounded in trauma and violence informed and culturally inclusive care. The Centre offers language-specific group sessions focused on sexual and reproductive health, healthy relationships, trauma awareness, and system navigation, integrating peer facilitators from participants' own cultural communities, as well as providing childcare and transit support to reduce access barriers. Evaluations of SHORE Centre's newcomer health programs indicate increased knowledge, improved healthcare navigation, and greater comfort in discussing sensitive topics among refugee and immigrant participants, demonstrating the program's effectiveness in addressing health inequities (Daher et al., 2022). Similarly, The Together Project, the Multicultural Health Brokers Co-op, and Access Alliance's Newcomer Health Program are all multi-level initiatives that have demonstrated effectiveness in serving equity-denied populations through holistic, community-engaged approaches. Building on these successful models, implementing a multi-level program in Ottawa would greatly benefit MEIW experiencing IPV by delivering interventions across individual, relational, community, and systemic levels. In response to the complex and layered impacts of IPV on MEIW and their children, this research proposes two complementary solutions. The first focuses on adapting and enhancing existing interventions in Ottawa to more effectively respond to this issue within current resource frameworks. The second is a new initiative titled "Generations of Strength" a trauma and violence-informed, culturally responsive, multi-level

intervention designed to address the intergenerational transmission of trauma within Middle Eastern immigrant families.

The first suggestion emphasizes how existing interventions in Ottawa can be strategically modified without requiring significant new financial investment. Local organizations can optimize current resources through improved coordination, cross-sector partnerships, and culturally responsive and evidence-informed training. For instance, integrating trauma and violence informed and culturally responsive practices within already existing funded community and health services can enhance impact without additional cost. Investing in such adaptive and existing interventions represents a cost-effective and sustainable approach to addressing the impacts of IPV within MEIW. Conducting research in Ottawa can further identify which program adjustments yield the greatest benefits, ensuring that existing resources are used efficiently and equitably. For example, a community center that provides housing support could partner with an immigrant-serving organization to deliver integrated services that address both immediate housing needs and the underlying social and cultural factors contributing to IPV. Such collaboration would enhance service accessibility, promote cultural responsiveness, and strengthen trust between service providers and Middle Eastern immigrant families.

The new initiative “Generations of Strength” program offers a promising, multi-level model tailored to the needs of MEIW and their children, specifically to address intergenerational trauma. The program is projected as a 12-month, community-embedded intervention delivered through partnerships with immigrant settlement agencies, community health centers, cultural associations and a family health clinic. It includes four integrated streams: (1) Therapeutic Support, including trauma and violence informed focused group therapy, mother-child therapy, and one-on-one counselling; (2) Cultural parenting and empowerment workshops, led by trained

facilitators from the community, focused on parenting after trauma, understanding child development, and navigating new cultural expectations without losing cultural identity; and (3) Advocacy and systems navigation, providing direct assistance in accessing housing, legal protection, income support, and healthcare services, (4) Family health clinic is proposed as a vital extension of care. The clinic would offer trauma and violence informed, culturally responsive health services tailored to the unique needs of MEIW and their children, particularly during the perinatal period.

This community-based program is trauma and violence informed, culturally responsive, and policy informed, aiming to tackle emotional and structural dimensions of intergenerational trauma among this group. Delivered by culturally matched providers and in women's native languages (Arabic, Farsi etc.), the program incorporates culturally grounded parenting workshops, therapeutic support groups and mother–child bonding activities to foster emotional healing and strengthen relational repair. This multi-level program acknowledges the role of broader structural barriers such as (lack of housing, racism and limited access to culturally responsive health and social services) by embedding advocacy and systems navigation support. It aims to move beyond conventional approaches that isolate mental health treatment from the realities of systemic oppression by centering healing within the family while simultaneously challenging and addressing the conditions that reproduce trauma across generations. To ensure a comprehensive and evidence-based approach, the program draws on established frameworks widely used in perinatal research and practice, such as the Polomeno Framework (Polomeno, 2000). The Polomeno Family Intervention Framework presents a promising avenue to address intergenerational trauma in Middle Eastern immigrant families affected by IPV. By targeting the perinatal period, a significant transitional phase where both parental identity and family

dynamics are being restructured, Polomeno's framework supports an early intervention strategy that promotes emotional safety, strengthens family intimacy, and enhances long-term child well-being (Polomeno, 2000).

In the context of MEIW experiencing IPV, Polomeno's approach is particularly beneficial as it redefines the perinatal period as an opportunity for family-level prevention and emotional interventions. The Polomeno Framework fills this gap by focusing on the emotional ecology of the family by promoting communication, mutual respect, and shared meaning between partners, even amid complex or strained relationships. It also supports women in reflecting on their values, expectations, and emotional needs within the parenting transition which can buffer the child from absorbing unspoken trauma. The framework aligns with the principles of the SEM. At the individual level, it supports parental mental wellbeing and emotional regulation. At the interpersonal level, it fosters positive communication, reduces parenting stress and improve child emotional outcomes. While at the community and institutional levels, this model can be operationalized through culturally tailored home-visiting and community events designed to serve and support immigrant families. Collectively, these multi-level strategies can create a protective buffer that helps prevent the transmission of trauma across generations.

"The Safe Pathways" program, introduced earlier in this chapter, is a proposed multi-level program designed to dismantle the systemic barriers that obstruct MEIW's access to safety, legal protection, and essential health services. It provides institutional support through embedded legal and policy navigators within key community touchpoints. While this program addresses structural inequities, the later proposed "Generations of Strength" program complements it by centering healing within the family unit. Together, these two programs form a comprehensive,

multi-level response: *Safe Pathways* mitigates the external, institutional challenges MEIW face, while *Generations of Strength* fosters relational repair, emotional strength, and parent–child bonding within families affected by IPV.

6.5. A Glimmer of Hope: On the Pathway to Empowerment and Independence

Emerges strongly from Theme 5 (Coping Strategies) where highlights moments of agency and resilience where MEIW use personal and community resources to regain control over their lives. Through critical theory, these moments of hope and empowerment illustrate that MEIW are not passive recipients of services but actors pushing back against gendered, racialized, and immigration-related power structures that constrain their choices. An intersectional lens helps explain why empowerment looked different across participants some mobilized motherhood, some relied on faith or community, others on legal avenues, because their agency was shaped by the intersecting effects of gender, culture, migration status, and language. The SEM shows that empowerment did not happen only at the individual level, women were able to move toward safety when interpersonal supports (friends, counselors), community resources, and system-level responses (trauma- and violence-informed, culturally responsive services) aligned. Together, these frameworks make clear that resilience is not just a personal quality, but something made possible when power is redistributed across levels.

Despite the complex experience of IPV, Chapter five in this thesis concluded with a range of transformative experiences that revealed participants' behaviour and movement toward healing. Amid the pain and silence described in earlier themes, participants also shared moments that reflected hope for change, and the pursuit of a better future for themselves and their children. This cross-cutting theme emerged throughout all the main themes presented in the results chapter, with particular prominence in the coping strategies theme. This cutting theme, woven

throughout the narratives, highlights the capacities of MEIW to regain control over their lives, even in the face of complex and intersectional challenges and barriers.

Several women described moments of strength and key actions including, disclosing abuse for the first time, accessing mental health support, or taking legal steps to protect themselves and their children. These narratives of empowerment demonstrate that even within contexts of hardship, MEIW can find pathways to regain their autonomy and rebuild their lives. This aligns with research emphasizing survivors' capacity for resistance and transformation, even in the midst of oppressive circumstances (Lapierre, 2010; Nixon, Bonnycastle, & Ens, 2017; Sattarzadeh, 2022). In this context, we should acknowledge that MEIW not merely as victims but as active agents of change in their lives. These women worked hard to navigate cultural stigma and systemic exclusion in their efforts to seek help. This aligns with findings by Shishehgar et al., 2024, who emphasize that despite facing multiple structural and cultural barriers, immigrant women demonstrate resilience and agency in reshaping their pathways to safety and independence.

Participants often framed empowerment as a gradual and non-linear process that intertwined with motherhood, cultural identity, and community belonging. For instance, some women cited their children as a key motivation for leaving the abusive relationship and accessing resources, reflecting the centrality of maternal roles in shaping decisions (Nixon, Bonnycastle & Ens, 2017). Others credited support from culturally responsive counselors or ethno-specific community agencies, underlining the importance of trust and cultural safety in recovery (Murray et al., 2015). These findings echo the work of Etowa & Adongo (2007), who argue that immigrant survivors of IPV often achieve empowerment through culturally responsive interventions.

In sum, the findings reveal that empowerment is not solely an outcome, but an ongoing, dynamic process shaped by relational, structural, and cultural factors. By considering the voices of MEIW and examining how structural inequities shape their lived experiences, this study adopts a critical theory lens to challenge dominant narratives and advocate for transformative change in practice.

6.6 Implications for Practice, Policy, Education, and Research

Building on the key findings of this research, this section presents practical and theoretical implications that emerge from the study. By highlighting how these findings can inform IPV practice, policy, education, and future research, particularly in relation to MEIW's experiences of IPV during the perinatal period, this section aims to contribute to the development of more responsive and culturally grounded interventions.

6.6.1. Implications for Nursing Practice

This section outlines the implications for both general and advanced nursing practice

6.6.1.1 General Nursing Practice

Based on this research study, four recommendations are proposed for nursing practice. The first recommendation encompasses the dissemination of the findings through workshops, conferences, and scientific journals to hospitals, nursing schools, community centers, Ottawa public health, clinical educators, and clients and their families as part of my knowledge translation plan. This step aims to raise awareness about the need of culturally responsive interventions for MEIW experiencing IPV during the perinatal period. Increased awareness can help in breaking down the discrimination, racism and stigma around this issue from various levels, and will also allow nurses to provide culturally responsive care to their MEIW patients during the perinatal period (Alshammari, et al., 2018; Connor et. al., 2013).

The second practice recommendation involves recruiting clinical educators in some wards (e.g. birthing and maternity units) who have extensive knowledge of the IPV complexities, and the unique challenges faced by MEIW during the perinatal period. Hospitals would be able to provide specialized training to these educators in trauma and violence informed care, culturally responsive IPV screening and interventions. These educators will not only build the capacity of nurses and nursing students to effectively navigate the complex terrain of IPV cases, but they will also optimize their clinical learning modules about client/survivor-centered and culturally responsive approaches (Jack, Wilson & Bradbury-Jones, 2023).

The third recommendation is to continue to increase MEIW's knowledge and awareness of IPV during the perinatal period. The findings of this research show that MEIW during the perinatal may not seek help from healthcare providers including nurses because of the fear of stigma. For example, the participants verbalized their fear of facing stigma and discrimination when seeking help. Increasing awareness and putting this awareness into action by nursing educators through collaboration with host clinical institutions and nursing staff, will increase the MEIW's comfort level to share their experiences and seek help in this matter. As MEIW may share their successful experiences of seeking help with other MEIW, having experienced a good care provided by nurses will be widely shared among these MEIW, encouraging the other MEIW to seek help (Debs-Ivall, 2016). For example, Lindsjö et al., explained how immigrant women share their experiences of accessing healthcare services within their communities (2023). Also, Dias et al., underscores that immigrant women often share their healthcare experiences with other women in the same community. This sharing may impact other MEIW decisions to seek or avoid certain healthcare services based on the stories of successes or failures (2010). Equally important, beyond awareness-raising, culturally responsive nursing practice must also prioritize

outreach to women who remain disconnected from health and social systems. Nurses can play a pivotal role in bridging this gap by collaborating with community leaders, cultural organizations, and settlement agencies to identify and support MEIW who may be isolated by language, immigration status, or stigma. This proactive approach can include home visits, and culturally mediated peer-support models.

Lastly, the results chapter shows how the MEIW experience several oppressions based on their race, gender, cultural, immigration and reproductive factors which increase their vulnerability of IPV. The fourth recommendation is to apply an intersectional lens in nursing practice to enhanced and deepen nurses' awareness of the multiple, intersecting risks faced by MEIW (Crenshaw, 2015; Nash, 2008). In nursing practice, patients are approached holistically (Watson,1985). As such, all the factors that are affecting the patient's well-being need to be addressed. Physical, emotional, social, and psychological well-being are all affected by overlapping multiple oppressions that these MEIW are experiencing. Using approach like intersectionality and the SEM in nursing interventions will allow for more comprehensive healthcare services for MEIW experiencing IPV, while addressing the complex realities in their lives (Fseifes & Etowa, 2024). In addition, it is essential to recognize that nurses do not work in isolation. By collaborating with social workers, physicians, cultural mediators, and community-based organizations, nurses can collectively address the complex social, cultural, and structural realities that shape the lives of MEIW. Such an integrative and interdisciplinary approach not only strengthens holistic care but also aligns with critical theory's aim to challenge and transform the systems that perpetuate inequity. For example, this study shows how MEIW may perceive certain forms of IPV as tokenistic expressions of love, shaped by deeply rooted cultural norms about family honour and gender roles. This cultural framing can influence their decisions to

tolerate, excuse, or remain silent about IPV, and may make them less likely to disclose IPV or seek help through formal channels such as healthcare providers. In this context, nurses should understand that MEIW may have the tendency to interpret IPV based on the cultural norms as a type of love which may affect their decision to leave or stay in the relationship. Therefore, nurses and other healthcare providers should collaboratively plan for interventions that recognize these cultural norms along with the other risk factors. These interventions should be developed with culturally responsive and a nonjudgmental approach, while acknowledging the IPV experiences among MEIW. Implementing a client-centered approach in this context helps mitigate additional factors that contribute to the marginalization of this population (Giesbrecht et al., 2023; Latta & Goodman, 2005; Park et al., 2021).

Ultimately, nurses must move beyond standard IPV screening checklists to build genuine trust and understand how cultural beliefs shape MEIW's interpretation of her partner's behaviour. While these checklists provide an important starting point for identifying risk, they may not capture the cultural and contextual nuances that influence how MEIW interpret and disclose abuse. Therefore, nurses must integrate culturally responsive dialogue into their assessment practices. Recognizing and respecting these cultural nuances can help prevent survivor blaming and promote care that upholds each woman's dignity and agency, while also addressing the broader structural barriers that perpetuate her vulnerability.

6.6.1.2 Advanced Nursing Practice

Advanced practice nurses (APNs), including nurse practitioners, clinical nurse specialists, and nurse midwives, play a critical role in responding to the complex needs of MEIW experiencing IPV during the perinatal period. This study's findings call for enhanced advocacy, clinical competence, and cultural responsiveness from nurses in advanced practice roles.

The first implication is for APNs to serve as clinical change agents in developing and implementing culturally responsive, trauma and violence informed, and intersectional models of care. As healthcare providers with greater autonomy and scope of practice, APNs can incorporate IPV screening, risk assessment, and culturally tailored safety planning into routine perinatal care, ensuring that MEIW during the perinatal period receive timely and compassionate support.

Secondly, APNs are well-positioned to advocate for system-level change (Kostas-Polston et al., 2015). This includes initiating and leading quality improvement initiatives aimed at tackling the systemic and structural barriers faced by MEIW such as racism, immigration-related stressors, and language barriers. APNs can use evidence from this research to inform institutional policy revisions and contribute to organizational strategies that promote health equity. However, despite this potential, APNs may encounter institutional and professional constraints that limit their advocacy efforts including heavy clinical workloads, hierarchical decision-making structures, and limited authority in policy arenas. These barriers might make it difficult for APNs to fully exercise their potential as change agents, despite their proximity to the populations most affected by inequities.

Lastly, APNs should engage in scholarly practice and research that advances culturally responsive interventions and models of care for MEIW during the perinatal period populations. Collaborating with academic institutions and immigrant-serving organizations, APNs can co-lead community and participatory action research and contribute to a growing evidence base on IPV among MEIW during the perinatal period. They can also engage in mentoring and teaching other nurses on the importance of intersectionality in IPV care for MEIW during the perinatal period.

6.6.2. Implications for Policy and Policymakers

Canada addresses IPV against women, including MEIW, through a range of strategies, policies, and initiatives. The Federal Strategy to Address Gender-Based Violence (Government of Canada,2017) and the National Action Plan to End Gender-Based Violence (2022–2032) (Government of Canada, 2024) both recognize immigrant women as a priority population, and promote culturally responsive and intersectional approaches to prevention and treatment. Immigration, Refugees and Citizenship Canada (IRCC) has also implemented protective measures such as Temporary Resident Permits (TRPs) and other public policies that allow immigrant abused women with an unstable immigration status to apply for permanent residence under certain circumstances.

Additionally, the Government of Canada provides funding to community-based organizations that offer multilingual, culturally sensitive services, including legal aid, shelters and emergency housing. Provinces such as Ontario play a key role in providing specialized IPV services. For example, Ontario's Family Violence Prevention Program supports initiatives that empower women who experience IPV and their families (Government of Canada, 2025).

Although Canada has implemented these strategies to address IPV among immigrant women, significant gaps appear to remain in their implementation, particularly for MEIW during the perinatal period. Some of these programs and initiatives may fall short especially for MEIW during the perinatal period with precarious immigration status, limited access to language services, or those who are experiencing systemic racism and cultural conflicts. These shortcomings may mirror a disconnect between policy intentions and lived experiences faced by MEIW during the perinatal period, who continue to encounter barriers related to language, immigration status, cultural stigma, and lack of trust in institutions. These disconnects may

reveal that program goals are not consistently translated into effective and accessible practice. My research addresses this gap by illuminating the intersecting barriers that MEIW face. When policymakers integrate cultural dimensions into their understanding of MEIW's experiences of IPV, service delivery systems may become more responsive, equitable, and effective in meeting their needs. In addition, policy makers must recognize the MEIW as agents of change in defining their own care and support.

As such, the policy implications derived from this research offer concrete, equity-informed recommendations for strengthening service delivery and informing inclusive and responsive policies. The following sections explain the implications in detail.

The first implication involves bridging the gap between policy design and practical implementation. Policymakers should ensure that culturally responsive and trauma and violence informed principles are consistently implemented through mandatory standards, policies, and accountability frameworks across all IPV interventions among equity denied groups such as MEIW during the perinatal period. Furthermore, federal and provincial health policies should formally recognize the perinatal period as a priority window for IPV screening and trauma and violence informed intervention. Maternal health and perinatal care strategies must integrate culturally responsive IPV education and response protocols to address the unique needs of MEIW during the perinatal period.

The second implication involves expanding access to different IPV services regardless of immigration status. Creating inclusive policies must guarantee access to health care, housing, and legal support for all MEIW during the perinatal period experiencing IPV, including those with precarious or no immigration status. This will ensure that their safety does not depend on documentation merely. Intersectional service models should be mandated in IPV program design

and evaluation to address multiple overlapping barriers such as racism, language barriers and economic disadvantages.

The third implication would be taking initiative in investing in capacity building for service providers. Policy directives may include ongoing training for healthcare workers, social workers, and shelter support workers in culturally responsive, and trauma and violence informed care, with particular emphasis on the unique experiences of MEIW during the perinatal period. Additionally, increased and stable funding may be allocated to community-based, immigrant-led organizations that provide culturally grounded and trusted supports often unavailable within mainstream services. Financial support may also be directed towards community-based perinatal peer support programs that employ Middle Eastern cultural mediators and survivor mentors. These programs should be embedded in local health units and newcomer settlement agencies to bridge and facilitate system access and reduce stigma. Also, the federal Gender-Based Analysis Plus (GBA+) framework could be expanded to explicitly consider intersectional factors such as migration history, maternal status, and the perinatal period, when shaping IPV, immigration, and maternal health policies (Government of Canada, 2025).

The fourth and last implication should be geared toward the government, who would consider institutionalizing and centering the experience of MEIW in policymaking. This initiative can be achieved by creating formal well-structured channels for MEIW during the perinatal period with experience of IPV to take part in policy development, evaluation, and advisory roles. Their insights should directly inform the redesign of services and allocation of funding to ensure that interventions are grounded in the realities of those most affected. In the same context, policymakers should strengthen intersectoral collaboration by developing comprehensive policy frameworks that improve collaboration between health care, immigration,

legal services, housing, and anti-violence sectors. Such coordination is essential to provide immigrant women with seamless, holistic support that addresses the complex and intersecting challenges they face.

6.6.3. Implications for Educators

This study has three key implications from a nursing education perspective. The first implication involves nursing educators, professors and students. Participants mentioned that they primarily sought help from the hospitals when they sustained injuries, but did not recall being screened for IPV during their visits. Some participants expressed a fear of judgement or stigma if they sought help, and uncertainty about their rights and available resources. These challenges highlight the urgent need to integrate IPV and cultural competency training into nursing curricula to advance nurses' preparedness, knowledge, and attitudes (Alhalal, 2020).

Based on this study's findings, it is crucial to incorporate IPV and cultural competency into nursing curricula to better equip nurses in order to recognize and respond to IPV, specifically among MEIW during the perinatal period. Structured training on this topic including culturally responsive case studies on both IPV and immigrants is recommended (Georges, Ahmed, & Ghazali,2020). Nursing programs should include dedicated modules on IPV screening, assessment, and intervention addressing the unique vulnerabilities of MEIW, such as language barriers, cultural norms, experience of racism and fear of legal consequences.

Some nursing programs have begun to incorporate components of IPV and cultural competency training; however, dedicated modules addressing the unique vulnerabilities of immigrant women including MEIW during the perinatal period remain limited. For example, Saskatchewan Polytechnic offers bridging and orientation programs for internationally educated nurses that address cultural competency, language barriers, and ethical practice to prepare nurses

for diverse patient populations (Saskatchewan Polytechnic, n.d.). Additionally, several Canadian universities, including the University of Manitoba and the University of British Columbia, integrate interprofessional education with a focus on cultural diversity, equity, and collaborative practice, fostering culturally competent care (Ateah et al., 2011; University of British Columbia, 2023). On a national level, the Canadian Association of Schools of Nursing (CASN) and the Canadian Indigenous Nurses Association (CINA) have developed Cultural Humility and Cultural Safety Standards to promote anti-racist, trauma and violence informed, and relational care across nursing education programs (CASN, 2022). Furthermore, the British Columbia College of Nurses and Midwives (BCCNM) provides multi-module learning pathways focused on trauma and violence informed, strengths-based, and culturally safe nursing practices (BCCNM, 2023). While these initiatives lay important groundwork, there is an urgent need to develop structured IPV-specific training, featuring culturally responsive case studies and tailored content on immigrant populations, to better equip nurses in recognizing and responding to IPV among MEIW during the perinatal period. This recommendation can also be implemented by embedding culturally responsive approaches throughout the nursing curriculum, rather than developing separate cultural competency modules. For instance, faculty may dedicate a lecture during the semester to examine cultural dimensions of care, incorporate culturally informed questions into examinations, or encourage students to engage in short independent learning activities, such as completing a two-hour online certificate on cultural safety or equity in practice. Embedding these elements across existing courses helps normalize cultural responsiveness as a core component of professional learning, rather than treating it as an isolated or supplementary topic.

Moreover, Intersectionality along with related concepts, should be embedded within the nursing curricula to assist nurses to understand how factors such as immigration status, systemic

discrimination, socioeconomic constraints, and other social determinants of health shape women's experiences of IPV. Nursing students should also be equipped to provide trauma and violence informed and client-centered care that is responsive to cultural and social complexities. By integrating these elements into nursing education, future nurses will be better prepared to identify IPV, provide appropriate interventions, and advocate for policies that improve care for immigrant women experiencing IPV.

The second implication pertains to enhancing practical training and simulation to better prepare nurses in addressing IPV among MEIW during the perinatal period. IPV is a sensitive issue, and many participants showed hesitancy to declare IPV. Theoretical knowledge alone about IPV is insufficient; nurses need practical training such as simulations, role-playing, and case-based learning, to build the communication skills and clinical judgment that are necessary for client-centered care in such complex situations. For instance, Bryant and Benson (2015) evaluated IPV simulation scenarios in undergraduate nursing curricula, finding both faculty and students reported high satisfaction and increased confidence in assessment, safety planning, and communication tasks. A study involving standardized patient simulations among nursing students similarly demonstrated significant gains in confidence and knowledge for IPV assessment and intervention (Blumling et al.,2018). Furthermore, virtual simulation-based educational training geared toward perinatal IPV screening led to measurable improvements in students' knowledge and skill levels (Selwyn et al., 2024). Interprofessional simulations pairing nursing and social work students in IPV safety-planning and assessment also enhanced participants' confidence, teamwork, and understanding of survivor-centered intervention processes (Childress et al.,2024).

Clinical training in both community and hospital settings may incorporate crisis intervention strategies, risk assessment techniques, and safety planning, to ensure that nurses can confidently support MEIW experiencing IPV and connect them with appropriate resources. Integrating simulation-based learning into nursing education will help nursing students to be better equipped to handle real-world IPV cases with compassion, cultural awareness, and professional competence**.**

Likewise, clinical placements and experiential learning should incorporate direct exposure to IPV-related care. For example, partnering with women's shelters, organizations supporting IPV survivors, crisis centers, and specialized IPV healthcare programs, can provide nursing students with practical knowledge on client-centered interventions, specific for IPV survivors, interprofessional collaboration, and community resources. Furthermore, structured preceptor-guided experiences can assist students to develop the confidence, communication skills, and clinical judgment, needed to navigate complex IPV cases. Incorporating IPV education into clinical training would guarantee that future nurses are not only knowledgeable but also competent and compassionate in real-world practice (Burnett et al., 2020; Zordan et al., 2022).

The third implication is the need to foster peer support and reflective practice within the nursing programs. Addressing IPV in clinical practices can be emotionally overwhelming for nursing students. Emotional preparedness and self-reflection in IPV education is very crucial. Nursing programs should incorporate structured debriefing sessions, peer support groups, and other reflective exercises where nursing students can reflect on their clinical practicum in this context, share challenges and develop self-care and other coping strategies for handling IPV related cases.

Engaging in reflective practice (Machost & Stains, 2023) while navigating the complexities of IPV care in their clinical placement, these reflective practices will help with building their resilience and foster their professional growth. This can be supported by having a confidence building workshop. The purpose of this kind of workshop is to increase the confidence of these students to work with IPV survivors. Such a workshop should provide an introduction to IPV and its specific dynamics, encourage students to share their prior knowledge, and reflect on new experiences, and offer opportunities to learn directly from nurses with expertise in IPV care.

Including a dedicated question-and-reflection period with experienced nursing practitioners can enrich these workshops, and ongoing student feedback should be used to continually refine and enhance their effectiveness. By embedding peer support and reflective practice into nursing education, programs can better prepare students to deliver compassionate, competent, and sustainable care for individuals experiencing IPV.

6.5.4. Implications for Researchers

This study proposes two key recommendations for nursing research. The first recommendation is to advance qualitative research on IPV among MEIW, which can be built based on existing qualitative research such as Creswell and Creswell (2017). It is essential to center the voices of MEIW's needs during the perinatal period and include them in the research to develop knowledge that meaningfully informs practice and policy, thereby improving the quality of healthcare for immigrant women (Merry & Pelaez, 2021; Van Den Muijsenbergh et al., 2016). Conducting qualitative research with MEIW can involve several challenges such as language barriers, difficulties in accessing participants (particularly for those with undocumented status),

and ethical concerns like the potential to cause harm. It is crucial to acknowledge and address these barriers in order to enhance the representation of MEIW in evidence-based research.

Researchers have a crucial role in empowering MEIW and facilitating their active participation by prioritizing trust, safety, and accessibility as well as ensuring ethical and meaningful engagement with them throughout the research process (Abma et al.,2019). In line with this, participatory research is strongly recommended (Salma & Giri, 2021). Participatory research actively involves people who are being studied to be included as co-researchers, rather than treating them as passive subjects. This will ensure that their experiences and perspectives shape the research design, implementation, and outcomes (Jumarali et al.,2021; Zabelski et al.,2024).

The second implication for nursing research is the need to generate robust evidence that supports the development of culturally responsive interventions tailored to the unique needs of MEIW during the perinatal period. This involves conducting rigorous and context-specific studies that reflect the experiences of MEIW, contributing to a stronger foundation for evidence-based practice in nursing. By producing research that is both culturally and contextually relevant, nursing and healthcare professionals can design and implement interventions that are more aligned with the diverse realities of MEIW's lives.

Evidence-based practice is crucial for delivering adequate health care for MEIW during the perinatal period. Collecting evidence on the effectiveness of these interventions based on the nursing practice will be the foundational step towards developing informed client-centered interventions that enhance nursing care quality, improve patient health outcomes, and guide evidence-based policy decisions (Albanesi et al., 2021; Taft & Campbell, 2024). By ensuring that current research mirrors the unique cultural contexts of MEIW, more effective interventions

can be tailored that support this population while respecting their experiences and cultural diversity (Henriksen et al.,2023; Magnussen et al., 2011).

6.7 Strengths and Limitations

This section presents the strengths and limitations of this study conducted on MEIW living in Ottawa and experiencing IPV during the perinatal period.

6.7.1 Strengths

Among this study strengths, eight key aspects stand out. The first strength is that this research is the first of its kind in the Ottawa area, and even in Canada more broadly, specifically examining IPV among MEIW. While previous studies as mentioned in chapter one have explored aspects of IPV among immigrant women in general, none have focused exclusively on MEIW during the perinatal period (Ali, O'Cathain & Croot, 2019; Band-Winterstein, 2015, Barkho, Fakhouri & Arnetz, 2011; Edin et al., 2010 ; Flanagan et al., 2015; Gilchrist et al.,2019; Grace et al., 2022; Izaguirre & Calvete, 2014; Mehta, & Gagnon, 2016). This study offers a comprehensive exploration of the unique IPV experiences faced by MEIW living in Ottawa during the perinatal period.

Second, this research study is also the only one to date to capture the perspectives of MEIW living in Ottawa by offering a platform for MEIW to share their IPV experiences during the perinatal period, the study not only fills a significant gap in the literature but also supports the value of their voices. This approach fostered a sense of respect and recognition and allowed the participants to feel heard and acknowledged. This research represents a meaningful step toward advancing inclusive, equity-informed inquiry. By centering an equity-denied group often overlooked in academic research and policy discussions, this study represents a meaningful step toward inclusive, equity-informed inquiry.

Another strength of this study lies in its use of intersectionality (Crenshaw, 1989) as the theoretical framework. Unlike many previous studies in this area, which often employ more generalized or single-axis approaches, this research applies intersectionality to highlight the interconnected forms of oppression, such as gender, race, immigration status, and socioeconomic inequality that shape the IPV experiences of MEIW. The application of intersectionality thus deepens the analysis and enhances the significance of the findings, positioning this study as a meaningful contribution to equity-focused scholarship.

Fourth, this study allowed participants to share their experiences freely and without restriction. The interview questions were intentionally open-ended and nonjudgmental, avoiding overly specific prompts that might constrain participants' narratives. This approach gave the women the freedom to articulate their experiences in their own words and to highlight aspects they deemed most significant. By enabling participants to guide the conversation, the narrative design honored their agency and voice, generating rich, nuanced data that captured the depth and complexity of their IPV experiences. This approach deepens our understanding of IPV within the intersecting contexts of immigration, culture, and gendered power dynamics.

Fifth, this study focuses on a unique and particularly vulnerable population that is underrepresented in IPV research, as noted in the scoping review chapter. By centering the experiences of MEIW, this research addresses a critical knowledge gap in the current research. By focusing on this group, this study addresses a critical gap in current research and contributes valuable insights that are often overlooked in mainstream IPV discourse. This focus boosts the relevance, inclusivity, and equity of the study, and lays the groundwork for more culturally responsive policies and practices.

Sixth, the use of a focus group discussion to explore and validate the preliminary findings is a key strength of this research. This approach not only augments the study's credibility and trustworthiness but also intensifies community engagement. By involving community members in validating the preliminary findings, the research ensures that the findings genuinely reflect the experiences of the women from the same community.

Seventh, this study employs a qualitative case study approach (Creswell & Creswell, 2017), which, when combined with intersectionality as the guiding theoretical framework, offers a powerful methodology for exploring the complexity of IPV among MEIW. This approach allowed for an in-depth, contextualized understanding of participants' experiences, capturing the overlapping social, cultural, and structural factors that shape their experiences. The integration of rich, narrative data with a critical theoretical lens contributes to a comprehensive and nuanced analysis that is often missing from more conventional IPV research.

Finally, a key strength of this study lies in the researcher's fluency in both English and Arabic. This linguistic competency allowed for seamless translation of interview questions and participant responses, facilitating effective communication and building trust with participants. In some interviews, the researcher translated between English and Arabic as needed, ensuring that participants could express themselves comfortably in their preferred language.

6.7.2 Limitations

The first limitation relates to the recruitment method used in this study. Participants were recruited through immigrants community organization, an approach chosen due to the challenges of accessing individuals for research on such a sensitive topic. While this approach facilitated access to participants in a safe and supportive environment, it may have limited the diversity of perspectives, particularly from MEIW who have not sought formal support. However, the

selection criteria remained rigorous, focusing specifically on MEIW who experienced IPV during their perinatal period, ensuring the relevance and depth of the data collected.

Second, another limitation of this study was the requirement for participants to be sufficiently fluent in English to participate in the study. This language criterion may have excluded women who had recently immigrated to Canada or who were less proficient in English, thereby limiting the diversity of perspectives represented particularly those of individuals who might face the greatest barriers to accessing services or expressing their experiences. The decision to limit participation to English-speaking women was to ensure data quality and consistency. This study used in-depth, semi-structured interviews to capture nuanced experiences of IPV, it was important to ensure accuracy in meaning making, emotional tone, and reflexive interpretation during both data collection and analysis. Using a single interview language reduced the risk of translation loss, interpreter bias, and inconsistencies that might arise when comparing narratives across languages. However, the participants who felt comfortable with using Arabic in answering some questions or who were too emotional to answer in English, were accommodated accordingly. This accommodation was not needed for participants who their native language Turkish or Persian because they demonstrated sufficient English fluency, and they did not switch to their native language during the interview.

Third, while the researcher is fluent in both English and Arabic, translating the interview questions and participants' responses in some interviews from English to Arabic and vice versa posed a potential limitation. Some participants, while fluent in English, felt more comfortable responding in their native language. Subtle nuances in language could have influenced participants' responses which could lead to variations in the interpretation of the questions. Language barriers may also impact the accuracy and depth of responses, mainly in the context of

complicated experiences like IPV (Squires, 2009). To mitigate this, I ensured questions were phrased in plain language and allowed participants ample time to clarify or elaborate on their answers in their preferred language. Furthermore, member checking and clarifying follow-up questions during interviews helped to reduce misunderstandings and enhance the trustworthiness of the data.

Fourth, in a sensitive context such as IPV, the reliance on data from the interviews is another possible limitation. Participants may underreport their experiences of IPV due to fear, stigma, or recall bias, where participants may not accurately retain or may minimize sensitive information (Langhinrichsen-Rohling et al., 2012; Mclocklin et al.,2024; Misra & Selwyn, 2012). Ultimately, some participants who are still living with the abusers may not feel comfortable disclosing their current experiences.

6.8. Conclusion

This doctoral research provides a crucial contribution to the understanding of IPV among MEIW living in Ottawa during the perinatal period. By employing an intersectional lens alongside the SEM, this study demonstrates that IPV in this context is deeply shaped by the intersecting forces of gender, race, immigration status, language barriers, and systemic inequities. These factors not only influence MEIW's vulnerability to IPV but also sustain cycles of silence and intergenerational trauma that profoundly impact both mothers and their children.

The findings clearly show that the perinatal period represents a critical yet often overlooked window for intervention. Silence surrounding perinatal IPV, rooted in cultural expectations of idealized motherhood and compounded by fear of systemic repercussions, calls for innovative strategies that empower women's voices rather than perpetuate their

marginalization. As such, this research underscores the urgency for multi-level responses that are trauma and violence informed, culturally congruent, and structurally aware.

Policy reform must bridge the persistent gap between well-intentioned frameworks and lived realities. There is a pressing need to strengthen immigration policies, expand access to equitable social and legal services regardless of immigration status, and ensure that culturally responsive IPV screening and support are integrated into perinatal care. Furthermore, breaking the silencing of IPV requires fostering genuine collaboration across healthcare providers, community-based organizations, legal advocates, and policy makers.

In conclusion, addressing perinatal IPV among MEIW demands more than isolated interventions; it requires an intersectional, multi-sectoral approach that dismantles structural barriers and amplifies survivors' voices. By centering culturally safe, family-oriented, and community-driven solutions, we can disrupt cycles of violence and trauma, foster resilience, and ultimately advance equity and wellbeing for MEIW and their children across generations.

References

Abma, T., Banks, S., Cook, T., Dias, S., Madsen, W., Springett, J., & Wright, M. T. (2019). *Participatory research for health and social well-being*. Springer. http://dx.doi.org/10.1007/978-3-319-93191-3

Aboulhassan, S., & Brumley, K. M. (2019). Carrying the burden of a culture: bargaining with patriarchy and the gendered reputation of Arab American women. *Journal of Family Issues*, *40*(5), 637-661. https://doi.org/10.1177/0192513X18821403

Adams, M. E., & Campbell, J. (2012). Being undocumented & intimate partner violence (IPV): Multiple vulnerabilities through the lens of feminist intersectionality*, Women's Health & Urban Life, 11(1),* 15-34. https://hdl.handle.net/1807/32411

Adger, W. N. (2006). Vulnerability. *Global environmental change, 16*(3), 268-281. https://doi.org/10.1016/j.gloenvcha.2006.02.006

Adisa T.A, Abdulraheem I. & Isiaka S.B. (2019). Patriarchal hegemony: Investigating the impact of patriarchy on women's work-life balance. *Gender Manag: An Int J*. 34(1), 19–33 https://doi.org/10.1108/GM-07-2018-0095

Ahmed, R., & Mao, Y. (2024). An intersectional approach to understanding beliefs and attitudes toward mental health issues among Muslim immigrant women in Canada. *Health Communication, 39*(10), 2014–2025. DOI: 10.1080/10410236.2023.2252644

Ahmadzai, M. (2015). A Study on Visible Minority Immigrant Women's Experiences with Domestic Violence. *Social Justice and Community Engagement.* 14. http://scholars.wlu.ca/brantford_sjce/14

Ahmadzai, M., Stewart, C., & Sethi, B. (2016). A study on visible minority immigrant women's experiences with domestic violence. *Open Journal of Social Sciences*, *4*(1), 269– 286. https://scholars.wlu.ca/brantford_sjce/14

Albanesi, C., Tomasetto, C., & Guardabassi, V. (2021). Evaluating interventions with victims of intimate partner violence: A community psychology approach. *BMC Women's Health, 21*(1), 138. https://doi.org/10.1186/s12905-021-01268-7

Alhalal, E. (2020). The effects of an intimate partner violence educational intervention on nurses: A quasi-experimental study. *Nurse education in practice*, *47*, 102854. DOI: 10.1016/j.nepr.2020.102854

Alhusen, J. L., Ray, E., Sharps, P., & Bullock, L. (2015). Intimate partner violence during pregnancy: maternal and neonatal outcomes. *Journal of women's health,*(1), 100-106. DOI: 10.1089/jwh.2014.4872

Ali, P. A., O'Cathain, A., & Croot, E. (2019). Not managing expectations: a grounded theory of intimate partner violence from the perspective of Pakistani people. *Journal of interpersonal violence, 34*(19), 4085-4113. https://doi.org/10.1177/0886260516672939

Alothman, H. M., AbdelRahman, A. R. A., Aderibigbe, S. A., & Ali, M. (2024). Risk factors associated with intimate partner violence (IPV) against Jordanian married women: A social ecological perspective. *Heliyon*, *10*(10). https://doi.org/10.1016/j.heliyon.2024.e30364

Alsrayheen, E. (2019). *The lived experiences of Middle Eastern immigrant women during their cancer survivorship journey* (Doctoral dissertation, University of New Brunswick.). https://unbscholar.dspace.lib.unb.ca/server/api/core/bitstreams/82338806-0396-4270-9f76-087345e88c13/content

Alsrayheen, E., Aldiabat, K., & Aquino-Russell, C. (2022). The lived experiences of Middle Eastern immigrant women during their cancer survivorship journey: A phenomenological study. *The Qualitative Report, 27*(8), 1660-1688. https://doi.org/10.46743/2160-3715/2022.5513

Alteneiji, E. (2023). Value changes in gender roles: Perspectives from three generations of Emirati women. *Cogent Social Sciences*, *9*(1), 2184899. https://doi.org/10.1080/23311886.2023.2184899

Aly, H., & Johnson, S. (2023). From struggle to strength in African and Middle Eastern newcomers' integration stories to Canada: A participatory health-equity research study. *International Journal of Community Health, 18*(2), 114–137. https://pubmed.ncbi.nlm.nih.gov/38687776/

Amin, M., Taha, Z., & Al-Sayed, S. (2024). Negotiating motherhood: Cultural expectations and barriers to maternal health communication among immigrant women in Canada. *Qualitative Health Research, 34*(7), 1124–1138. https://doi.org/10.1177/10497323231100285

Ansell, N., Mwathunga, E., Hajdu, F., Robson, E., Hlabana, T., van Blerk, L., & Hemsteede, R. (2023). Ethical principles, social harm and the economic relations of research: Negotiating ethics committee requirements and community expectations in ethnographic research in rural Malawi. *Qualitative Inquiry*, *29*(6), 725-736. https://doi.org/10.1177/10778004221124631

Arksey, H., & O'Malley, L. (2005). Scoping studies: towards a methodological framework. *International journal of social research methodology, 8*(1), 19-32. https://doi.org/10.1080/1364557032000119616

Ashcroft, B., Griffiths, G., & Tiffin, H. (2007). *Post-colonial studies: The key concepts.* Routledge. https://doi.org/10.4324/978023777855

Aspers, P., & Corte, U. (2019). What is qualitative in qualitative research. *Qualitative sociology, 42*(2), 139-160. https://doi.org/10.1007/s11133-019-9413-7

Ateah, C. A., Snow, W., Wener, P., & Lafreniere, D. (2011). Teaching cultural competence in nursing and healthcare: A review of educational interventions. *Journal of Nursing Education*, 50(2), 78–84. https://doi.org/10.3928/01484834-20101230-02

Ayres, L., Kavanaugh, K., & Knafl, K. A. (2003). Within-case and across-case approaches to qualitative data analysis. *Qualitative health research, 13*(6), 871-883. https://doi.org/10.1177/1049732303013006008

Bachem, R., Levin, Y., Yuval, K., Langer, N. K., Solomon, Z., & Bernstein, A. (2024). Complex post-traumatic stress disorder in intergenerational trauma transmission among Eritrean asylum-seeking mother–child dyads. *European Journal of Psychotraumatology, 15*(1), Article 2300588. https://doi.org/10.1080/20008066.2023.2300588

Bagwell-Gray, M. E., Messing, J. T., & Baldwin-White, A. (2015). Intimate partner sexual violence: a review of terms, definitions, and prevalence. *Trauma, Violence, & Abuse, 16*(3), 316-335. https://doi.org/10.1177/1524838014557290

Baker, S. E., & Edwards, R. (2012). How many qualitative interviews is enough. *National Centre for Research Methods, Southampton*. http://eprints.brighton.ac.uk/11632/

Band-Winterstein, T. (2015). Aging in the shadow of violence: a phenomenological conceptual framework for understanding elderly women who experienced lifelong IPV. *Journal of elder abuse & neglect, 27*(4-5), 303-327. https://doi.org/10.1080/08946566.2015.1091422

Barbara, G., Facchin, F., Micci, L., Rendiniello, M., Giulini, P., Cattaneo, C., ... & Kustermann, A. (2020). COVID-19, lockdown, and intimate partner violence: some data from an Italian service and suggestions for future approaches. *Journal of women's health, 29(10),* 1239-1242. doi: 10.1089/jwh.2020.8590.

Barkho, E., Fakhouri, M., & Arnetz, J. E. (2011). Intimate partner violence among Iraqi immigrant women in Metro Detroit: A pilot study. *Journal of Immigrant and Minority Health*, *13*(4), 725-731. doi.org/10.1007/s10903-010-9399-4

Baser, B. & Halperin, A. (2019). Diasporas from the Middle East: Displacement, transnational identities and homeland politics. *British Journal of Middle Eastern Studies, 46*(1), 1-9. https://doi.org/10.1080/13530194.2019.1569308

Bassey, M. (1999). *Case study research in educational settings*. McGraw-Hill Education (UK).

Baxter, P., & Jack, S. (2008). Qualitative case study methodology: Study design and implementation for novice researchers. *The Qualitative Report, 13*(4), 544–559. https://doi.org/10.46743/2160-3715/2008.1573

Berg, B. L. (2004). *Qualitative research methods for the social sciences*. Pearson Education.

Bhabha, H. K. (2012). *The location of culture*. London, New York: Routledge.

Biana, H. T. (2020). Extending bell hooks' feminist theory. *Journal of International Women's Studies*, *21*(1), 13-29. https://vc.bridgew.edu/jiws/vol21/iss1/3

Bilge, S. (2010). Recent feminist outlooks on intersectionality. *Diogenes*, *57*(1), 58-72. https://doi.org/10.1177/0392192110374245

Bingham, A. J., & Witkowsky, P. (2021). Deductive and inductive approaches to qualitative data analysis. *Analyzing and interpreting qualitative data: After the interview*, *1*, 133-146. DOI:10.3102/1682697

Bloom B. E., Hamilton K., Adeke B., Tuhebwe D., Atuyambe L. M., Kiene S. M. (2021). 'Endure and excuse': A mixed-methods study to understand disclosure of intimate partner violence among women living with HIV in Uganda. *Culture, Health & Sexuality*, 24(4), 1–21. https://doi.org/10.1080/13691058.2020.1861328

Bloor, M. (Ed.). (2001). *Focus groups in social research*. Sage.

Blumling, A., Kameg, K., Cline, T., Szpak, J., & Koller, C. (2018). Evaluation of a standardized patient simulation on undergraduate nursing students' knowledge and confidence pertaining to intimate partner violence. *Journal of forensic nursing*, *14*(3), 174-179. https://doi.org/10.1097/jfn.0000000000000212

Bolter, J. (2019). Explainer: Who is an immigrant. *Migration Policy Institute*. https://www. migrationpolicy. org/content/explainer-who-immigrant.

Bowen, G. A. (2009). Document analysis as a qualitative research method. *Qualitative research journal. 9*(1*)*, 27-40. http://dx.doi.org/10.3316/QRJ0902027

Boy, A., & Kulczycki, A. (2008). What we know about intimate partner violence in the Middle East and North Africa. *Violence against women, 14*(1), 53-70. https://doi.org/10.1177/1077801207311860

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative research in psychology*, *3*(2), 77-101. https://psycnet.apa.org/doi/10.1191/1478088706qp063oa

Braun, V., & Clarke, V. (2021). *Thematic analysis: A practical guide*. SAGE Publications Ltd.

Braun, V., Clarke, V. and Rance, N. (2014). How to use thematic analysis with interview data (Process Research). In: Vossler, A. and Moller, N., Eds., *The Counselling & Psychotherapy Research Handbook,* Sage, London, 183-197.

British Columbia College of Nurses and Midwives (BCCNM). (2023). *Cultural safety and humility learning pathway.* https://www.bccnm.ca/LPN/learning/cultural_safety_humility/Pages/Default.aspx

Bronfenbrenner, U. (1979). T*he Ecology of Human Development: Experiments by Nature and Design.* Cambridge, MA: Harvard University Press.

Bryant, K., & Benson, M. (2015). *Using simulation to introduce nursing students to the assessment of intimate partner violence*. Nursing Education Perspectives, 36(6), 390–392. https://doi.org/10.5480/13-1192

Btoush, R., & Campbell, J. C. (2009). Ethical conduct in intimate partner violence research: Challenges and strategies. *Nursing outlook, 57*(4), 210-216. http://dx.doi.org/10.1016/j.outlook.2008.10.005

Burczycka, M. (2015). Section 3: Police-reported intimate partner violence. *Juristat, family violence in Canada: A statistical profile*, 47-55. https://www150.statcan.gc.ca/n1/pub/85-002-x/2021001/article/00001/03-eng.htm

Burgess-Proctor, A. (2006). Intersections of race, class, gender, and crime: Future directions for feminist criminology. *Feminist criminology*, *1*(1), 27-47. https://doi.org/10.1177/1557085105282899

Canadian Association of Schools of Nursing (CASN). (2022). *Cultural humility and cultural safety standards for nursing education in Canada*. https://www.casn.ca/2025/02/cultural-humility-and-cultural-safety-standards-for-nursing-education-in-canada/

Candela, A. G. (2019). Exploring the function of member checking. *The Qualitative Report, 24*(3), 619–628. https://doi.org/10.46743/2160-3715/2019.3726

Cannon, C., Ferreira, R. J., & Buttell, F. (2019). Critical race theory, parenting, and intimate partner violence: analyzing race and gender. *Research on Social Work Practice*, *29*(5), 590-602. https://doi.org/10.1177/1049731518784181

Carbado, D. W., Crenshaw, K. W., Mays, V. M., & Tomlinson, B. (2013). Intersectionality: Mapping the movements of a theory. *Du Bois review: social science research on race*, *10*(2), 303-312. https://doi.org/10.1017/s1742058x13000349

Castillo, E. G., Ijadi-Maghsoodi, R., Shadravan, S., Moore, E., Mensah III, M. O., Docherty, M., ... & Wells, K. B. (2019). Community interventions to promote mental health and social equity. *Current psychiatry reports*, *21*(5), 35. https://doi.org/10.1007/s11920-019-1017-0

Census. (2021). *Top places of birth of immigrants, Ontario, 2016 and 2021*. Focus on Geography Series, 2021 Census - Ontario

Center for Disease Control and Prevention (CDC). (2021). *The Social-Ecological Model: A framework for prevention.* Retrieved from https://www.cdc.gov/violenceprevention/about/social-ecologicalmodel.html

Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis*. Sage.

Childress, S., Mammah, R., Voth Schrag, R., Arenas-Itotia, K., Orwig, T., Roye, J., ... & Jarrell, L. (2024). Preparing to intervene in intimate partner violence: An interprofessional safety planning and assessment simulation. *Journal of social work education*, *60*(3), 448-462. https://doi.org/10.1016/j.ecns.2024.101635

Cho, H. (2012). Racial differences in the prevalence of intimate partner violence against women and associated factors. *Journal of Interpersonal Violence*, *27*(2), 344-363. 10.1177/0886260511416469

Citizenship & Immigration Canada. (2015). *Refugee and Asylum.* Refugees and asylum - Canada.ca

Clark, L. E., Allen, R. H., Goyal, V., Raker, C., & Gottlieb, A. S. (2014). Reproductive coercion and co-occurring intimate partner violence in obstetrics and gynecology patients. *American journal of obstetrics and gynecology*, *210*(1), 42-42. https://doi.org/10.1097%2FAOG.0000000000003374

Clark, C. J., Hill, A., Jabbar, K. & Silverman, J. G. (2009). Violence during pregnancy in Jordan: its prevalence and associated risk and protective factors. *Violence Against Women*,*15*, 720-735. https://doi.org/10.1177/1077801209332191

CNEO.(2025). Shelters For Abused Women. https://cneo-nceo.ca/results/?searchLocation=Ottawa&topicPath=23&latitude=45.424615&longitude=-75.683516

Coll, C. V., Ewerling, F., García-Moreno, C., Hellwig, F., & Barros, A. J. (2020). Intimate partner violence in 46 low-income and middle-income countries: an appraisal of the most vulnerable groups of women using national health surveys. *BMJ global health, 5*(1), e002208. https://doi.org/10.1136%2Fbmjgh-2019-002208

Collins, P. H. (2000). Gender, black feminism, and black political economy. *The Annals of the American Academy of Political and Social Science*, *568*(1), 41-53. https://doi.org/10.1177/000271620056800105

Collins, P. H. (2002). *Black feminist thought: Knowledge, consciousness, and the politics of empowerment*. New York, NY: Routledge.

Collins, P. H. (2015). Intersectionality's definitional dilemmas. *Annual review of sociology*, *41*(1), 1-20. https://doi.org/10.1146/annurev-soc-073014-112142

Collins, P. H., & Bilge, S. (2016). *Intersectionality*. Hoboken, NJ: John Wiley & Sons.

Connor, P. D., Nouer, S. S., Speck, P. M., Mackey, S. N., & Tipton, N. G. (2013). Nursing students and intimate partner violence education: Improving and integrating knowledge into health-care curricula. *Journal of Professional Nursing, 29*(4), 233–239. http://dx.doi.org/10.1016/j.profnurs.2012.05.011

Conroy, A. A. (2014). Gender, power, and intimate partner violence: a study on couples from rural Malawi. *Journal of interpersonal violence*, *29*(5), 866-888. doi: 10.1177/0886260513505907.

Couture-Carron, A., Zaidi, A. U., & Ammar, N. H. (2022). Battered immigrant women and the police: A Canadian perspective. *International Journal of Offender Therapy and Comparative Criminology*, *66*(1), 50-69. https://doi.org/10.1177/0306624x20986534

Crawford, A. (2023). A critical review of social exclusion and inclusion among immigrant and refugee women. *Advances in Public Health, 2023*, 8889358. https://doi.org/10.1155/2023/8889358

Crenshaw, K. (1989). Demarginalizing the intersection of race and sex: A black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics. *University of Chicago Legal forum*, *140*, 139-176. http://chicagounbound.uchicago.edu/uclf/vol1989/iss1/8?utm_source=chicagounbound.uchicago.edu%2Fuclf%2Fvol1989%2Fiss1%2F8&utm_medium=PDF&utm_campaign=PDFCoverPages

Crenshaw, K. (1990). Mapping the margins: Intersectionality, identity politics, and violence against women of color. *Stan. L. Rev.*, *43*, 1241- 1299. https://doi.org/10.2307/1229039

Crenshaw, K. (2015). Why intersectionality can't wait. *The Washington Post*. https://www.washingtonpost.com/news/in-theory/wp/2015/09/24/why-intersectionality-cant-wait/

Creswell, J. W., & Creswell, J. D. (2017). *Research design: qualitative, quantitative, and mixed methods approaches*. Sage publications.

Creswell, J.W. and Poth, C.N. (2018). *Qualitative inquiry and research design choosing among five approaches*. 4th Edition, SAGE Publications, Inc.

Crossman, K. A., & Hardesty, J. L. (2018). Placing coercive control at the center: What are the processes of coercive control and what makes control coercive? *Psychology of Violence, 8*(2), 196–206. https://doi.org/10.1037/vio0000094

Crowe, S., Cresswell, K., Robertson, A., Huby, G., Avery, A., & Sheikh, A. (2011). The case study approach. *BMC medical research methodology*, *11*(1), 1-9. https://doi.org/10.1186/1471-2288-11-100

Daher, J., Butt, P., Clark, H., & Bedi, G. (2022). *A Snapshot of SHORE Centre's Newcomer Health Programs.* Guelph, ON: Community Engaged Scholarship Institute. https://atrium.lib.uoguelph.ca/bitstreams/beafd92b-287a-4590-a2db-762f4fffa36e/download

Danieli, Y. (1988). Confronting the unimaginable: Psychotherapists' reactions to victims of the Nazi Holocaust. In *Human adaptation to extreme stress: From the Holocaust to Vietnam* (pp. 219-238). Boston, MA: Springer US. https://doi.org/10.1007/978-1-4899-0786-8_10

Damra, J. K. (2022). The effects of psychodrama intervention on intimate partner violence and quality of life: Trial of Syrian refugee abused women. *Journal of International Women's Studies*, *23*(1), 333-346. https://vc.bridgew.edu/jiws/vol23/iss1/33

Damra, J. K., & Abujilban, S. (2022). Reasons for not seeking professional help by abused refugee women: A qualitative study. *Journal of interpersonal violence*, *37*(5-6), 2877-2895. https://doi.org/10.1177/0886260520943731

Daoud, N. (2021). "I will stay with him through thick and thin": Factors influencing the incidence and persistence of intimate partner violence against Syrian refugee women in Jordan. *Journal of Immigrant & Refugee Studies*, *19*(2), 170-183. DOI: https://doi.org/10.1080/15562948.2020.1754993

Daoud, N. (2019). Counting the uncounted burdens: intimate partner violence in migrant communities-systematic review of the literature. *International Journal of Gender Studies in Developing Societies, 3(2),* 126-152. https://doi.org/10.1504/IJGSDS.2019.102160

Daoud, N., O'Campo, P., Urquia, M. L., & Heaman, M. (2012). Neighbourhood context and abuse among immigrant and non-immigrant women in Canada: findings from the Maternity Experiences Survey. *International journal of public health*, *57*(4), 679-689. doi: 10.1007/s00038-012-0367-8.

Daoud N., Sergienko R., Shoham-Vardi E. (2017). Intimate partner violence prevalence, recurrence, types, and risk factors among Arab, and Jewish immigrant and nonimmigrant women of childbearing age in Israel. *Journal of Interpersonal Violence. 35*(15-16), 2869-2896. https://doi.org/10.1177/0886260517705665

Davis, K. (2008). Intersectionality as buzzword: A sociology of science perspective on what makes a feminist theory successful. *Feminist theory*, *9*(1), 67-85. https://doi.org/10.1177/1464700108086364

Debs-Ivall, S. (2016). *The lived experiences of immigrant Canadian women with the healthcare system* (Doctoral dissertation). Walden University. https://scholarworks.waldenu.edu/dissertations/2722/

Dekel, B., & Andipatin, M. (2016). Abused women's understandings of intimate partner violence and the link to intimate femicide. In *Forum Qualitative Sozialforschung/Forum: Qualitative Social Research 17*(1). DOI: https://doi.org/10.17169/fqs-17.1.2394

De La Rue, L., Polanin, J. R., Espelage, D. L., & Pigott, T. D. (2017). A meta-analysis of school-based interventions aimed to prevent or reduce violence in teen dating relationships. *Review of Educational Research, 87*(1), 7-34. https://doi.org/10.3102/0034654316632061

Denis, A. (2008). Review essay: Intersectional analysis: A contribution of feminism to sociology. *International Sociology*, *23*(5), 677-694. https://doi.org/10.1177/0268580908094468

Denzin, N. K. (2012). Triangulation 2.0. *Journal of mixed methods research, 6*(2), 80-88. https://doi.org/10.1177/1558689812437186

Denzin, N. K., Lincoln, Y. S., & Giardina, M. D. (2006). Disciplining qualitative research. *International journal of qualitative studies in education*, *19*(6), 769-782. https://doi.org/10.1080/09518390600975990

Devries, K. M., et al. (2023). Intimate partner violence against women before, during, and after pregnancy: A systematic review and meta-analysis. *PLoS Medicine, 20*(2), e1004129. https://doi.org/10.1371/journal.pmed.1004129

Dewey, J. (1916). *Democracy and education: An introduction to the philosophy of education*. New York: MacMillan

Dias, S., Gama, A., & Rocha, C. (2010). Immigrant women's perceptions and experiences of health-care services: Insights from a focus-group study. *Journal of Public Health, 18*, 489–496. https://doi.org/10.1007/s10389-010-0326-x

Dichter, M. E., Thomas, K. A., Crits-Christoph, P., Ogden, S. N., & Rhodes, K. V. (2018). Coercive control in intimate partner violence: Relationship with women's experience of violence, use of violence, and danger. *Psychology of violence*, *8*(5), 596. https://doi.org/10.1037/vio0000158

Dobash, R. E., & Dobash, R. P. (1981). Social science and social action: The case of wife beating. *Journal of Family Issues*, *2*(4), 439-470.

Dowds, E. (2020). Towards a contextual definition of rape: Consent, coercion and constructive force. *The Modern Law Review,* 83(1), 35-63. https://doi.org/10.1111/1468-2230.12461

Duhaney, P. (2022). Contextualizing the experiences of Black women arrested for intimate partner violence in Canada. *Journal of interpersonal violence, 37*(21-22), 21189-21216. https://doi.org/10.1177/08862605211056723

Du Mont, J., Hyman, I., O'Brien, K., White, M. E., Odette, F., & Tyyskä, V. (2012). Factors associated with intimate partner violence by a former partner by immigration status and length of residence in Canada. *Annals of Epidemiology*, *22*(11), 772-777. https://doi.org/10.1016/j.annepidem.2012.09.001

Durieux-Paillard S. (2011). *Differences in language, religious beliefs and culture: The need for culturally responsive health services*. Open University Press.

Dvir, Y., Ford, J. D., Hill, M., & Frazier, J. A. (2014). Childhood maltreatment, emotional dysregulation, and psychiatric comorbidities. *Harvard Review of Psychiatry, 22*(3), 149–16. https://doi.org/10.1097/hrp.0000000000000014

Edelheim, J., Joppe, M., Flaherty, J., Höckert, E., Boluk, K. A., Guia, J., & Peterson, M. (2022). Axiology, value and values. *In Teaching Tourism* (pp. 12-20). Edward Elgar Publishing.

Edin, K. E., Dahlgren, L., Lalos, A., & Högberg, U. (2010). "Keeping up a front": narratives about intimate partner violence, pregnancy, and antenatal care. *Violence against women, 16*(2), 189-206. https://doi.org/10.1177/1077801209355703

Edwards, S. J. (2005). Research participation and the right to withdraw. *Bioethics*, *19*(2), 112-130. DOI: 10.1111/j.1467-8519.2005.00429.x

Ellsberg, M., & Heise, L. 2005: Researching Violence Against Women. A Practical Guide for Researchers and Activists*, World Health Organization, 7*(13). http://dx.doi.org/10.4236/psych.2016.713155

Elo, S., Kääriäinen, M., Kanste, O., Pölkki, T., Utriainen, K., & Kyngäs, H. (2014). Qualitative content analysis: A focus on trustworthiness. *SAGE open, 4*(1), DOI: 10.1177/2158244014522633

Erez, E., & Globokar, J. (2009). Compounding vulnerabilities: The impact of immigration status and circumstances on battered immigrant women. In W. F. Mcdonald (Ed.), *Immigration, crime and justice* (pp. 129–145). Bingley, England: Emerald. DOI:10.1108/S1521-6136(2009)0000013011

Erez, E., & Harper, S. (2018). *Intersectionality, immigration, and domestic violence*. *The handbook of race, ethnicity, crime, and justice,* Wiley Blackwell.

Etowa, J., & Adongo, L. (2007). Cultural competence: Beyond culturally sensitive care for childbearing black women. *Journal of the Motherhood Initiative for Research and Community Involvement*, 9(2), 70.

Feder, L., Holditch Niolon, P., Campbell, J., Wallinder, J., Nelson, R., & Larrouy, H. (2011). The need for experimental methodology in intimate partner violence: Finding programs that effectively prevent IPV. *Violence Against Women, 17*(3), 340-358. https://doi.org/10.1177/1077801211398620

Finch, H., Lewis, J. (2003). Focus groups. In Ritchie, J., Lewis, J. (Eds.), *Qualitative research practice: A guide for social science students and researchers*. London: Sage

Finnbogadóttir, H., & Dykes, A. K. (2012). Midwives' awareness and experiences regarding domestic violence among pregnant women in southern Sweden. *Midwifery*, *28*(2), 181-189. doi: 10.1016/j.midw.2010.11.010.

Fishel, C. C. (2008). The Nursing & Allied Health (CINAHL) data base: a guide to effective searching. *Medical Reference Services Quarterly*, *4*(3), 1-16. https://doi.org/10.1300/J115v04n03_01

Flanagan, J. C., Gordon, K. C., Moore, T. M., & Stuart, G. L. (2015). Women's stress, depression, and relationship adjustment profiles as they relate to intimate partner violence and mental health during pregnancy and postpartum. *Psychology of violence*, *5*(1), 66-73. https://doi.org/10.1037%2Fa0036895

Fong, V. C., Hawes, D., & Allen, J. L. (2019). A systematic review of risk and protective factors for externalizing problems in children exposed to intimate partner violence. *Trauma, Violence, & Abuse*, *20*(2), 149-167. https://doi.org/10.1177/1524838017692383

Fonteyne, H., Podritske, K., Park, T., & Hegadoren, K. (2024). Immigrant women's experiences of domestic violence in Canada: A qualitative file audit. *Journal of family violence*, *39*(4), 613-622. https://doi.org/10.1007/s10896-023-00490-1

Fraser, N. (1989). *Unruly practices: Power, discourse, and gender in contemporary social theory.* University of Minnesota Press.

Freeman, T. (2006). 'Best practice in focus group research: making sense of different views. *Journal of advanced nursing*, *56*(5), 491-497. https://doi.org/10.1111/j.1365-2648.2006.04043.x

Frith, H. (2000). Focusing on sex: Using focus groups in sex research. *Sexualities*, *3*(3), 275-297. https://doi.org/10.1177/136346000003003001

Fseifes, M., & Etowa, J. (2024). The COVID-19 pandemic and intimate partner violence among immigrant women in Canada: A narrative review. *Women, 4*(4), 480–502. https://doi.org/10.3390/women4040036

Fusch, P. I., & Ness, L. R. (2015). Are we there yet? Data saturation in qualitative research. *Walden University, 20*(9), 1408-1416. https://scholarworks.waldenu.edu/facpubs/455

Gagnon, A. J., Zimbeck, M., Zeitlin, J., Abenhaim, H., Delisle, M.-F., Heaman, M., & Leduc, N. (2017). Migrants' perinatal health in Canada: A scoping review. *BMC Pregnancy and Childbirth, 17*, 17. doi: 10.1016/j.socscimed.2009.06.027

Galtung, J. (1969). Violence, peace, and peace research. *Journal of peace research*, *6*(3), 167-191. https://doi.org/10.1177/002234336900600301

Garneau, S., & Bouchard, C. (2013). Les légitimations complexes de l'internationalisation de l'enseignement supérieur: le cas de la mobilité des étudiants maghrébins en France et au Québec. *Cahiers québécois de démographie, 42*(2), 201-239. http://dx.doi.org/10.7202/1020608ar

Garnweidner- Holme, L. M., Lukasse, M., Solheim, M., & Henriksen, L. (2017). Talking about intimate partner violence in multi-cultural antenatal care: a qualitative study of pregnant women's advice for better communication in South-East Norway. *BMC pregnancy and childbirth*, *17*(1), 1-10. Doi: 10.1186/s12884-017-1308-6

Gentles, S. J., Charles, C., Ploeg, J., & McKibbon, K. A. (2015). Sampling in qualitative research: Insights from an overview of the methods literature. *The qualitative report, 20*(11), 1772-1789. doi: 10.1186/s13643-016-0343-0.

Gelfand, M. J., & Jackson, J. C. (2016). From one mind to many: The emerging science of cultural norms. *Current Opinion in Psychology*, *8*, 175-181. https://doi.org/10.1016/j.copsyc.2015.11.002

Georges, C., Ahmed, S., & Ghazali, S. (2020). *The effects of an intimate partner violence educational intervention on nurses: a quasi-experimental study. Nurse Education Today, 87,* 104376. DOI: 10.1016/j.nepr.2020.102854

Gerring, J. (2004). What is a case study and what is it good for?. *American political science review*, 98(2), 341-354. https://doi.org/10.1017/S0003055404001182

Ghafournia, N. (2014). Culture, domestic violence and intersectionality: Beyond the dilemma of cultural relativism and universalism. *The International Journal of Critical Cultural Studies*, *11*(2), 23. https://doi.org/10.18848/2327-0055/CGP/v11i02/43668

Gharaibeh, M., & Oweis, A. (2009). Why do Jordanian women stay in an abusive relationship: Implications for health and social well-being. *Journal of Nursing Scholarship*, *41*(4), 376-384. https://doi.org/10.1111/j.1547-5069.2009.01305.x

Giesbrecht, C. J., Kikulwe, D., Watkinson, A. M., Sato, C. L., Este, D. C., & Falihi, A. (2023). Supporting newcomer women who experience intimate partner violence and their children: Insights from service providers. *Affilia, 38*(1), 127–148. https://doi.org/10.1177/08861099221099318

Gilanshah, F. (2011). The life experience of Middle Eastern immigrant women to the United States: The case of Iranian women in Minnesota. In *Forum on Public Policy: A Journal of the Oxford Round Table*.

Gilchrist, G., Dennis, F., Radcliffe, P., Henderson, J., Howard, L. M., & Gadd, D. (2019). The interplay between substance use and intimate partner violence perpetration: A meta-ethnography. *International Journal of Drug Policy, 65*, 8-23. https://doi.org/10.1016/j.drugpo.2018.12.009

González, A. O., & Collins, P. H. (2019). Interview with Patricia Hill Collins on critical thinking, intersectionality and educational: Key objectives for critical articulation on inclusive education. *Journal for Critical Education Policy Studies (JCEPS), 17*(2). https://doi.org/10.31231/osf.io%2F9sf2u

Goodkind, J. R., Amer, S., Christian, C., Hess, J. M., Bybee, D., Isakson, B. L., ... & Shantzek, C. (2017). Challenges and innovations in a community-based participatory randomized controlled trial. *Health Education & Behavior*, *44*(1), 123-130. DOI: 10.1002/ajcp.12418

Gopaldas, A. (2013). Intersectionality 101. *Journal of Public Policy & Marketing*, *32*(1), 90-94. https://doi.org/10.1509/jppm.12.044

Gosangi, B., Rubinowitz, A. N., Irugu, D., Gange, C., Bader, A., & Cortopassi, I. (2021). COVID-19 ARDS: a review of imaging features and overview of mechanical ventilation and its complications. *Emergency radiology,* 1-12. doi: 10.1007/s10140-021-01976-5.

Government of Canada. (2017). *The federal Gender-based Violence Strategy.* The federal Gender-based Violence Strategy - Canada.ca

Government of Canada. (2024). *In Brief: National Acton Plan to End Gender-Based Violence.* https://www.canada.ca/content/dam/wage-fegc/documents/gbv/National%20Action%20Plan%20on%20Gender-based%20Violence%20-%20In%20Brief%20-%20English.pdf>.

Government of Canada. (2025). *Family Violence Prevention Program.* https://www.sac-isc.gc.ca/eng/1100100035253/1533304683142

Government of Canada. (2025). *Gender-based Analysis Plus (GBA Plus)***.** https://www.canada.ca/en/women-gender-equality/gender-based-analysis-plus.html

Grace, K. T., Alexander, K. A., Jeffers, N. K., Miller, E., Decker, M. R., Campbell, J., & Glass, N. (2020). Experiences of reproductive coercion among Latina women and strategies for minimizing harm:“The path makes us strong”. *Journal of Midwifery & Women's Health*, *65*(2), 248-256. doi: 10.1111/jmwh.13061.

Grace, K. T., & Anderson, J. C. (2018). Reproductive coercion: a systematic review. *Trauma, Violence, & Abuse*, *19*(4), 371-390. https://pubmed.ncbi.nlm.nih.gov/27535921/

Grace, K. T., Decker, M. R., Alexander, K. A., Campbell, J., Miller, E., Perrin, N., & Glass, N. (2022). Reproductive coercion, intimate partner violence, and unintended pregnancy among Latina women. *Journal of interpersonal violence, 37*(3-4), 1604-1636. https://doi.org/10.1177/0886260520922363

Grace, K. T., & Fleming, C. (2016). A systematic review of reproductive coercion in international settings. *World Medical & Health Policy, 8*(4), 382-408. https://doi.org/10.1002/wmh3.209

Green, B. N., Johnson, C. D., & Adams, A. (2006). Writing narrative literature reviews for peer-reviewed journals: secrets of the trade. *Journal of chiropractic medicine*, *5*(3), 101-117. https://doi.org/10.1016/S0899-3467(07)60142-6

Green, J. and Thorogood, N. (2009) *Qualitative methods for health research.* Sage, London.

Green, J., Willis, K., Hughes, E., Small, R., Welch, N., Gibbs, L., & Daly, J. (2007). Generating best evidence from qualitative research: the role of data analysis. *Australian and New Zealand journal of public health, 31*(6), 545-550. https://doi.org/10.1111/j.1753-6405.2007.00141.x

Griffin, M. G., Resick, P. A., Waldrop, A. E., & Mechanic, M. B. (2003). Participation in trauma research: Is there evidence of harm?. *Journal of traumatic stress, 16*(3), 221-227. https://doi.org/10.1023/a:1023735821900

Guba, E. G., & Lincoln, Y. S. (2005). Competing paradigms in qualitative research. *Handbook of qualitative research*, *2*(163-194), 105-117.

Guest, G., Bunce, A., & Johnson, L. (2006). How many interviews are enough? An experiment with data saturation and variability. *Field methods, 18*(1), 59-82. https://doi.org/10.1177/1525822X05279903

Gunarathne L., Apputhurai P., Nedeljkovic M., Bhowmik J. (2024). Factors associated with married women's attitude toward intimate partner violence: A study on 20 low-and middle-income countries. *Health Care for Women International*, 46(5), 1–21. https://doi.org/10.1080/07399332.2024.2319214

Guruge, S., Khanlou, N., & Gastaldo, D. (2010). Intimate male partner violence in the migration process: Intersections of gender, race and class. *Journal of Advanced Nursing*, *66*(1), 103-113. DOI: 10.1111/j.1365-2648.2009.05184.x

Guruge, S., Roche, B., & Catallo, C. (2012). Violence against women: an exploration of the physical and mental health trends among immigrant and refugee women in Canada. *Nursing research and practice*, *2012*(1), 434592. DOI: 10.1155/2012/434592

Hahn, C. K., Gilmore, A. K., Aguayo, R. O., & Rheingold, A. A. (2018). Perinatal intimate partner violence. *Obstetrics and Gynecology Clinics, 45(3),* 535-547. https://doi.org/10.1016%2Fj.ogc.2018.04.008

Hamberger, L. K., Larsen, S., & Ambuel, B. (2020). "It helped a lot to go over it": Intimate partner violence research risks and benefits from participating in an 18-month longitudinal study. *Journal of family violence, 35*(1), 43-52. https://doi.org/10.1007/s10896-019-00075-x

Hamberger, L. K., Larsen, S. E., & Lehrner, A. (2017). Coercive control in intimate partner violence. *Aggression and Violent Behavior*, *37*, 1-11. https://doi.org/10.1016/j.avb.2017.08.003

Hammoury, N., & Khawaja, M. (2007). Screening for domestic violence during pregnancy in an antenatal clinic in Lebanon. *European Journal of Public Health*, *17*(6), 605-606. https://doi.org/10.1093/eurpub/ckm009

Hammoury, N., Khawaja, M., Mahfoud, Z., Afifi, R. A., & Madi, H. (2009). Domestic violence against women during pregnancy: The case of Palestinian refugees attending an antenatal clinic in Lebanon. *Journal of Women's Health*, *18*(3), 337-345. DOI: 10.1089/jwh.2007.0740

Hancock, T. U., & Siu, K. (2009). A culturally sensitive intervention with domestically violent Latino immigrant men. *Journal of Family Violence, 24*(2), 123-132. https://psycnet.apa.org/doi/10.1007/s10896-008-9217-0

Hardesty, J. L., Haselschwerdt, M. L., & Crossman, K. A. (2019). Qualitative research on interpersonal violence: Guidance for early career scholars. *Journal of interpersonal violence*, *34*(23-24), 4794-4816. https://psycnet.apa.org/doi/10.1177/0886260519871532

Hardesty, J. L., Khaw, L., Ridgway, M. D., Weber, C., & Miles, T. (2013). Coercive control and abused women's decisions about their pets when seeking shelter. *Journal of Interpersonal Violence, 28*(13), 2617-2639. https://doi.org/10.1177/0886260513487994

Hardesty, J. L., & Ogolsky, B. G. (2020). A socioecological perspective on intimate partner violence research: A decade in review. *Journal of marriage and family, 82*(1), 454-477. https://doi.org/10.1111/jomf.12652

Haslam, C., Haslam, S. A., Jetten, J., Cruwys, T., & Steffens, N. K. (2021). Life change, social identity, and health. *Annual Review of Psychology, 72,* 635-661. https://doi.org/10.1146/annurev-psych-060120-111721

Hass, G. A., Ammar, N., & Orloff, L. (2006). Battered immigrants and US citizen spouses. *Legal Momentum, 24,* 1-10. http://www.ncdsv.org/images/LM_BatteredImmigrantsAndUScitizenSpouses_4-24-2006.pdf

Hassan, R. (1995). Women in Islam: Qur'anic ideals versus Muslim realities. *Planned parenthood challenges*, (2), 5-9. PMID: 12346481.

Heise, L. L. (1998). Violence against women: An integrated, ecological framework. *Violence against women, 4*(3), 262-290. https://doi.org/10.1177/1077801298004003002

Hellmuth, J. C., & Leonard, K. E. (2013). Methods for assessing and addressing participant protection concerns in intimate partner violence research. *Partner abuse*, *4*(4), 482-493. https://doi.org/10.1891/1946-6560.4.4.482

Hennink, M., & Kaiser, B. N. (2022). Sample sizes for saturation in qualitative research: A systematic review of empirical tests. *Social science & medicine*, *292*, 114523. https://doi.org/10.1016/j.socscimed.2021.114523

Henriksen, L., Kisa, S., Lukasse, M., Flaathen, E. M., Mortensen, B., Karlsen, E., & Garnweidner-Holme, L. (2023). Cultural sensitivity in interventions aiming to reduce or prevent intimate partner violence during pregnancy: A scoping review. *Trauma, Violence, & Abuse*, *24*(1), 97-109. https://doi.org/10.1177/15248380211021788

Heywood, I., Sammut, D., & Bradbury-Jones, C. (2019). A qualitative exploration of 'thrivership'among women who have experienced domestic violence and abuse: Development of a new model. *BMC women's health*, *19*(1), 1-15. https://doi.org/10.1186%2Fs12905-019-0789-z

Hinton, L., Locock, L., Knight, M., & Shakespeare, J. (2022). Exploring the experiences of African refugee women with perinatal care in high-income countries: A qualitative evidence synthesis. *BMC Pregnancy and Childbirth, 22*, 79. https://doi.org/10.1186/s12884-022-04957-9

Hlavka, H. R., Kruttschnitt, C., & Carbone-López, K. C. (2007). Revictimizing the victims? Interviewing women about interpersonal violence. *Journal of Interpersonal Violence, 22(*7), 894-920. https://psycnet.apa.org/doi/10.1177/0886260507301332

Holtmann, C., & Rickards, T. (2018). Domestic/intimate partner violence in the lives of immigrant women: a New Brunswick response. *Canadian Journal of Public Health*, *109*(3), 294-302. https://doi.org/10.17269/s41997-018-0056-3

Hooks, B. (1990). Postmodern blackness. *Postmodern Culture, 1*(1). http://muse.jhu.edu/journals/postmodern_culture/v001/1.1hooks.html.

Hynes, M. E., Sterk, C. E., Hennink, M., Patel, S., DePadilla, L., & Yount, K. M. (2016). Exploring gender norms, agency and intimate partner violence among displaced Colombian women: A qualitative assessment. *Global public health*, *11*(1-2), 17-33. https://doi.org/10.1080/17441692.2015.1068825

Innes, A., Bunce, A., Manzur, H., & Lewis, N. V. (2024). Experiences of violence while in insecure migration status: a qualitative evidence synthesis. *Globalization and Health*, *20*(1), 83. https://doi.org/10.1186/s12992-024-01085-1

Ivanova, O., Rai, M., Mlahagwa, W., Tumuhairwe, J., Bakuli, A., Nyakato, V. N., & Kemigisha, E. (2019). A cross-sectional mixed-methods study of sexual and reproductive health knowledge, experiences and access to services among refugee adolescent girls in the Nakivale refugee settlement, Uganda. *Reproductive health*, *16*(1), 1-11. https://doi.org/10.1186/s12978-019-0698-5

Izaguirre, A., & Calvete, E. (2014). Intimate partner violence during pregnancy: Women's narratives about their mothering experiences. *Psychosocial Intervention, 23*(3), 209-215. https://psycnet.apa.org/doi/10.1016/j.psi.2014.07.010

Jack, S. M., Wilson, D., & Bradbury-Jones, C. (2023). Advancing nursing's response to the wicked problem of intimate partner violence. *Journal of Advanced Nursing, 79*(4), e18–e20. doi: 10.1111/jan.15664

Jofre-Bonet, M., Rossello-Roig, M., & Serra-Sastre, V. (2024). Intimate partner violence and children's health outcomes. *SSM-Population Health*, *25*, 101611. https://doi.org/10.1016/j.ssmph.2024.101611

Jumarali, S. N., Nnawulezi, N., Royson, S., Lippy, C., Rivera, A. N., & Toopet, T. (2021). Participatory research engagement of vulnerable populations: Employing survivor-centered, trauma-informed approaches. *Journal of Participatory Research Methods, 2*(2). https://doi.org/10.35844/001c.24414

Kawachi, I., Subramanian, S. V., & Almeida-Filho, N. (2002). A glossary for health inequalities. *Journal of Epidemiology & Community Health, 56*(9), 647-652. https://doi.org/10.1136/jech.56.9.647

Kelly, Y., Zilanawala, A., Booker, C., & Sacker, A. (2018). Social media use and adolescent mental health: Findings from the UK Millennium Cohort Study. *EClinicalMedicine, 6,* 59-68. https://doi.org/10.1016/j.eclinm.2018.12.005

Khan, A. G., Eid, N., Baddah, L., Elabed, L., Makki, M., Tariq, M., ... & Kusunoki, Y. (2022). A Qualitative study of Arab-American perspectives on intimate partner violence in Dearborn, Michigan. *Violence Against Women,1*(1), doi:10.1177/10778012211032696

Khanlou, N., Haque, N., Skinner, A., Mantini, A., & Kurtz Landy, C. (2017). Scoping review on maternal health among immigrant and refugee women in Canada: Prenatal, intrapartum, and postnatal care. *Journal of Pregnancy,* 8783294.

Khawaja, M., & Hammoury, N. (2008). Coerced sexual intercourse within marriage: a clinic-based study of pregnant Palestinian refugees in Lebanon. *Journal of midwifery & women's health*, *53*(2), 150-154. https://doi.org/10.1016/j.jmwh.2007.09.001

Kincheloe, J. L., & McLaren, P. (2011). Rethinking critical theory and qualitative research. In *Key works in critical pedagogy* (pp. 285-326). Brill. https://doi.org/10.1007/978-94-6091-397-6_23

Kingston, D., Heaman, M., Chalmers, B., Kaczorowski, J., O'Brien, B., Lee, L., ... & Maternity Experiences Study Group of the Canadian Perinatal Surveillance System. (2016). Comparison of maternity experiences of Canadian-born and recent and non-recent immigrant women: findings from the Canadian Maternity Experiences Survey. *Journal of Obstetrics and gynaecology Canada*, *33*(11), 1105-1115. https://doi.org/10.1016/S1701-2163(16)35078-2

Kitzinger, J. (2000). Focus groups with users and providers of health care. *Quality Research in Health Care*, *311*(7000), 299-302 https://doi.org/10.1136/bmj.311.7000.299

Koch, T. (1994). Establishing rigour in qualitative research: the decision trail. *Journal of advanced nursing, 19*(5), 976-986. https://doi.org/10.1111/j.1365-2648.1994.tb01177.x

Koller, P. & Darida, P. (2020). Emotional behaviour with verbal violence: Problems and solutions. *Interdisciplinary Journal Papier Human Review*, *1*(2), 1-6. https://doi.org/10.47667/ijphr.v1i2.41

Korstjens, I., & Moser, A. (2017). Series: Practical guidance to qualitative research. Part 2: Context, research questions and designs. *European Journal of General Practice, 23*(1), 274-279. doi: 10.1080/13814788.2017.1375090.

Kostas-Polston, E. A., Thanavaro, J., Arvidson, C., Taub, L. F. M., & FAANP Health Policy Work Group. (2015). Advanced practice nursing: Shaping health through policy. *Journal of the American Association of Nurse Practitioners*, *27*(1), 11-20. https://doi.org/10.1002/2327-6924.12192

Krigel, K., & Benjamin, O. (2021). Women working in the shadow of violence: Studying the temporality of work and violence embeddedness (WAVE). *In Women's studies international forum,84,* 102433. http://dx.doi.org/10.1016/j.wsif.2020.102433

Kruger, L. J., Rodgers, R. F., Long, S. J., & Lowy, A. S. (2019). Individual interviews or focus groups? Interview format and women's self-disclosure. *International Journal of Social Research Methodology, 22*(3), 245-255. https://doi.org/10.1080/13645579.2018.1518857

Langhinrichsen-Rohling, J., McCullars, A., & Misra, T. A. (2012). Motivations for men and women's intimate partner violence perpetration: A comprehensive review. *Partner Abuse, 3*(4), 429–468. https://doi.org/10.1891/1946-6560.3.4.429

Lapierre, S. (2010). Striving to be 'good'mothers: abused women's experiences of mothering. *Child Abuse Review*, *19*(5), 342-357. https://psycnet.apa.org/doi/10.1002/car.1113

Latta, R. E., & Goodman, L. A. (2005). Considering the interplay of cultural context and service provision in intimate partner violence: The case of Haitian immigrant women. *Violence Against Women, 11*(11), 1441–1464. https://psycnet.apa.org/doi/10.1177/1077801205280273

Lévesque, S., Boulebsol, C., Lessard, G., Bigaouette, M., Fernet, M., & Valderrama, A. (2022). Portrayal of domestic-violence trajectories during the perinatal period: A qualitative study. *Violence Against Women, 28*(1), 89–112. https://doi.org/10.1177/10778012211014564

Lewis, G., Jones, B., & Baker, C. (2012). Translanguaging: Developing its conceptualisation and contextualisation. *Educational Research and Evaluation, 18*(7), 655–670. http://doi.org/10.1080/13803611.2012.718490

Li, Q., Kirby, R. S., Sigler, R. T., Hwang, S. S., LaGory, M. E., & Goldenberg, R. L. (2010). A multilevel analysis of individual, household, and neighborhood correlates of intimate partner violence among low-income pregnant women in Jefferson County, Alabama. *American journal of public health, 100(*3), 531-539. https://doi.org/10.2105%2FAJPH.2008.151159

Lin, D., Hu, B., Xiu, Y., Ji, R., Zeng, H., Chen, H., & Wu, Y. (2024). Risk factors for premature rupture of membranes in pregnant women: a systematic review and meta-analysis. *BMJ open*, *14*(3), https://doi.org/10.1136/bmjopen-2023-077727

Lincoln, Y. S., and Guba, E.G (1985). *Naturalistic inquiry*. Sage

Lindsjö, C., Sjögren Forss, K., Kumlien, C., Kottorp, A., & Rämgård, M. (2023). Migrant women's engagement in health-promotive activities through a women's health collaboration. *Frontiers in Public Health, 11*, 1106972.doi: 10.3389/fpubh.2023.1106972

Liu, Y., & Proulx, J. (2023). Perinatal care experiences of racialized immigrant mothers: The role of systemic racism and language access. *Maternal and Child Health Journal, 27*(9), 1452–1461. https://doi.org/10.1007/s10995-023-03645-8

Logan, T. K., Walker, R., & Cole, J. (2015). Silenced suffering: The need for a better understanding of partner sexual violence. *Trauma, Violence, & Abuse*, *16*(2), 111-135. https://doi.org/10.1177/1524838013517560

Machost, H., & Stains, M. (2023). Reflective practices in education: A primer for practitioners. *CBE,Life Sciences Education*, *22*(2), es2. https://doi.org/10.1187/cbe.22-07-0148

Magnussen, L., Shoultz, J., Richardson, K., Oneha, M. F., Campbell, J. C., Matsunaga, D. S., ... & Arias, C. (2011). Responding to the needs of culturally diverse women who experience

intimate partner violence who experience intimate partner violence. *Hawaii medical journal, 70*(1), 9. http://www.ncbi.nlm.nih.gov/pmc/articles/pmc3071194/

Maguire, M., & Delahunt, B. (2017). Doing a thematic analysis: A practical, step-by-step guide for learning and teaching scholars. *All Ireland Journal of Higher Education, 9*(3). http://ojs.aishe.org/index.php/aishe-j/article/view/335

Mantovani, N., & Thomas, H. (2014). Choosing motherhood: The complexities of pregnancy decision-making among young black women 'looked after by the State. *Midwifery*, *30*(3), e72-e78. https://doi.org/10.1016/j.midw.2013.10.015

McKim, C. (2023). Meaningful member-checking: a structured approach to member-checking. *American Journal of Qualitative Research*, *7*(2), 41-52. https://doi.org/10.29333/ajqr/12973

McLane, P., & Chan, T. (2018). Stories, voices, and explanations: how qualitative methods may help augment emergency medicine research. *Canadian Journal of Emergency Medicine, 20*(4), 491-492. doi:10.1017/cem.2018.409

Mclocklin, G., Kellezi, B., Stevenson, C., & Mackay, J. (2024). Disclosure decisions and help-seeking experiences amongst victim-survivors of non-consensual intimate-image distribution. *Victims & Offenders*. https://doi.org/10.1080/15564886.2024.2329107

Mehta, P., & Gagnon, A. J. (2016). Responses of international migrant women to abuse associated with pregnancy. *Violence against women*, *22*(3), 292-306. doi:10.1177/1077801215583622.

Meleis, A. I., & Im, E. O. (1999). Transcending marginalization in knowledge development. *Nursing Inquiry*, *6*(2), 94-102. https://doi.org/10.1046/j.1440-1800.1999.00015.x

Meleis, A. I. (2010). *Transitions Theory: Middle range and situations specific theories in nursing research and practice*. NewYork: Springer.

Mercer, R. (2004). Becoming a mother versus maternal role attainment. *Journal of Nursing Scholarship*, *36*(3), 226-232. https://doi.org/10.1111/j.1547-5069.2004.04042.x

Merriam, S. B. (2009). *Qualitative research: A guide to design and implementation*. San Francisco, CA: Jossey-Bass.

Merry, L., Low, A., Carnevale, F., & Gagnon, A. J. (2016). Participation of child-bearing international migrant women in research: The ethical balance. *Nursing Ethics, 23*(1), 61–78. DOI: 10.1177/0969733014557134

Merry, L., & Pelaez, S. (2021). Knowledge translation and better health and health care for migrants in Canada: What is the responsibility of health funders and researchers? *Canadian Family Physician, 67*(6), 403–405. doi: 10.46747/cfp.6706403

Miles, M. B., & Huberman, A. M. (2014). *Qualitative data analysis: An expanded sourcebook.* Sage.

Mishkin, K. E., Ahmed, H. M., & Maqsood, S. S. (2022). Factors associated with experiencing lifetime intimate partner violence among pregnant displaced women living in refugee camps in Erbil, Iraq. *Global public health*, *17*(12), 3455-3464. https://doi.org/10.1080/17441692.2022.2048409

Misra, T. A., & Selwyn, C. (2012). Rates of bidirectional versus unidirectional intimate partner violence across samples, sexual orientations, and race/ethnicities: A comprehensive review. *Partner Abuse, 3*(2), 199–230. https://psycnet.apa.org/doi/10.1891/1946-6560.3.2.199

Mohrdar, N. *Managing Contradictions of Multiculturalism: Narratives of Belonging and Being Canadian Among Canadian Middle Eastern Women* (Doctoral dissertation, Toronto Metropolitan University).

Mojahed, A., Alaidarous, N., Kopp, M., Pogarell, A., Thiel, F., & Garthus-Niegel, S. (2021). Prevalence of intimate partner violence among intimate partners during the perinatal period: A narrative literature review. *Frontiers in Psychiatry*, *12,* 601236. https://doi.org/10.3389/fpsyt.2021.601236

Mojahed, A., Alaidarous, N., Shabta, H., Hegewald, J., & Garthus-Niegel, S. (2022). Intimate partner violence against women in the Arab countries: a systematic review of risk factors. *Trauma, Violence, & Abuse*, 1-18. https://doi.org/10.1177%2F1524838020953099

Moshtagh, M., Amiri, R., Sharafi, S., & Arab-Zozani, M. (2023). Intimate partner violence in the Middle East region: A systematic review and meta-analysis. *Trauma, Violence, & Abuse, 24*(2), 613–631. https://doi.org/10.1177/15248380211036060

Murray, C. E., Kaslow, N. J., & Graves, K. N. (2013). *Responding to family violence: A comprehensive, research-based guide for therapists*. Routledge.

Nash, J. C. (2019). *Black feminism reimagined: After intersectionality*. Duke University Press.

Nash, J. C. (2008). Re-thinking intersectionality. *Feminist Review, 89*(1), 1–15. https://doi.org/10.1057/fr.200

National Household Survey. (2011). *Immigration and Ethnocultural Diversity in Canada.* Statistics Canada. Immigration and Ethnocultural Diversity in Canada (statcan.gc.ca)

Nelson, R. G. (2021). The sex in your violence: patriarchy and power in anthropological world building and everyday life. *Current anthropology*, *62*(S23), S92-S102. https://doi.org/10.1086/711605

Niroomand, S., Gholizadeh, L., & Baird, K. (2024). Iranian immigrant women's experiences of intimate partner violence: A literature review. *Journal of Immigrant and Minority Health, 26*, 905–924. https://doi.org/10.1007/s10903-024-01610-9

Nixon, K. L., Bonnycastle, C., & Ens, S. (2017). Challenging the notion of failure to protect: Exploring the protective strategies of abused mothers living in urban and remote communities and implications for practice. *Child abuse review*, *26*(1), 63-74. https://doi.org/10.1002/car.2417

Njeze, C., Bird-Naytowhow, K., Pearl, T., & Hatala, A. R. (2020). Intersectionality of resilience: A strengths-based case study approach with Indigenous youth in an urban Canadian context. *Qualitative health research, 30*(13), 2001-2018. doi: 10.1177/1049732320940702.

Njie-Carr, V. P., Sabri, B., Messing, J. T., Suarez, C., Ward-Lasher, A., Wachter, K., ... & Campbell, J. (2021). Understanding intimate partner violence among immigrant and refugee women: A grounded theory analysis. *Journal of Aggression, Maltreatment & Trauma*, *30*(6), 792-810. https://doi.org/10.1080/10926771.2020.1796870

Noble, H., & Heale, R. (2019). Triangulation in research, with examples. *Evidence-based nursing, 22*(3), 67-68. http://dx.doi.org/10.1136/ebnurs-2019-103145

Norris, A. L., Rich, C., Kaplan, C., Krieger, N., Carey, K. B., & Carey, M. P. (2020). Intersections between young women's racial/ethnic identities and sexual orientation on

rates of sexual violence and substance use. *Psychology & Sexuality, 12*(1-2), 141-161. https://doi.org/10.1080%2F19419899.2020.1729848

Nowell, L. S., Norris, J. M., White, D. E., & Moules, N. J. (2017). Thematic analysis: Striving to meet the trustworthiness criteria. *International journal of qualitative methods, 16*(1), https://doi.org/10.1177/1609406917733847

O'Doherty, L., et al. (2015). Screening women for intimate partner violence in healthcare settings. *Cochrane Database of Systematic Reviews, 7*, CD007007. https://doi.org/10.1002/14651858.CD007007.pub3

Okeke-Ihejirika, P., Yohani, S., Muster, J., Ndem, A., Chambers, T., & Pow, V. (2020). A scoping review on intimate partner violence in Canada's immigrant communities. *Trauma, Violence, & Abuse, 21*(4), 788-810. doi: 10.1177/1524838018789156.

Okour, A. M., & Badarneh, R. (2011). Spousal violence against pregnant women from a Bedouin community in Jordan. *Journal of Women's Health*, *20*(12), 1853–1859. https://doi.org/10.1089/jwh.2010.2588

Ontario (2025).Ontario Works. https://www.ontario.ca/page/ontario-works

Ottawa Police. (2024). *2024 Intimate Partner Violence preliminary statistics shows a consistent increase.* Ottawa Police.

Overstreet, N. M., Okuyan, M., & Fisher, C. B. (2018). Perceived risks and benefits in IPV and HIV research: Listening to the voices of HIV-positive African American women. *Journal of Empirical Research on Human Research Ethics, 13*(5), 511-524. https://doi.org/10.1177%2F1556264618797557

Oweis, A., Gharaibeh, M., & Alhourani, A. (2010). Prevalence of violence during pregnancy: Findings from a Jordanian survey. *Maternal and Child Health Journal*, *14*, 437-445. https://doi.org/10.1007/s10995-009-0465-2

Oxford Learner's Dictionary (2019). Retrieved from: https://www.oxfordlearnersdictionaries.com/us/

Ozturk, B. (2019). *Unheard stories from middle eastern immigrant women ipv survivors*: a *qualitative study*. The University of Alabama.

Ozturk, B., & Nelson-Gardell, D. (2023). From lived experience: listening to stories of healing from Middle Eastern immigrant IPV survivors. *Violence against women*, *30*(6-7), 1708-1725. https://doi.org/10.1177/10778012231155166

Park, T., Mullins, A., Zahir, N., Salami, B., Lasiuk, G., & Hegadoren, K. (2021). Domestic violence and immigrant women: A glimpse behind a veiled door. *Violence Against Women, 27*(15-16), 2910–2926. DOI: 10.1177/1077801220984174

Patton, M. Q. (2002). Two decades of developments in qualitative inquiry: A personal, experiential perspective. *Qualitative social work, 1*(3), 261-283. https://doi.org/10.1177/1473325002001003636

Payne, G., & Williams, M. (2005). Generalization in qualitative research. *Sociology, 39*(2), 295-314. https://doi.org/10.1177/0038038505050540

Polit, D. F., & Beck, C. T. (2012). *Nursing research: Generating and assessing evidence for nursing practice*. Lippincott Williams & Wilkins.

Polomeno, V. (2000). The Polomeno family-intervention framework for perinatal education: Preparing couples for the transition to parenthood. *Journal of Perinatal Education, 9*(1), 31–40. https://doi.org/10.1624/105812400X87482

Popay, J. (2006). Guidance on the Conduct of Narrative Synthesis in Systematic Reviews. *ESRC Methods Programme.* DOI:10.13140/2.1.1018.4643

Pulerwitz, J., Hughes, L., Mehta, M., Kidanu, A., Verani, F., & Tewolde, S. (2015). Changing gender norms and reducing intimate partner violence: results from a quasi-experimental intervention study with young men in Ethiopia. *American Journal of Public Health*, *105*(1), 132-137. https://doi.org/10.2105%2FAJPH.2014.302214

Quenby, S., Gallos, I. D., Dhillon-Smith, R. K., Podesek, M., Stephenson, M. D., Fisher, J., ... & Coomarasamy, A. (2021). Miscarriage matters: the epidemiological, physical, psychological, and economic costs of early pregnancy loss. *The Lancet*, *397*(10285), 1658-1667. https://doi.org/10.1016/s0140-6736(21)00682-6

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

Rahimi, S. (2024). Saturation in qualitative research: An evolutionary concept analysis. *International Journal of Nursing Studies Advances, 6*, 100174. https://doi.org/10.1016/j.ijnsa.2024.100174

Rai, A., Ravi, K., Shrestha, N., & Alvarez-Hernandez, L. R. (2023). Culturally responsive domestic violence interventions for immigrant communities in the United States: A scoping review. *Journal of Social Work in the Global Community*, *7*(1), 1. https://doi.org/10.5590/JSWGC.2023.8.1.01

Reese, E. M., Barlow, M. J., Dillon, M., Villalon, S., Barnes, M. D., & Crandall, A. (2022). Intergenerational transmission of trauma: the mediating effects of family

health. *International journal of environmental research and public health*, *19*(10), 5944. https://doi.org/10.3390/ijerph19105944

Reichel, D. (2017). Determinants of intimate partner violence in Europe: The role of socioeconomic status, inequality, and partner behaviour. *Journal of interpersonal violence*, *32*(12), 1853-1873. doi: 10.1177/0886260517698951.

Roberts, A. L., Gilman, S. E., Fitzmaurice, G., Decker, M. R., & Koenen, K. C. (2010). Witness of intimate partner violence in childhood and perpetration of intimate partner violence in adulthood. *Epidemiology*, *21*(6), 809-818. doi: 10.1097/EDE.0b013e3181f39f03

Rollero, C. (2020). The social dimensions of intimate partner violence: A qualitative study with male perpetrators. *Sexuality & Culture*, *24*(3), 749-763. https://link.springer.com/article/10.1007/s12119-019-09661-z

Rutledge, P. B., & Hogg, J. L. C. (2020). In-Depth Interviews. *The International Encyclopedia of Media Psychology*, 1-7. https://doi.org/10.1002/9781119011071.iemp0019

Sabri, B., Lee, J., & Saha, J. (2022). Conducting intervention research with immigrant survivors of intimate partner violence: Barriers and facilitators of recruitment and retention. *Journal of interpersonal violence*, *37*(19-20), NP18060-NP18084. https://doi.org/10.1177/08862605211035866

Sabri, B., Tharmarajah, S., Njie-Carr, V. P., Messing, J. T., Loerzel, E., Arscott, J., & Campbell, J. C. (2022). Safety planning with marginalized survivors of intimate partner violence: Challenges of conducting safety planning intervention research with marginalized women. *Trauma, Violence, & Abuse*, *23*(5), 1728-1751. https://doi.org/10.1177/15248380211013136

Salma, J., & Giri, D. (2021). Engaging immigrant and racialized communities in community-based participatory research during the COVID-19 pandemic: Challenges and opportunities. *International Journal of Qualitative Methods, 20*. https://doi.org/10.1177/16094069211036293

Saltzman, L. E., Johnson, C. H., Gilbert, B. C., & Goodwin, M. M. (2003). Physical abuse around the time of pregnancy: an examination of prevalence and risk factors in 16 states. *Maternal and child health journal, 7*(1), 31-43. doi: 10.1023/a:1022589501039.

Sanchez, E., Patel, A., & Crowley, L. (2022). "I don't want to worry them": Emotional suppression and protective silence in Latina mothers during the perinatal period. *Social Science & Medicine, 312*, 115345. https://doi.org/10.1016/j.socscimed.2022.115345

SAPACP. (2025). *The sexual Assault and Partner Abuse Care Program.* https://www.ottawahospital.on.ca/en/clinical-services/deptpgrmcs/programs/sexual-assault-and-partner-abuse-care-program/

Saskatchewan Polytechnic. (n.d.). *Registered Nursing Bridging Program for Internationally Educated Nurses.*https://saskpolytech.ca/programs-and-courses/programs/Registered-Nursing-Bridging-Program-for-Internationally-Educated-Nurses.aspx

Sattarzadeh, S. D. (2022). Resilience: Reimagining resilience (and ourselves). *Journal of Critical Thought and Praxis*, *11*(3). https://doi.org/10.31274/jctp.13026

Saunders, B., Sim, J., Kingstone, T., Baker, S., Waterfield, J., Bartlam, B., … & Jinks, C. (2018). Saturation in qualitative research: Exploring its conceptualization and operationalization. *Quality & Quantity, 52*, 1893–1907. doi: 10.1007/s11135-017-0574-8

Scharpf, F., Paulus, M., Christner, N., Beerbaum, L., Kammermeier, M., & Hecker, T. (2023). Intergenerational transmission of mental health risk in refugee families: The role of

maternal psychopathology and emotional availability. *Development and Psychopathology, 36*(4), 1582–1595. https://doi.org/10.1017/S0954579423000846

Scott-Storey, K., O'Donnell, S., Ford-Gilboe, M., Varcoe, C., Wathen, N., Malcolm, J., & Vincent, C. (2023). What about the men? a critical review of men's experiences of intimate partner violence. *Trauma, Violence, & Abuse*, *24*(2), 858-872. https://doi.org/10.1177/15248380211043827

Selwyn, C. N., Moore, L. P., Thomas, R., & Mosley, B. D. (2024). Virtual simulation-based educational training enhances nursing students' preparedness to conduct perinatal intimate partner violence screenings. *Clinical Simulation in Nursing*, *97*, 101635. http://dx.doi.org/10.1016/j.ecns.2024.101635

Shalabi, M., Adel, M., Yoon, E., Aziz, K., Lee, S., Shah, P. S., & Canadian Neonatal Network. (2015). Risk of infection using peripherally inserted central and umbilical catheters in preterm neonates. *Pediatrics, 136*(6), 1073-1079. https://doi.org/10.1542/peds.2015-2710

Sharma, P., Sen, M. S., Sinha, U. K., & Kumar, D. (2024). Childhood Trauma, Emotional Regulation, Alexithymia, and Psychological Symptoms Among Adolescents: A Mediational Analysis. *Indian Journal of Psychological Medicine*, 02537176241258251.

Shenton, A. K. (2004). Strategies for ensuring trustworthiness in qualitative research projects. *Education for information, 22*(2), 63-75. http://dx.doi.org/10.3233/EFI-2004-22201

Shishehgar, S., Gholizadeh, L., DiGiacomo, M., & Davidson, P. M. (2024). Asylum-seeker women: coping strategies and mental wellbeing. *International Journal of Social Psychiatry, 71*(2), 307–314. https://doi.org/10.1177/00207640241291498

Showalter, K., & McCloskey, R. J. (2021). A qualitative study of intimate partner violence and employment instability. *Journal of interpersonal violence*, *36*(23-24), NP12730-NP12755.

Sieber, J. E. (1992). *Planning ethically responsible research*. Sage Publications.

Srivastava, P. (2006). Reconciling multiple researcher positionalities and languages in international research. *Research in Comparative and International Education, 1*(3), 210. http://doi.org/10.2304/rcie.2006.1.3.210

Stake, R. (1995). *The art of case study research*. Thousand Oaks, California: Sage Publications Inc.

Statistics Canada. (2023). *Women and Girls.* https://www150.statcan.gc.ca/n1/pub/12-581-x/2023001/sec7-eng.htm

Statistics Canada. (2022). *Annual Demographic Estimates: Canada Provinces and Territories.* https://www.canada.ca/en/immigration-refugees-citizenship/corporate/transparency/committees/cimm-nov-07-2023/immigration-levels-plan-2024-2026.html

Statistics Canada. (2021). *Labour force status by immigrant status and sex, age group 25-54 years, Canada, 2021 Census (Table 98-10-0446-01).* Government of Canada. Retrieved from https://www150.statcan.gc.ca/t1/tbl1/en/tv.action?pid=9810044601.

Statistics Canada. (2020). *Table 10: Top challenges facing clients of residential facilities for victims of abuse, by type of facility and region,* 2020/2021. https://www150.statcan.gc.ca/n1/pub/85-002-x/2022001/article/00006/tbl/tbl10-eng.htm

Statistics Canada. (2017). *Intimate Partner Violence.* https://www.justice.gc.ca/eng/rp-pr/jr/jf-pf/2017/may01.html

Stark, E. (2013) Coercive control. In: Lombard N, McMillan L (eds) *Violence Against Women: Current Theory and Practice in Domestic Abuse, Sexual Violence and Exploitation*. London: Jessica Kingsley.

Stewart, D. E., & Cecutti, A. (1993). Physical abuse in pregnancy. *CMAJ: Canadian Medical Association Journal*, *149*(9), 1257-1263. DOI:10.1097/00006254-199407000-00007

Stewart, D. E., Gagnon, A. J., Merry, L. A., & Dennis, C. L. (2012). Risk factors and health profiles of recent migrant women who experienced violence associated with pregnancy. *Journal of Women's Health*, *21*(10), 1100-1106. doi: 10.1089/jwh.2011.3415

Stewart, D. E., MacMillan, H., & Wathen, N. (2013). Intimate partner violence. *The Canadian Journal of Psychiatry*, *58*(6), E1-E15. https://doi.org/10.1177/070674371305800601

Sumner, L. A., Valentine, J., Eisenman, D., Ahmed, S., Myers, H., Wyatt, G., ... & Rodriguez, M. A. (2011). The influence of prenatal trauma, stress, social support, and years of residency in the US on postpartum maternal health status among low-income Latinas. *Maternal and child health journal*, *15*(7), 1046-1054. https://psycnet.apa.org/doi/10.1007/s10995-010-0649-9

Squires, A. (2009). Methodological challenges in cross-language qualitative research: A research review. *International Journal of Nursing Studies, 46*(2), 277–287. https://doi.org/10.1016/j.ijnurstu.2008.08.006

Tabibi, J., Ahmad, S., Baker, L., & Lalonde, D. (2018). Intimate partner violence against immigrant and refugee women. *Learning Network,* 26.

https://www.gbvlearningnetwork.ca/our-work/issuebased_newsletters/issue-26/Issue_26.pdf

Taft, C. T., & Campbell, J. C. (2024). Promoting the use of evidence-based practice for those who engage in intimate partner violence. *American Journal of Preventive Medicine, 66*(1), 189–192. https://doi.org/10.1016/j.amepre.2023.08.017

Taillieu, T. L., & Brownridge, D. A. (2010). Violence against pregnant women: Prevalence, patterns, risk factors, theories, and directions for future research. *Aggression and Violent Behaviour, 15(1*), 14-35. https://psycnet.apa.org/doi/10.1016/j.avb.2009.07.013

Tarzia, L., Douglas, H., & Sheeran, N. (2022). Reproductive coercion and abuse against women from minority ethnic backgrounds: views of service providers in Australia. Culture, Health & Sexuality, *24*(4), 466-481. DOI: 10.1080/13691058.2020.1859617

Tastsoglou, E., & Hudon, T. (2024). The continuum of gender-based violence experienced by migrant and refugee women in Canada: Perspectives from key informants. *Frontiers in Sociology, 5*, Article 1420124. https://doi.org/10.3389/fsoc.2024.1420124 frontiersin.org+2

Tavrow, P., Paulus, K., Huynh, D., Yoo, C., Liang, D., Pathomrit, W., & Withers, M. (2023). Psychosocial barriers to, and enablers of, intimate partner violence disclosure among Asian-American immigrant women. *Culture, Health & Sexuality*, *25*(12), 1659-1674. DOI: 10.1080/13691058.2023.2175910

Thomas, E., & Magilvy, J. K. (2011). Qualitative rigor or research validity in qualitative research. *Journal for specialists in pediatric nursing*, *16*(2), 151–155. DOI: 10.1111/j.1744-6155.2011.00283.x

Tomm-Bonde, L. (2012). The naïve nurse: revisiting vulnerability for nursing. BMC nursing, *11*(1), 1-7. https://doi.org/10.1186/1472-6955-11-5

Tran, T. D., Nguyen, H., & Fisher, J. (2016). Attitudes towards intimate partner violence against women among women and men in 39 low- and middle-income countries. *PLOS ONE, 11*(11), e0167438. https://doi.org/10.1371/journal.pone.0167438

Tri-Council policy statement. (2010). *The Consent Process.* Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans – TCPS 2 (2018) (ethics.gc.ca)

Truong M., Sharif M., Olsen A., Pasalich D., Calabria B., Priest N. (2022). Attitudes and beliefs about family and domestic violence in faith-based communities: An exploratory qualitative study. *Australian Journal of Social Issues, 57*(4), 880–897. https://doi.org/10.1002/ajs4.210

University of British Columbia. (2023). *Interprofessional education at UBC*. Retrieved from https://health.ubc.ca/education/resources/interprofessional-education-collaborative-practice-frameworks

Urquia, M. L., O'Campo, P. J., Heaman, M. I., Janssen, P. A., & Thiessen, K. R. (2011). Experiences of violence before and during pregnancy and adverse pregnancy outcomes: an analysis of the Canadian Maternity Experiences Survey. *BMC pregnancy and childbirth, 11*(1), 1-9. https://doi.org/10.1186/1471-2393-11-42

Usher, K., Jackson, D., Fatema, S. R., & Jones, R. (2023). Domestic violence against women has increased during the COVID-19 pandemic: A perspective paper about the need for change to current and future practice. *International Journal of Mental Health Nursing*, *32*(5), 1439-1445. https://doi.org/10.1111/inm.13200

Valsecchi, G., Iacoviello, V., Berent, J., Borinca, I., & Falomir-Pichastor, J. M. (2023). Men's gender norms and gender-hierarchy-legitimizing ideologies: The effect of priming traditional masculinity versus a feminization of men's norms. *Gender issues*, *40*(2), 145-167. https://doi.org/10.1007/s12147-022-09308-8

Van Den Muijsenbergh, M., Teunissen, E., van Weel-Baumgarten, E., & van Weel, C. (2016). Giving voice to the voiceless: How to involve vulnerable migrants in healthcare research. *British Journal of General Practice, 66*(647), 284–285. https://doi.org/10.3399/bjgp16X685321

Van Wynsberghe, R., & Khan, S. (2007). Redefining case study. *International journal of qualitative methods, 6*(2), 80-94. https://doi.org/10.1177/160940690700600208

Varpio, L., Ajjawi, R., Monrouxe, L. V., O'Brien, B. C., & Rees, C. E. (2017). Shedding the cobra effect: Problematising thematic emergence, triangulation, saturation, and member checking. *Medical Education, 51*(1), 40–40. https://doi.org/10.1111/medu.13124

Yin, R. K. (2009). *Case study research: Design and methods*. Sage.

Walby, S., & Towers, J. (2018). Untangling the concept of coercive control: Theorizing domestic violent crime. *Criminology & criminal justice*, *18*(1), 7-28. https://doi.org/10.1177/1748895817743541

Watson, J. (1985). *The philosophy and science of caring*. University Press of Colorado.

Weitzman, A. (2018). Does increasing women's education reduce their risk of intimate partner violence? Evidence from an education policy reform. *Criminology, 56*(3), 574-607. doi: 10.1371/journal.pone.0085084

Welch, M. (1999). Critical theory and feminist critique. Perspectives on philosophy of science in nursing. *An Historical and Contemporary Anthology, 1*(1), 355-358. http://dx.doi.org/10.1046/j.1466-769X.2000.0072a.x

Weller, S. C., Vickers, B., Bernard, H. R., Blackburn, A. M., Borgatti, S., Gravlee, C. C., & Johnson, J. C. (2018). Open-ended interview questions and saturation. *PloS one*, *13*(6), e0198606. https://doi.org/10.1371/journal.pone.0198606

Wengraf, T. (2011). *Qualitative research interviewing: Biographic narrative and semi-structured methods*. Sage.

Williams, G. B., & Brackley, M. H. (2009). Intimate partner violence, pregnancy and the decision for abortion. *Issues in Mental Health Nursing, 30*(4), 272-278. DOI: 10.1080/01612840802710902

Williams, D. R., Lawrence, J. A., & Davis, B. A. (2022). The intergenerational impact of structural racism and cumulative trauma on depression. *American Journal of Psychiatry, 179*(9), 703–713. https://doi.org/10.1176/appi.ajp.21101000

Wilson, S. (2001). What is an Indigenous research methodology?. *Canadian Journal of Native Education, 25*(2), 175-179. https://www.researchgate.net/publication/234754037

WOCRC.(2025). Gender Based Violence. https://wocrc.ca/programs/violence-against-women/

World Health Organization. (2013). *Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence*. World Health Organization. https://www.who.int/publications/i/item/9789241564625

World Health Organization. (2020). *COVID-19 and violence against women: What the health sector/system can do.* https://extranet.who.int/iris/restricted/handle/10665/331699.

World Health Organization. (2021). *Violence against women prevalence estimates, 2018: global, regional and national prevalence estimates for intimate partner violence against women and global and regional prevalence estimates for non-partner sexual violence against women*. https://www.who.int/news-room/fact-sheets/detail/violence-against-women

World Health Organization. (2024). *Understanding and addressing intimate partner violence against women.* World Health Organization. https://www.who.int/news-room/fact-sheets/detail/violence-against-women

Zabelski, S., Cascalheira, C. J., Shaw, T. J., Helminen, E. C., Messinger, A. M., Edwards, K. M., & Scheer, J. R. (2024). Community-based participatory research with sexual and gender minority trauma survivors: Challenges, solutions, and recommendations for future research. *Journal of Interpersonal Violence*. 40(13-14):3068-3084. https://doi.org/10.1177/08862605241265441

Zero, O., Tobin-Tyler, E., & Goldman, R. E. (2023). Barriers to disclosure of intimate partner violence among undocumented Spanish-speaking immigrants in the United States. *Violence against women*, *29*(15-16), 3182-3201. https://doi.org/10.1177/10778012231196055

Zordan, R., Lethborg, C., Forster, J., Mason, T., Walker, V., McBrearty, K., & Torcasio, C. (2022). Development, implementation, and evaluation of a trauma-informed simulation-based training program for graduate nurses: A single arm feasibility and pilot study. *Nurse Education Today, 117,* 105460. https://doi.org/10.1016/j.nedt.2022.105460

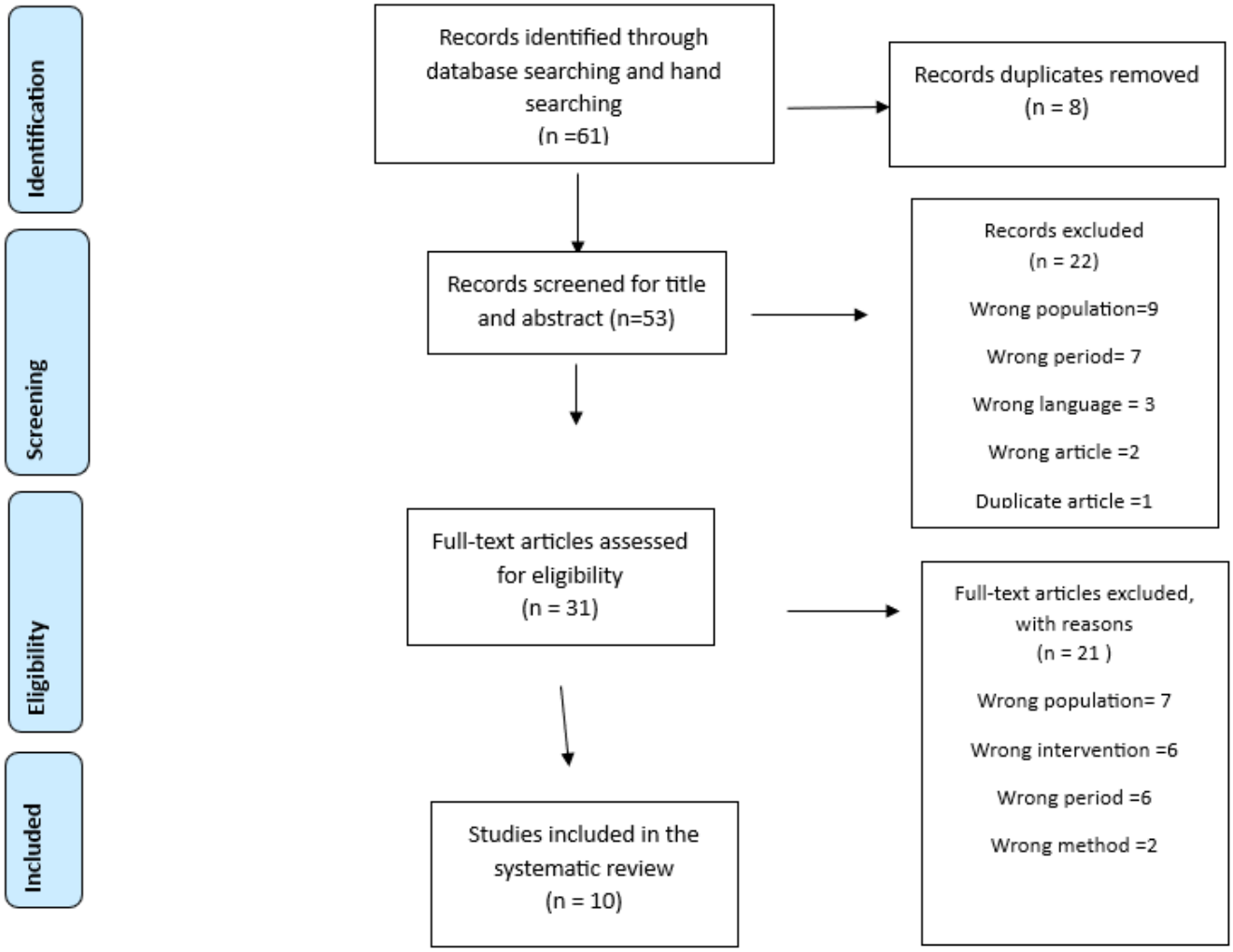
Appendix A: Search Terms for Scoping Review

Category	Search terms
Phenomena	#1. Intimate partner violence "Intimate partner violence" OR "IPV" OR "intimate partner abuse" OR "intimate violence" OR "partner violence" OR "partner abuse" OR "domestic abuse" OR "domestic violence" OR "wife abuse" OR "abuse of wife" OR "couple violence" OR "marital violence" OR "intimate aggression" OR "dating violence" OR "family violence" OR "physical violence" OR "physical abuse" OR " gender violence" OR "gender based violence" OR "gender and sexual violence" OR "sexual assault" OR "sexual abuse" OR "emotional violence" "emotional abuse" OR "abused women" OR "women abuse" OR "battered wom*n" OR "physiological abuse" OR "physiological violence" OR "sexual and gender based violence" OR "wife beating" OR "spouse abuse" OR "dating violence" OR "GBV" OR "VAW" OR "sexual violence" OR "relationship violence"
Population	#2. Population "Middle Eastern immigrant wom*n" OR "Middle Eastern migrant wom*n" "Refugees" "internally displaced Middle Eastern wom*n" OR "Middle Eastern displace wom*n" OR "IDP" OR "war affected Middle Eastern wom*n" OR "conflict affected Middle Eastern wom*n" OR "Middle Eastern Asylum seekers" OR Bahrain, Egypt, Iran, Iraq, Jordan, Kuwait, Lebanon, Oman, Palestine, Qatar, Saudi Arabia, Syria, Turkey, United Arab Emirates, and Yemen
#3	#1 AND #2
#4. Specific period	"perinatal period" OR " pregnancy" OR "after pregnancy" OR "postpartum" OR "before pregnancy" OR "postnatal" OR "prenatal" OR "antenatal" OR "maternal" or "pregnant"
#5	# 3 AND # 4

Appendix B: Inclusion and Exclusion Criteria for Scoping Review

Criteria	Inclusion criteria	Exclusion criteria
Publication date	Published between 2000 and 2022 for all Canadian and international literature	Published before 2000
Language	Study is published in English	Study is published in languages other than English
Document Type/Study Design	Primary studies	Does not meet document type/study design criteria
Methodology	Quantitative, qualitative, and mixed methods	Reviews
Country	The scoping review will capture all Canadian-based as well as a broader international literature	No country will be excluded
Population	Middle Eastern immigrant women including IDP and refugees	Other immigrant women or non-immigrant women
IPV	All types of IPV	Any other gender-based violence such as human trafficking or underage marriage

Appendix C: PRISMA Diagram



Appendix D: Informed Consent Form for Interview

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School of Nursing

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Ottawa ON K1H 8M5 Canada

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Study Title: Intimate Partner Violence (IPV) Experiences of Middle Eastern Immigrant Women Living during the Perinatal Period in Ottawa Capital Region

Researcher: Manal Fseifes IEN, Med, PhD(c), School of Nursing
Faculty of Health Sciences, University of Ottawa
Email:
Supervisor: Josephine Etowa, RN, PhD, School of Nursing
Faculty of Health Sciences, University of Ottawa
Email:
Phone:

Invitation to Participate: I am invited to participate in the IPV experiences of Middle Eastern Immigrant women research study conducted by Manal Fseifes and the thesis supervisor, Dr. Josephine Etowa.

Objectives: The main goal of this doctoral thesis project is to understand the intimate partner violence experiences among Middle Eastern women living during the perinatal period in Capital Ottawa Region.

Participation: I am aware that my participation in this project will consist of completing a demographic survey that will take approximately 10 minutes to complete, followed by a face-to-face interview which will last approximately for 1 hour. I will also be asked to provide contact information, if I agree to be contacted in the future for potential follow-up questions related to this study or to participate in a focus group for two hours discussion to validate the preliminary results of the study. During the interview the researcher will ask me questions and invite me to share my perspectives pertaining my experiences of intimate partner violence. The interview will be scheduled face to face at a convenient time and safe space in the organization in which recruitment took place. I am aware that the interview will be audio- recorded, and the recording will be transcribed and that notes may be taken during the interview to document non-verbal communications such as facial expressions.

Risks:

There is a risk of emotional stress. I am aware that there is free psychological counseling, which is available in Ontario at ConnexOntario. Toll-free by phone: 1-866-531-2600, Online web chat: https://1576prairiefyre.cloudcollaboration.ca/ccmwa/chat/a91000d1-9584-466b-bb4f-6b039b802173?client=99_238_242_204. A list of psychological resources is available for me and attached to this consent form.

Benefits

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This study will give me the opportunity to share my experiences related to intimate partner violence. My perspectives may provide insight about the risk factors of IPV, and this will help in understating the IPV in Middle Eastern communities.

Confidentiality

I am aware that Manal Fseifes and Dr. Josephine Etowa will be the only people with access to the personal information I provide. This information will be kept in a secure location and will not be disclosed to anyone, nor will my name or any personal identifiers be used on study materials.

Once I agree to participate in this study, researchers will protect my anonymity by using a code name in all written information. Records of my interview will be identified only by this research code; my real name will not be connected to them in any way. I also understand that my responses to the interview questions will not be connected to my identity in any way. However, I understand that the researcher is mandated by law to report abuse or child mistreatment, elder abuse or intent to cause harm to self or others to authorities.

Any information collected during the whole study will be maintained on a confidential basis and access will be restricted to the study supervisor and student researcher. This information will be kept in a secure location in a locked cupboard in the supervisor room and my personal identifiers will not be disclosed, nor will details of my answers be given to anyone. As soon as I give consent to participate in the study, the researchers will protect my anonymity by using a code name that I choose in all written information. The socio-demographic form and the records of my interview will be identified only by this code: my real name will not be used in any material.

I am aware that everyone who has access to the raw data will be asked to sign a confidentiality agreement. In any reports coming from this research all information that could be used to identify me, will be substituted with code names. The results of this study may be described in oral and written presentations and may be published in professional journals. However, at all times the results will be presented in a combined group format only and no personal identifiers will be used.

Conservation of Data:

I am aware that Data collected will be kept in a locked filing cabinet in Professor Etowa's secured office at the University of Ottawa. The research team will store the consent form and my contact information in a separate folder from research data. The audio recordings of the interview will be downloaded onto a password-protected computer and be transcribed into written texts as a password protected document. Once the transcription is

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completed, the research team will store the files on password-protected computers. These computers will be stored in a locked filing cabinet in a secured office. Only the research team will have access to this office. All audio files will be destroyed post transcription. Interview transcripts and notes will be destroyed 5 years after the study has been completed.

Compensation:

Once the researchers receive my consent to participate in the interview, I will receive an $ 20 Walmart gift card. If I choose to withdraw from the study, I will still receive this compensation.

Voluntary Participation:

I am under no obligation to participate and if I choose to participate, I can withdraw from the study at any time and/or refuse to answer any questions, without suffering any negative consequences. I understand that due to the anonymous nature of the surveys (i.e., I will not provide my name), if I request my individual information to be removed, I will need to provide the research team with my code name that I chose on this consent form.

It is also clear that I can withdraw from the research at anytime, without having to justify why I chose to do so. The content of my interview will be destroyed (transcriptions will be shredded and audio-files destroyed) if I choose to withdraw from the study and the information I provided will not be used in the analysis. I am able to withdraw my data at any time, even after publication of the results (thesis). If the request is made after publications, my raw data will be destroyed to prevent their use for other projects.

Ethics:

If I have any questions regarding the ethical conduct of this study, I may contact the Office of Research Ethics and Integrity via email (ethics@uottawa.ca) or telephone (613-562-5387). It is recommended that I keep a copy of this consent form for my records.

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. Consent Form Signature Page

- I have reviewed all of the information in this consent form related to the study called

Intimate Partner Violence (IPV) Experiences of Middle Eastern Immigrant Women Living during the Perinatal Period in Ottawa Capital Region

I have been given the opportunity to discuss this study. All of my questions have been answered to my satisfaction.

This signature on this consent form means that I agree to take part in this study. I understand that I am free to withdraw at any time without affecting the services that I am receiving from the organization.

- ☐ I agree to audio recordings as described in this consent form.
- ☐ I do not agree to audio recordings as described in this consent form.

_____ _____/ _____/ ____

Signature of Participant Name (Printed) Year Month Day

_____ _____ _____/ _____/ ____Signature of Investigator Name (Printed) Year Month Day

I will be given a signed copy of this consent form.

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Appendix E: Informed Consent Form for Focus Group Discussion

(Member Checking Activity)

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University of Ottawa
Faculty of Health Sciences
School of Nursing

Study Title: Intimate Partner Violence (IPV) Experiences of Middle Eastern Immigrant Women Living during the Perinatal Period in Ottawa Capital Region

Researcher: Manal Fseifes IEN, Med, PhD(c), School of Nursing
Faculty of Health Sciences, University of Ottawa
Email:
Supervisor: Josephine Etowa, RN, PhD, School of Nursing
Faculty of Health Sciences, University of Ottawa
Email:

Invitation to Participate: I am invited to participate in the IPV experiences of Middle Eastern Immigrant women doctoral thesis project conducted by Manal Fseifes and the thesis supervisor, Dr. Josephine Etowa.

Objectives: The main goal of this project is to understand the intimate partner violence experiences among Middle Eastern women living during the perinatal period in Capital Ottawa Region.

Participation: I am aware that I will only participate in a focus group. Participation will consist of joining a focus group discussion which will last approximately for 90 to 120 minutes at safe place. I will also be asked to provide contact information, if I agree to be contacted in the future for potential follow-up questions related to the study. During the focus group the researcher will present the initial results of a study and ask me questions and invite me to share my perspectives and experiences of intimate partner violence in order to confirm these results. The focus group will be scheduled face to face at a convenient time and safe space in the organization in which recruitment took place. I am aware that the focus group will be audio-recorded, and the recording will be transcribed and that notes may be taken during the focus group to document non-verbal communications such as facial expressions.

Risks: I understand that there is a risk of emotional stress that I may experience. I am aware that there is free psychological counseling, which is available in Ontario at ConnexOntario. Toll-free by phone: 1-866-531-2600, Online web chat: https://1576prairiefyre.cloudcollaboration.ca/ccmwa/chat/a91000d1-9584466b-bb4f-6b039b802173?client=99_238_242_204. A list of psychological resources is available for me and it is attached to this consent form.

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Benefits

This study will give me the opportunity to share my experiences related to intimate partner violence. My perspectives may contribute to understand the risk factors of IPV.

Voluntary Participation:

I am under no obligation to participate and if I choose to participate, I can withdraw from the study at any time and/or refuse to answer any questions, without suffering any negative consequences. It is also clear that I can withdraw from the research at anytime, without having to justify why I chose to do so. The content of my participation will be destroyed (transcriptions will be shredded and audio-files destroyed) if I choose to withdraw from the study and the information I provided will not be used in the analysis. I am able to withdraw my data at any time, even after publication of the results (thesis). If the request is made after publications, my raw data will be destroyed to prevent their use for other projects.

Confidentiality

I am aware that Manal Fseifes and Dr. Josephine Etowa will be the only people with an access to the personal information I provide. This information will be kept in a secure location and will not be disclosed to anyone. My name or any personal identifiers will not be used in the study materials. I also understand that my responses to the focus group questions will not be connected to my identity in any way. However, I understand that the researcher is mandated by law to report abuse or child mistreatment, elder abuse or intent to cause harm to self or others to authorities.

I understand that Focus group members should keep the information provided in the group confidential and that we are not allowed to share the information with to with others. I understand that I need to respect the anonymity of other participants and the confidentiality of the information they share in the group.

Any information collected during the whole study will be maintained on a confidential basis and access to these information will be restricted to the study supervisor and student researcher. This information will be kept in a secure location in a locked cupboard in the supervisor room and my personal identifiers will not be disclosed, nor will details of my answers be given to anyone. As soon as I give consent to participate in the study, the researchers will protect my anonymity by using a code name that I choose in all written information. The records of my participation in the focus group will be identified only by this code and my real name will not be used in any material.

I am aware that everyone who has access to the raw data will be asked to sign a confidentiality agreement. In any reports coming from this research all information that could be used to identify me, will be substituted with code names. The results of this study may be described in oral and written

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presentations and may be published in professional journals. However, at all times the results will be presented in a combined group format only and no personal identifiers will be used.

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Limits of confidentiality:

I understand that since *the focus group discussion meeting involves several participants, confidentiality cannot be absolutely guaranteed. Confidentiality is kept only when all persons keep everything that is shared in focus group confidential and not share any information with anyone outside of the group discussion. To protect my confidentiality, I need to think through and decide what I will and will not share in a group setting. I may also use a madeup name while taking part in the focus group discussion meeting to enhance my privacy. I understand that I need to protect the confidentiality of others by not sharing any information that was disclosed in the focus group discussion.*

I also understand that the researcher has an obligation to report any *child or elder abuse, and if ones life or someone else's life is in danger.*

Conservation of Data:

I am aware that data collected will be kept in a locked filing cabinet in Professor Etowa's secured office at the University of Ottawa. Research team will store the consent form and my contact information in a separate folder from research data. The digital recordings of the focus group discussion will be downloaded onto a password-protected computer and be transcribed into written texts as a password protected document. Once the transcription is completed, they will store the files on password-protected computers. These computers will be stored in a locked filing cabinet in a secured office. Only the research team will have access to this office. All audio files will be destroyed post transcription. Focus group transcripts and notes will be destroyed 5 years after the study has been completed.

Compensation:

Once the researchers receive my consent to participate in the focus group, I will receive an $ 20 Walmart gift card. If I choose to withdraw from the study, I will still receive this compensation.

Ethics:

If I have any questions regarding the ethical conduct of this study, I may contact the Ethics Office: Tabaret Hall, 550 Cumberland Street,
Room 154, Ottawa, Ontario, Canada K1N 6N5
613-562-5387 or ethics@uottawa.ca

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○ I have reviewed all of the information in this consent form related to the study called

Intimate Partner Violence (IPV) Experiences of Middle Eastern Immigrant Women Living during the Perinatal Period in Ottawa Capital Region

I have been given the opportunity to discuss this study. All of my questions have been answered to my satisfaction.

This signature on this consent form means that I agree to take part in this study. I understand that I am free to withdraw at any time without affecting the services that I am receiving from the organization.

□ I agree to audio recordings as described in this consent form.

□ I agree to keep everything discussed in this group strictly confidential.

_____ _____ _____/ _____/ _____

Signature of Participant Name (Printed) Year Month Day

_____ _____ _____/ _____/ _____

Signature of Investigator Name (Printed) Year Month Day

I will be given a signed copy of this consent form.

List of Professional Psychological Resources

1. Counselling Services https://www.counsellingconnect.org/

2. Psychological Services-Montfort Hospital **call** 613-746-4621

3. Distress Centre's crisis line (24 hours/day): -**call** 613-238-3311

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613 562-5443

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Faculty of Health
Sciences

School of Nursing

4. Eastern Ottawa resources center Helpline for abused women (24 hours/day): - call 613-745-4818

5. Unsafe at Home Service for Women Experience Violence (24 hours/day): - **text** 613-704-5535 or **Chat** unsafeathomeottawa.ca

6. Mental Health Crisis Line (24 hours/day): -Telephone: 613-722-6914 or 1-866-996-0991 (Toll Free) -By email at: info@crisisline.ca

7. Ontario Mental Health Hotline: -By telephone: 1-866-531-2600 -By chatting: http://livechat.connexontario.ca/ECCChat/MHHchat.html

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Appendix F: Participants' Information Sheet for Interview

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School of Nursing

Appendix F: Participant Information sheet for the interview

Study Title: Intimate Partner Violence (IPV) Experiences of Middle Eastern Immigrant Women Living during the Perinatal Period in Ottawa Capital Region

This letter of information provides details on the aforementioned study.

Participant information leaflet

You are invited to take part in our research study by filling a demographic form as well as participating an in-depth interview. Please find the details on this project below.

Researcher: Manal Fseifes IEN, Med, PhD(c), School of Nursing

Faculty of Health Sciences, University of Ottawa

Email:

Supervisor: Josephine Etowa, RN, PhD, School of Nursing

Faculty of Health Sciences, University of Ottawa

Email:

Introduction

Before you decide, we would like you to understand why the research is being done and what it would involve. Please take the time to read it carefully and discuss it with others or your caseworker if you wish. The researcher will go through it with you and answer any questions you might have. This will take about 10 minutes. Be sure to ask the researcher if anything is not clear or if you would like more information. Thank you for taking the time to read this information.

Purpose of the study

This is a study about intimate partner violence (IPV) among Middle Eastern immigrant women living during the perinatal period in Ottawa Capital Region. These women are at risk to IPV because they are exposed to multiple IPV risk factors at the same time. Therefore, I want to look at these risk factors. The perinatal period is defined as the period during ante, intra and post partum. It may begin one year before to two years after the birth of the child.

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Participation:

In order to participate in this project, the participant needs to identify themselves as a Middle Eastern woman. They also need to identify themselves as a woman who has come to Canada as an immigrant and who has experienced intimate partner violence during any stage of their life. In addition, the participant should be in her postnatal period up to one year of having the baby. Participation will consist of completing a socio-demographic form. The form consists of some questions about the age, marital status etc. and it may take 10 minutes to complete, followed by in-person interview which will last around one hour at safe space. The time of the interview will depend on your availability. If you agree, the interview will be audio recorded and transcribed by the researcher and it will be reviewed to confirm transcription accuracy. Notes will be taken during the interview to document non-verbal communications such as facial expressions.

Benefits

Throughout the interview I will ask you some questions. You may find these useful in helping you reflect on your experience. Within this supportive atmosphere, sharing your experience will empower you and aid in the healing process.

Participants that consent to participate in the interview, will receive a Walmart gift card of $20 as a thank you for taking part in the study and reimbursing for their time.

Voluntary Participation

All components of this study are completely voluntary. It is up to you to decide whether or not to participate in this research. If you do decide to participate you will be asked to give consent. You can withdraw from the study at anytime without any consequences.

Confidentiality

Any information collected during the whole study will be maintained on a confidential basis and access will be restricted to the study supervisor and student researcher.

The results of the study

The study's overall findings may be described in oral and written presentation and may published in a scientific journal, but these results will not mention you in any way and no personal identifiers will be used. These results will be used and incorporated into a student thesis.

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Risks:

There might be a risk of emotional stress as result of the participation However, a list of professional psychological resources will be provided after the interview.

Concerns or further information about the research

If you have a concern about any aspect of this study or need further information about the study, you should ask to speak to Manal Fseifes, who will do her best to answer your questions. Thank you for taking the time to read this information sheet and considering taking part.

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Appendix G: List of Professional Psychological Resources

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1. Counselling Services https://www.counsellingconnect.org/
2. Psychological Services-Montfort Hospital **call** 613-746-4621
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4. Eastern Ottawa resources center Helpline for abused women (24 hours/day): - **call** 613-745-4818
5. Unsafe at Home Service for Women Experience Violence (24 hours/day): - **text** 613-704-5535 or **Chat** unsafeathomeottawa.ca
6. Mental Health Crisis Line (24 hours/day): -Telephone: 613-722-6914 or 1-866-996-0991 (Toll Free) -By email at: info@crisisline.ca
7. Ontario Mental Health Hotline: -By telephone: 1-866-531-2600 -By chatting: http://livechat.connexontario.ca/ECCChat/MHHchat.html

Appendix H: Recruitment Poster

Collaborative Critical Research for Equity and Transformation in Health
CO-CREATH
Recherche collaborative critique pour l'équité et la transformation en santé

Study Title: Intimate partner violence (IPV) Experiences of Middle Eastern immigrant women living during the Perinatal Period in the Greater Ottawa Region

The above titled study aims to understand the IPV experiences of Middle Eastern immigrant women during the perinatal period to generate evidence to help health and social service providers to provide culturally responsive care to this population of women. Perinatal period is defined as the period during ante, intra and post-partum (i.e., before, during and after pregnancy).

- **Are you a Middle Eastern immigrant woman?**
- **Have you experienced violence from your partner during the perinatal period?**
- **Are you a postpartum woman up to one year from the birth of your baby (ies)?**

If so, we invite you to participate in our study to share your ***beliefs, life experiences, and real stories*** regarding your experience of intimate partner violence. Joining this study will involve taking part in a one-hour audio recorded interview.

Your participation in this study is entirely voluntary and private. Once the researchers receive your consent to participate in the interview, you will receive a $ 20 Walmart gift card as a thank you for taking part in the study. Participation will be first come, first served.

For more information about participation in this study, please contact:
Manal Fseifes M.Ed. PhD Student Researcher

(Supervisor: Josephine Etowa RN PhD)

Appendix I: Socio-Demographic Questionnaire

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Faculty of Health Sciences School of Nursing

Study Title: Intimate Partner Violence (IPV) Experiences of Middle Eastern Immigrant Women Living in Ottawa During the Perinatal Period

Please answer the questions by filling in the space provided or by selecting the answer as indicated.

Part 1:

	You	Husband/Partner
1) Age:	..... years old	..... years old
2) Ethnicity:	.....	.....
3) Religion:	.....	.....
4) Education level:	.....	.....
5) Occupation:	.....	.....
6) Monthly income:	.....	.....

7) Your Marital status: Married/ Divorced/ Widow/ Separated

If married, this is: First time/ Not the first time

Part 2:

1) How long have you been with this husband? ..... years

2) How long have you been in Canada? ..... years

3) Number of children do you have with this husband: ..... person(s)

4) How long have you been in this abusive relationship? ..... years

5) Number of family members living with you in this relationship: ..... person(s)

6) Have you had a previous relationship that included abuse during the perinatal period? Yes
No

Part 3:

What factors do you think that contribute to IPV problem during your perinatal period?

_____

_____

_____

_____

- Thank you for your co-operation-

Appendix J: In-Depth Interview Guide

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Faculty of Health Sciences School of Nursing

In-depth Interview (IDI) Guide

Study Title: Intimate partner violence (IPV) Experiences of Middle Eastern immigrant women(MEIW) living during the Perinatal Period in Ottawa

Date of interview: _____

Start time: _____

Finish time: _____

Interviewer: _____

This interview guide aims to guide the researcher when conducting the interviews with the participants. As a guide, it is not necessary to ask all the questions systematically. The responses of the participant will also guide the interview questions.

Introduction

My name is Manal Fseifes. I am an International Educated Nurse and a candidate in the PhD program at the School of Nursing of the University of Ottawa. I am conducting a research study on IPV among MEIW living in Ottawa during the perinatal period. Thank you for agreeing to join in this interview. Your experiences and feelings of IPV are significant for better understanding on how the various risk factors intersect to shape immigrant women's IPV experiences. I am mainly interested in hearing about your IPV experiences and beliefs that you had during your perinatal period. You are free to skip any question you do not want to answer. Information from this interview will be used ONLY for research purposes.

This is the second part of two parts for this research study. The first part involved completing a socio-economic questioner. This part is an individual interview, which will take about one hour your time. It will be audio-recorded. This study has received ethics approval from

the Research and Ethics Board of the University of Ottawa (Ethics Certificate). This interview guide is divided into six main parts: The first part is general information about you and your immigration process, the second part focuses on your experiences and definition of IPV, the third part on the help seeking behaviours, the fourth part on the associated risk factors of IPV during your perinatal period, and the fifth part will include questions about IPV impacts on abused women, the last section will be an opportunity to give any other feedback or comments you may have.

Before I begin the interview, I would like to remind you that your name and identity will remain confidential. Only me and my supervisor, Dr. Josephine Etowa will know your code used for your interview, socio demographic sheet and your phone number. Once I complete this interview, I will de-identify all audio recordings and transcriptions using the random identification code. However, some instances may require me to break confidentiality. The limits to confidentiality comprise any disclosure of (A) active threats to harm yourself or other people or (B) reports of current abuse toward a special population, such as individuals under the age of 18 or over the age of 65. In these cases, I have a legal obligation to break confidentiality and report to the appropriate venue (e.g., police, child and family services). Do you have any questions or concerns regarding the limits to confidentiality?

Part 1. General information

Before we talk about IPV, I hope to learn about your background and where you and your family come from.

1. Can you please tell me a bit about yourself?
2. Can you tell me about the relationship between you and your husband/ex-husband?
3. Tell me about your experiences living in Canada as an immigrant woman.

Part 2. Questions on women's understanding of IPV

I would like now to talk to you about your experiences with IPV.

1. How do you define relationship violence or intimate relationship violence?
2. Can you talk about any other exposure you have had to relationship violence? (Interpersonal Level)
    a. Witnessing? Experiencing child abuse?
3. Tell me about what you did to get help as it relates to your IPV experience.
4. Can you talk about your family's role in your IPV experience? (Microsystem level)
    a. Were you able to talk to them about it? How did they respond? b. Family dynamics?
5. How do you think your identity as an immigrant woman impacts your IPV experience? (Exosystem/Macrosystem)
    a. Cultural norms that put you at greater risk?
    b. Experiences of discrimination due to your racial/ethnic/ religious/ gender identity that altered your IPV experience?
    c. What about your decisions to seek help?

Part 3. Questions about help-seeking behaviour

1. Can you tell me about anything you found to keep you safe in your experience?
    a. Cultural norms? Family dynamics? Other factors?
2. What helped you during your IPV experience?
3. Where did you find your strength in the process?
4. What things did not help you?

Part 4. Questions about IPV causes and risk factors on abused women (if the answer is yes for any, a follow up question will be "can you elaborate why would you think that ….. was a risk factor for your experience of IPV?"

1. What do you think was the cause of your husband/ex-husband's violence toward you?
2. Do you think being immigrants increased the violence during the perinatal period?
3. Do you think being unable to speak English is a cause for IPV?
4. Do you think being isolated with no family in Canada increases the violence?
5. Do you think having a baby girl increases the violence?
6. Are you able to financially support yourself and your child/ren? If no, proceed to the next question
7. Do you think unemployment was a reason for the IPV?
8. Does your (ex) partner use alcohol or drugs or a combination of these?
9. Is your (ex) partner currently employed? If yes, for how long? If no, proceed to the next question
10. How long has your (ex) partner been unemployed?
11. Do you have family and/or friends who can provide support to you and your child/ren?
12. Has your current geographical living situation (in a new country) impacted your ability to access resources and/or seek safety measures for you and your child/ren? If yes, how?

Part 5. Questions about IPV impacts on abused women

1. What do you think have been the impacts of the abusive relationship on you during the perinatal period (pregnancy, childbirth, postpartum period, breastfeeding)?
2. What do you think have been the impacts of the abusive relationship on you during the perinatal period? On your fetus? On your baby/child?
3. What do you think have been the impacts of IPV on your children (if any)/ your extended family/ friends/ community at large?
4. How do you describe the effects of the abuse in terms of your physical health?
5. How do you describe your emotional state due to this abusive relationship?
6. What do you think is/was the impact of the abusive behaviour on your mental health?

Part 6. Credibility Questions for termination

1. I've finished asking the questions that I have, but I'm wondering if there is anything that I haven't asked that would seem important or would better help me understand your IPV experience?
2. How did you experience the interview?

   a. Do you have any suggestions for future interviews?
   b. Is there anything about me, or the way I asked questions that might have influenced the answers you gave?
3. After this interview did any new ideas come from this interview?

PART 7. Debriefing Questions

1. How are you feeling?
2. How did you find this process?
3. Do you feel safe to go at this point?
   a. If no, clarify with possible referral to community resources
   b. If yes, continue with the protocol
4. Do you have any other comments that you would like to add for this study?

8. Researcher closing statement

Thank you for your time, and it is an honour to have you as a participant in this study. Your contribution is very much appreciated.

Thank you.

Appendix K. Member Checking Guide

Faculté des sciences de la santé École des sciences infirmières

Faculty of Health Sciences School of Nursing

Study Title: Intimate Partner Violence Experiences of Middle Eastern Immigrant Women Living in Ottawa during the Perinatal Period

Hello, my name is Manal Fseifes, and I am a student in the doctorate nursing program at the School of Nursing at the Faculty of Health Sciences of the University of Ottawa. I have completed data collection for my study and analyzed your interview data. I would like to review these findings with you to ensure that they are accurate and fully reflect your experiences. This will give you the opportunity to correct me if I have misunderstood anything or if you would like to add any additional information that was not shared during the interview. If it is okay with you, I will be recording this meeting, and the recording will be transcribed. The purpose of recording and transcribing is so that we can have an attentive conversation. I assure you that all of your comments will remain confidential, and no identifiable information will be attached to the data. There are four questions, and you will have the opportunity to respond openly.

The procedure will start with me presenting the finding to you then I will ask you some questions.

1. After reviewing the findings, what are your general thoughts?
2. How accurately do you feel the findings captured your experiences and understanding of IPV?
3. What could be included in the findings to better reflect your experiences?
4. Is there anything you would like to remove from the findings, and if so, why?

That concludes our interview. Thank -you for participating in our study, your input greatly appreciated.

Appendix L: Participant Consent to be Contacted by the Research Team

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Faculty of Health Sciences School of Nursing

Study Title: Intimate Partner Violence Experiences of Middle Eastern Immigrant Women Living in Ottawa during the Perinatal Period.

I _____ hereby authorize Manal Fseifes, and the research team members to contact me through the information I provide below for the purposes of participating in other aspects of the study or in receiving study materials. I understand that my information will not be shared with other people.

I will receive a copy of this agreement for my records.

Contact details (phone #, email): _____

Best time for contact: daytime/evening_____

Signature: _____Name: _____

Date: _____

451 Smyth Rd

Ottawa (Ontario) K1H 8M5 Canada Ottawa.

Appendix M: Participant Information Sheet for Focus Group Discussion

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École des sciences infirmières

University of Ottawa
Faculty of Health Sciences
School of Nursing

Study Title: Intimate Partner Violence (IPV) Experiences of Middle Eastern Immigrant Women Living during the Perinatal Period in Ottawa Capital Region

This letter of information provides details on the aforementioned study.

Participant information leaflet

You are invited to take part in our research study by joining a focus group to discuss and validate the preliminary results that we collect from pervious interviews for this study. Please find the details on this project below.

Researcher: Manal Fseifes IEN, Med, PhD(c), School of Nursing
Faculty of Health Sciences, University of Ottawa
Email:
Supervisor: Josephine Etowa, RN, PhD, School of Nursing
Faculty of Health Sciences, University of Ottawa
Email:

Introduction

Before you decide, we would like you to understand why the research is being done and what it would involve. Please take the time to read it carefully and discuss it with others or your caseworker if you wish. The researcher will go through it with you and answer any questions you might have. This will take about 10 minutes. Thank you for taking the time to read this information.

Purpose of the study

This is a study about intimate partner violence (IPV) among Middle Eastern immigrant women living during the perinatal period in Ottawa Capital Region. These women are at risk to IPV more than other population because they are exposed to many IPV risk factors at the same time. Therefore, I want to look at these risk factors and try to find possible interventions. The perinatal period may begin one year before the pregnancy to two years after the birth of a child.

Participation

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In order to participate in this project, the participant needs to identify themselves as a Middle Eastern woman. They also need to identify themselves as a woman who has come to Canada as an immigrant and who has experienced intimate partner violence during any stage of their life. The participation consist of joining a focus group discussion for 90 to 120 minutes at a safe place. The time of the Focus group will be on **day/month/year at 00:00 in avenue**. The focus group will be audio recorded and transcribed by the researcher and it will be reviewed to confirm transcription accuracy. Notes will be taken during the focus group to document non-verbal communications such as facial expressions.

Benefits

Throughout the focus group, I will ask some questions regard the results of our study. You may find these useful in helping you reflect on your experience. Within this supportive atmosphere, sharing your experience and perspectives will empower you and increase your awareness of IPV. By participating in this study, you are contributing to finding suitable interventions to help society as a whole in minimizing the impact of IPV among Middle Eastern immigrant women.

Participants that consent to participate in the focus group discussion will receive a Walmart gift card of $20 as a thank you for taking part in the study.

Voluntary Participation

All components of this study are completely voluntary. If you do decide to participate you will be asked to give consent. You can withdraw from the study at anytime.

Confidentiality

Any information collected during the whole study will be maintained on a confidential basis and access will be restricted to the study supervisor and student researcher. The participants in the focus group will be asked to respect the anonymity of other participants and the confidentiality of the information they share in the group.

The results of the study

The study's overall findings may be described in oral and written presentation and may published in a scientific journal, but these results will not mention you in any way and no personal identifiers will be used. These results will be used and incorporated into a student thesis.

Risks:

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There might be a risk of emotional stress as result of the participation However, a list of professional psychological resources will be provided after the focus group.

Concerns or further information about the research

If you have a concern about any aspect of this study or need any further information about the study, you should speak to Manal Fseifes, who will do her best to answer your questions.

Thank you for taking the time to read this information sheet and considering taking part.

Voluntary Participation

All components of this study are completely voluntary. If you do decide to participate you will be asked to give consent. You can withdraw from the study at anytime.

Confidentiality

Any information collected during the whole study will be maintained on a confidential basis and access will be restricted to the study supervisor and student researcher. The participants in the focus group will be asked to respect the anonymity of other participants and the confidentiality of the information they share in the group.

The results of the study

The study's overall findings may be described in oral and written presentation and may published in a scientific journal, but these results will not mention you in any way and no personal identifiers will be used. These results will be used and incorporated into a student thesis.

Risks:

There might be a risk of emotional stress as result of the participation However, a list of professional psychological resources will be provided after the focus group.

Concerns or further information about the research

If you have a concern about any aspect of this study or need any further information about the study, you should speak to Manal Fseifes, who will do her best to answer your questions.

Thank you for taking the time to read this information sheet and considering taking part.

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Appendix N: Focus Group Discussion Guide

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Study Title: Intimate Partner Violence (IPV) Experiences of Middle Eastern Immigrant Women (MEIW) Living in Ottawa during the Perinatal Period

Name of Interviewer:

Date:

Hello, my name is Manal Fseifes, and I am a student in the doctorate nursing program at the School of Nursing at the Faculty of Health Sciences of the University of Ottawa. I will be conducting this focus group discussion (FGD) to get your views about the IVP experiences of MEIW living in Ottawa during the perinatal period. I will first present the findings and then I will ask you general questions and you will be given the opportunity to reflect on your point of view.

If it is okay with you, I will be recording this focus group discussion, and the recording will be transcribed. The purpose of recording and transcribing is so that we can have an attentive conversation. I assure you that all of your comments will remain confidential, and no identifiable information will be attached to the data.

Please be reminded that this focus group discussion is confidential. We ask that everyone respects the privacy of the discussions and refrains from sharing any information or details shared during this session outside of the group. This ensures a safe and respectful environment for all participants

Question set 1: questions about themes related to understanding of IPV

- Based on your understanding, does the definition of IPV presented in the findings correctly reflect how IPV is viewed in the Middle East?
- Are there any important features of IPV that you think should be included in the definition but are not mentioned in the findings?

Question set 2: questions about themes related to help seeking behaviours

- Do you agree with the findings regarding how MEIW seek help, and do these resonate with your personal or community experiences?
- Are there any other forms of support or resources that you believe should be mentioned as important for help-seeking but are not reflected in the findings?

Question set 3: questions about themes related to the impact of IPV on the women, her children and the society.

- What do you think about the result of the impact of IPV on the mental and physical health of women and children? Do these findings align with your personal and community experience?
- Are there any other health outcomes,either mental or physical,that you believe should be emphasized more strongly or added to the findings?
- Do you have other information you would like to add?

Question set 4: questions about themes related to associated risk factors of IPV

- Based on your understanding, do you think the findings accurately reflect the risk factors associated with IPV in the Middle East context?
- In your experience, do you think that MEIW face additional risk factors related to IPV that should be explored further in the study?

Question set 5: Other

- Are there are additional comments you would like to add that would help us to understand the IPV among MEIW during their perinatal period.

That concludes our interview.

Thank -you for participating in our study, your input greatly appreciated.