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ARABIC WOMEN'S EXPERIENCE OF CHILDHOOD SEXUAL ABUSE: A MIXED-METHODS STUDY

by

SHAHRAZAD MAHMOUD TIMRAZ

DISSERTATION

Submitted to the Graduate School

of Wayne State University,

Detroit, Michigan

in partial fulfillment of the requirements

for the degree of

DOCTOR OF PHILOSOPHY

2018

MAJOR: NURSING

Approved by:

Advisor	Date

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DEDICATION

This work is dedicated to my beloved parents, Gameela and Mahmoud, for loving me unconditionally, helping me in all things great and small, and for their prayers and constant support. I'm especially grateful to my mother for teaching me to be a strong and independent woman and for making me believe that nothing is impossible and the sky is my limit. I also dedicate this work to the memory of my grandfather, Mohammed Timraz, for inspiring me to pursue my PhD.

This work is dedicated to my husband and partner in this journey, Mohanned, for his constant support and encouragement to pursue my dream. I'm always and forever grateful for having you in my life. I also dedicate this work to my precious kids, Yasmeen and Mohammed, for teaching me to be a better person and for bringing joy, happiness, and laughter to my life.

I dedicate this work to my family and friends, especially Eman, for their support during this journey. Special thanks to my chair, Dr. Linda Lewin, and my committee members, Dr. Carmen Giurgescu, Dr. Karen Kavanaugh, and Dr. Debra Patterson for their continuous guidance and support and for keeping me on track. I'm thankful to be your student and to have the opportunity to work alongside you one day.

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This work is dedicated to all the survivors of child sexual abuse who have the courage and strength to find their way to live through that experience. Special thanks to the women who shared their story with me to make a difference and to empower other survivors who did not have the chance to speak aloud about their experience. Thank you for making this study possible.

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CHAPTER 1 INTRODUCTION

Background

Child sexual abuse (CSA) is a global problem that affects children across age, culture, religion, geography, and socioeconomic level leading to negative short- and long-term outcomes (Al-Fayez, Ohaeri, & Gado, 2012). CSA is defined as any sexual activities that are performed in the presence of a child or on the child including fondling, oral/vaginal/anal penetration, kissing, and sexual exploitation where there is an age or power differential between the child and perpetrator (McClennen, Keys, & Day, 2016; Polonko, Adam, Naeem, & Adinolfi, 2010). Worldwide, approximately 8%–13% of girls have experienced sexual abuse (Barth, Bermetz, Heim, Trelle, & Tonia, 2013), and about 19.7% of women have been sexually abused before the age of 18 (Pereda, Guilera, Forns, & Gomez-Benito, 2009). CSA is considered the second leading cause of post-traumatic stress disorder (PTSD), and in the United States, it is estimated that the cost of physical and mental health care of female survivors of physical or sexual abuse is over $270 billion annually (Gelles & Perlman, 2012). In addition to PTSD, adult CSA survivors are more likely to experience an array of negative psychological outcomes such as depression, anxiety, borderline personality disorder, and poor self-esteem (Cantón-Cortés & Cantón, 2010; Fergusson, McLeod, & Horwood, 2013; Pérez-Fuentes et al., 2013; Walsh, Fortier, & DiLillo, 2010). Nonetheless, there are some adult survivors who were able to recover and heal from the traumatic impact of CSA (Draucker et al., 2011; Phanichrat & Townshend, 2010). Although there are no universal outcomes that are agreed upon for CSA (Berliner & Elliott, 2002), the variation in the psychological outcomes could be attributed to the survivors' individual differences in their appraisal of the abuse and their coping behavior (Spaccarelli & Kim, 1995).

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Coping has been examined as a potential factor influencing the relationship between CSA and adverse psychological outcomes (Asberg & Renk, 2013; Cantón-Cortés & Cantón, 2010; Phanichrat & Townshend, 2010; Walsh et al., 2010). Coping refers to the individual's cognitive and behavioral response to an encounter that is appraised as stressful (Folkman & Lazarus, 1980). According to the existing literature, adult survivors of CSA have employed a wide range of coping strategies such as avoidant, distancing, dissociation, accepting responsibility, confrontation, using drugs, withdrawing from others, and seeking support (Cantón-Cortés & Cantón, 2010; Filipas & Ullman, 2006; Steel, Sanna, Hammond, Whipple, & Cross, 2004; Walsh et al., 2010). It is commonly cited that *avoidant* coping has been related to PTSD in survivors of CSA (Asberg & Renk, 2013; Cantón-Cortés & Cantón, 2010; Walsh et al., 2010). It is not surprising to realize that most of the studies on coping with CSA were conducted among survivors from diverse ethnic backgrounds (Asberg & Renk, 2013; Barker-Collo, Read, & Cowie, 2012; Cantón-Cortés & Cantón, 2010; Ligiéro, Fassinger, McCauley, Moore, & Lyytinen, 2009). Nonetheless, no studies were identified that explored coping strategies among female CSA survivors of Arabic descent. Coping is context-dependent and there are intrapersonal, interpersonal, and environmental factors that can determine the types of coping employed by the survivors. These factors include, but are not limited to, characteristics of the abuse, social support, culture, and social reactions to abuse disclosure (Asberg & Renk, 2013; Barker-Collo et al., 2012; Cantón-Cortés & Cantón, 2010; Ullman, 2007).

Cultural norms and values held by individuals and society may dictate the female survivors' coping with CSA (Kolhatkar & Berkowitz, 2014). Arabic culture is characterized by collectivism, family honor and loyalty, female virginity, patriarchy, and stigma concerning mental health problems (Kolhatkar & Berkowitz, 2014; Nassar-McMillan, Ajrouch, & Hakim-Larson,

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2013). These factors can influence the survivors' disclosure, reporting, and help-seeking as meaningful ways of coping (Haboush & Alyan, 2013; Haj-Yahia & Tamish, 2001). In a study conducted with Arab American female survivors by the principal investigator (PI), cultural values held by the women, including family honor, collectivism, and stigma regarding mental health treatment, impacted their decision to disclose CSA and seek professional help (Timraz, Lewin, Giurgescu, & Kavanaugh, 2018). Nonetheless, variations of coping among Arabic women might exist depending on their level of acculturation. Further studies are warranted to understand the other cultural values and beliefs that hinder or facilitate coping with CSA.

Problem Statement

Factors That Influence Coping and CSA Outcomes

Characteristics of CSA. Characteristics of abuse refer to the severity, duration, and frequency of abuse; the age of onset; and relation to the perpetrator (Cantón-Cortés & Cantón, 2010). The association between abuse severity and negative psychological outcomes is well established in the literature. For instance, a direct relationship between CSA severity (i.e., penetration), depression, sexual problems, and negative self-concept was found among adult female survivors of CSA (Lacelle, Hébert, Lavoie, Vitaro, & Tremblay, 2012; Sciolla et al., 2011). Additionally, CSA characteristics indirectly associated with psychological outcomes through their impact on coping. CSA severity, which can range from kissing to penetration, has been related to maladaptive coping, PTSD, and depression among Western and European CSA survivors (Ullman, Peter-Hagene, & Relyea, 2014). No studies were found that examine the relationship between abuse characteristics, coping, and psychological outcomes among CSA female survivors of Arabic descent.

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Cultural values and beliefs. Cultural expectations determine individuals' thinking, feeling, and acting in a situation (Barker-Collo et al., 2012). Thus, culture influences individuals' approach to cope with stressors. For instance, in a qualitative study among nine Latina female survivors of CSA, coping efforts were influenced by cultural values and beliefs about gender role, virginity, sexual experience, survivors of sexual abuse, and family norms (Ligiéro et al., 2009). Furthermore, a cross-sectional study among CSA female survivors from four ethnic groups concluded that there were significant differences in coping strategies among the groups (Barker-Collo et al., 2012). Feelings of shame and secrecy of the abuse were found to hinder disclosure and reporting of abuse among minority participants such as Asian and Hispanic survivors (Ullman & Filipas, 2005a). In addition to the values and beliefs of the Asian and Hispanic cultures, being a member of a minority group could be an additional burden hindering disclosure, especially with the survivors' concern of others perceiving CSA as a cultural issue rather than a social problem. Masking circumstances (e.g., CSA) that bring shame to the family and community is rooted in the internalization of an idealized identity of one's culture (Kanukollu & Mahalingam, 2011), and this idealization is different among survivors depending on their level of acculturation.

Social reactions to abuse disclosure. It is important to note that disclosing abuse and seeking help and support are active ways of coping with CSA (Jonzon & Lindblad, 2004; Sciolla et al., 2011). Social reaction to abuse disclosure varies among survivors depending on the timing and nature of disclosure and the person to whom the survivor discloses the abuse (Ullman, 2003). Negative social reaction to abuse disclosure can inversely impact coping and psychological outcomes. Generally, negative reactions such as disbelief or ignorance were found to be more common in cases of childhood disclosure compared to adulthood disclosure (Ullman, 2003; Usta & Farver, 2010). Furthermore, negative reactions to disclosure were related to PTSD and

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depression in adulthood (Sciolla et al., 2011; Ullman, 2007). It can be hypothesized that negative reactions to disclosure impact the survivor's decision to further disclose, which is an active way of coping with CSA, and exacerbate self-blame or avoidant coping. Cultural beliefs and values shape survivors' expectations of others' reactions, which influences whether they disclose or not.

Significance of the Study

It is well known that the U.S. population is diverse and multicultural. The number of Arabs living in the United States is approximately 3.7 million (Haboush & Alyan, 2013). In 2011, Michigan had the second largest Arabic population with 191,607 individuals (Arab American Institute, n.d.). Even though a large number of Arabs live in the United States, there is a dearth of studies on coping among females in this population who experienced CSA. Coping is context dependent, so the role of cultural values and beliefs held by the women cannot be ignored. (Haboush & Alyan, 2013; Haj-Yahia & Tamish, 2001). Overall, there is a paucity of research that explores the values and beliefs of the Arabic culture, including social reaction to abuse disclosure, abuse characteristics, coping, and psychological outcomes among female CSA survivors of Arabic descent. In explorations of the literature, the PI found only a few studies that examined the prevalence and/or psychological outcomes of CSA among Arabs (Al-Fayez et al., 2012; Haj-Yahia & Tamish, 2001; Usta, Mahfoud, Chahine, & Anani, 2008). Limited data suggest that in the Middle East, the estimated prevalence of CSA ranges from 7%–27% (Al-Fayez et al., 2012). To date, CSA research in the Middle East and North Africa (MENA) region is still lacking, and most studies are conducted among Western, European, Hispanic, and African American survivors (Polonko et al., 2010). Thus, the purpose of this dissertation research is to (1) explore CSA characteristics, Arabic cultura values and beliefs, acculturation, and social reactions to abuse disclosure among female CSA survivors of Arabic descent and (2) understand the survivor's perception of how these factors

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influence their coping and psychological outcomes. The findings of this study will have clinical implications for healthcare providers who work with this population and will contribute to the development of a culturally sensitive intervention for Arabic female survivors of CSA. Furthermore, this study will describe the experience of Arabic women who survived CSA and will empower other Arabic female survivors. Lastly, this study will be the first to use a mixed-methods design (MMD) to explore the impact of abuse characteristics, Arabic cultural values and beliefs, acculturation, and social reactions to abuse disclosure on coping strategies and long-term psychological outcomes, including PTSD and depression.

Purpose of the Study

The occurrence of CSA among Arabs is well documented, although few studies have been conducted in Arab countries. Arabic female survivors of CSA suffer a wide range of physical and psychological outcomes in the aftermath and during adulthood (Al-Fayez et al., 2012; Alami & Kadri, 2004; Haj-Yahia & Tamish, 2001). The PI found no studies cited in the literature that examined coping with CSA among Arabic women. Thus, this mixed-methods study will address Arabic women's coping with their experiences of CSA and long-term psychological outcomes. The qualitative and quantitative data will be collected in parallel, analyzed separately, and then merged. Semi-structured questions will be used to explore CSA characteristics, Arabic cultural values and beliefs, acculturation, social reactions to abuse disclosure, coping, and long-term psychological outcomes. Acculturation, social reactions to abuse disclosure, coping, and the long-term psychological outcomes PTSD and depression will also be collected through quantitative measures. All data will be merged for concurrent analysis. The aim for collecting both qualitative and quantitative data is to corroborate the results of the two types of data and to bring greater

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insight into the problem (i.e., complementarity) that would not be obtained separately from either type of data.

Specific Aims

The aims of this dissertation research are to:

Aim 1: Describe the CSA characteristics of female survivors of Arabic descent in their own words.

Aim 2a: Explore the female survivors' perception of Arabic cultural values and beliefs such as gender role, sexuality, virginity, honor, family, CSA, and surviving abuse.

Aim 2b: Explore the female survivors' level of acculturation and its impact on their coping with CSA.

Aim 3: Explore social reactions to abuse disclosure, the factors that provoke or hinder disclosure of abuse, and the survivors' feelings concerning these reactions.

Aim 4: Explore appraisal and coping strategies of female survivors of Arabic descent in the aftermath of abuse and during adulthood.

Aim 5: Explore the survivors' perception of how CSA characteristics, cultural values and beliefs, and social reaction to abuse disclosure influence their strategies for coping with CSA.

Aim 6: Explore the long-term psychological outcomes of CSA and the survivors' perception of how their coping strategies facilitate or limit their psychological adjustment during adulthood.

Aim 7: Explicate a comprehensive description of coping and psychological outcomes of CSA in female survivors of Arabic descent by combining the interview data with the quantitative measures of acculturation, social reactions, coping, PTSD, and depression.

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Summary

CSA is a nonpreventable social problem that impacts women worldwide. Globally, approximately 8%–13% of girls have experienced sexual abuse (Barth et al., 2013). CSA leads to negative adulthood adjustment and an array of psychological outcomes including PTSD and depression. It is well documented that coping with CSA influences long-term psychological outcomes and adjustment. Although there is myriad research on coping with CSA, no studies that explored coping among Arabic female survivors were found in the literature. Coping is context dependent and factors such as characteristics of abuse, cultural values and beliefs, and social reaction to abuse disclosure may greatly impact coping. Thus, these factors will be explored in the present study. To obtain a comprehensive understanding of coping and psychological outcomes of female CSA survivors of Arabic descent, a mixed-method approach will be implemented to guide the study.

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CHAPTER 2 LITERATURE REVIEW AND CONCEPTUAL FRAMEWORK

Overview of Child Sexual Abuse

Child sexual abuse (CSA) is an insidious and persistent problem that affects both genders worldwide. It is estimated that 2%–62% of women and 3%–16% of men have experienced CSA (Johnson, 2004). The physical injuries of CSA may heal with time, but the psychological, physiological, behavioral, and social sequelae may persist into adulthood (Cantón-Cortés & Cantón, 2010; Johnson, 2004).

Definition of CSA

Although there is societal agreement regarding some of the acts of CSA, variations of the definition exist (Finkelhor, 1994a), and those variations account for a wide range of prevalence rates (Priebe & Svedin, 2009; Wyatt & Peters, 1986). Despite the variations in definition, efforts have been made to categorize CSA based on its type and seriousness (i.e., contact, non-contact) (Finkelhor, 1994a; Priebe & Svedin, 2009). Legally, there are two essential components of CSA: (1) sexual activity that involves a child and (2) an abusive condition (Finkelhor, 1994a).

Sexual abuse refers to contact and non-contact activities that involve a child before the age of legal consent for the purpose of gratification and/or sexual stimulation of an adult or older child (Finkelhor, 1994a; Johnson, 2004). Contact sexual abuse refers to touching the child's private parts (genitals, anus, breast) or having the child touch the private parts of the other person (Finkelhor, 1994a; Wyatt & Peters, 1986). Contact sexual abuse has two categories: (1) contact abuse with penetration of the child's vagina, anus, or mouth by penis or object and (2) contact abuse without penetration including fondling, sexual kissing, and touching the sexual parts of the other person (Finkelhor, 1994a). Additionally, date rape or abuse by peers has been considered a type of CSA in several studies (Finkelhor, 1994a; Priebe & Svedin, 2009). In the PI's pilot study with 10 Arab

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American female CSA survivors, some females had experienced rape and forced fondling by peers during adolescence (Timraz et al., 2018). Non-contact sexual abuse refers to exhibitionism, voyeurism, and child pornography (Finkelhor, 1994a; Priebe & Svedin, 2009). As indicated by Finkelhor (1994a), an abusive condition exists when there is an age and/or power differential between the child and perpetrator, or in the presence of force or deception of a child. The presence of the two components of CSA (power deferential, sexual activity involving a child) varies widely in the literature. For instance, a large number of studies identified CSA as contact sexual abuse in the presence of at least five years age difference between the child and perpetrator (Cantón-Cortés & Cantón, 2010; Cantón-Cortés, Cortés, Cantón, & Justicia, 2011; Edwards, Freyd, Dube, Anda, & Felitti, 2012; Merrill, Thomsen, Sinclair, Gold, & Milner, 2001; Sciolla et al., 2011; Wilson & Scarpa, 2014). Nonetheless, two of the studies (Cantón-Cortés & Cantón, 2010; Cantón-Cortés et al., 2011) recognized CSA in the presence of a power differential between the child and perpetrator along with the age difference. A power differential between the survivors and perpetrators and the use of force were evident among those survivors who were abused by peers (Timraz et al., 2018). In the pilot study, I defined CSA broadly to include contact and non-contact CSA that occurs in the presence of age and/or power difference without any restriction on age difference. Having a broad definition was crucial to maximize the number of participants included in the study, especially with a hard to reach population such as Arab Americans.

Characteristics of CSA

CSA characteristics are often considered risk factors for the development of negative CSA psychological outcomes in adulthood (Young, Riggs, & Robinson, 2011); they include age of onset, frequency, duration, use of force and threat, number of perpetrators, relationship to the perpetrator, and type of sexual abuse (Merrill, Guimond, Thomsen, & Milner, 2003; Wilson &

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Scarpa, 2014). Age of onset refers to the ages of the women when they first encountered the abuse. Frequency refers to the number of times of CSA occurrence. Duration refers to the length of time of being abused, which may range from one day to years. Use of force and threat refers to using physical force and threatening the women with harm. Relationship to the perpetrator refers to the perpetrator being a family member, acquaintance, or stranger (Finkelhor, 1994a). The terms "severity" and "CSA characteristics" are used interchangeably in the literature. The next section will provide an overview of the literature that focuses on CSA characteristics and their relationship to coping and psychological outcomes.

CSA Characteristics, Coping, and Psychological Outcomes

Most of the available studies addressed CSA characteristics along with other factors such as CSA disclosure, coping and/or social support, and psychological outcomes (Asberg & Renk, 2013; Cantón-Cortés & Cantón, 2010; Edwards et al., 2012; Evans, Steel, & DiLillo, 2013; Sciolla et al., 2011; Steel et al., 2004). In an ethnically diverse sample of 285 participants, Steel et al. (2004) found a direct relationship between CSA characteristics, including the number of perpetrators and duration of abuse, and psychological distress in adulthood. Among CSA female college students, Cantón-Cortés and Cantón (2010) found that the relationship between avoidance coping and PTSD was stronger in the case of continuous familial abuse compared to one-time extrafamilial CSA. In a large study of 4,098 female CSA survivors, Merrill et al. (2001) investigated the role of parental support, abuse severity (i.e., type, force, relation to the perpetrator, frequency, number of perpetrators), and coping on predicting psychological adjustment in adulthood. The investigators found a relationship between abuse severity and psychological adjustment, and that relationship was partially mediated by constructive, self-destructive, and avoidant coping that were employed by the survivors. In a later study, Merrill et al. (2003)

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conducted a study that examined the effect of CSA severity on coping and sexual functioning and concluded that women who had experienced severe CSA (i.e., involved penetration by more than one person including a father figure for multiple times) employed avoidant and self-destructive coping more frequently compared to those who experienced less severe CSA. Although studies that explored CSA characteristics and other factors have varied in their aim and population, the impact of CSA characteristics on coping and psychological outcomes was consistent. Thus, it can be concluded that survivors who experienced severe CSA for a long period of time by someone known to them have PTSD, depression, and poor psychological adjustment in adulthood.

Sciolla et al. (2011) aimed to investigate the relationship between CSA severity, disclosure, and depression among African American and Latina women and concluded that severe CSA (e.g., digital penetration, rape) was strongly associated with depression in adulthood compared to less severe CSA (e.g., fondling). CSA survivors were mainly perpetrated by family members for a period that lasted from 2 weeks to several years, and the mean age of onset was 9.5 years. Regarding sexual health outcomes, Lacelle et al. (2012) found that severity of CSA (i.e., penetration, fondling, exhibitionism) was a strong predictor of risky sexual behavior, sexual problems (e.g., premenstrual pain), and negative sexual self-concept among female survivors of CSA when controlling for other forms of victimization (i.e., physical abuse, psychological abuse, domestic violence). Approximately 39.3% and 45% of the women were abused by a family member or acquaintance, respectively. The most common types of abuse experienced by the women were attempted or completed penetration (44.6%) followed by fondling (36.8%) and exhibitionism (18.6%). Although the women in the study by Lacelle et al. (2012) were Canadian, the results regarding abuse characteristics were similar to those from the study conducted by Sciolla et al. (2011) among African American and Latina women. Contrary to the study by Lacelle

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et al. (2012), Cantón-Cortés et al. (2011), who examined the relationship between feelings provoked by CSA and PTSD among 163 female survivors of CSA, found no direct relationship between CSA characteristics and PTSD symptom score. The contradiction in the results between these two studies could be contributed to their guiding aims and models.

In addition to the adverse relationship between the CSA characteristics and physiological and psychological outcomes such as sexual health, depression, and PTSD, the literature reveals other unfavorable relationships. For instance, Asberg and Renk (2013) reported an association between CSA and incarceration among CSA survivors. The authors investigated the role of CSA severity, social support and substance abuse as a predictor of incarceration among college students and incarcerated females and found that CSA was more prevalent and more severe among incarcerated survivors compared to college students. Overall, the authors concluded that CSA severity and substance use were risk factors for incarceration while social support was a protective factor. Although the literature reveals that studies exploring CSA characteristics and outcomes varied in their aim and population, the impact of CSA characteristics on coping and psychological outcomes was consistent. Thus, it can be concluded that survivors who experienced severe CSA for a long time by someone known to them are more likely to experience PTSD, depression, and poor psychological adjustment in adulthood.

CSA Experience and Ethnicity

The culture and ethnic background of individuals shape their view of the world and vice versa (Fontes, 1993). Race refers to the biologically determined features of a certain racial group who share specific characteristics like skin color (Haboush & Alyan, 2013; Watt & Norton, 2004). Culture and ethnicity vary widely among people of the same race; for example, those of either Middle Eastern or European descent are considered as White, but culturally and ethnically they

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are diverse. Ethnicity refers to the attitudes and practices including language, customs, and traditions that unify and distinguish one group from another. On the other hand, culture refers to the norms, values, and beliefs that are shared by a group and passed from one generation to another (Haboush & Alyan, 2013; Kolhatkar & Berkowitz, 2014). Culture encompasses the way of recognizing and handling violence and sexual assault among vulnerable individuals (Fontes, 1995). The survivors' cultural background influences their CSA experience in several domains, including the experience of abuse, coping (i.e., disclosure and seeking support), and psychological outcomes (Kenny & McEachern, 2000). The impact of a survivor's cultural background on coping and psychological outcomes has not been examined extensively in the literature (Ullman & Filipas, 2005a). Nonetheless, some studies have identified differences in CSA experience among survivors of diverse ethnic backgrounds, including prevalence, characteristics, disclosure, and psychological outcomes (Andrés-Hyman, Cott, & Gold, 2004; Futa, Hsu, & Hansen, 2001; Okur, van der Knaap, & Bogaerts, 2015; Ullman & Filipas, 2005a).

One of those studies was conducted among 461 female college students to examine ethnic differences in CSA experiences (Ullman & Filipas, 2005a). The authors concluded that CSA was more prevalent and severe among Black students followed by Hispanics, and less prevalent and severe in Whites and Asians. No ethnic differences in depressive and PTSD symptoms were found among the groups. On the contrary, Andrés-Hyman et al. (2004) examined the impact of ethnicity on PTSD symptoms among CSA female survivors and found that Hispanic survivors reported less intrusive PTSD symptoms compared to their Non-Hispanic Caucasian counterparts. The variation in outcomes was attributed to Hispanic ethnicity as a buffer against the negative impact of CSA. The conclusion by Andrés-Hyman et al. (2004) contradicted other research findings that CSA was not commonly well perceived in Hispanic culture (Ullman & Filipas, 2005a). Variation in the CSA

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prevalence and nature has also been documented among European survivors. For instance, a study that examined the prevalence and nature of CSA experience among four ethnic minority groups (Dutch Antillean, Surinamese, Turkish, Moroccan) and a native Dutch group in Netherland found that Moroccan and Turkish girls reported less CSA compared to the native Dutch girls. Surprisingly, the prevalence of CSA was similar between boys and girls in the Moroccan group, but higher among boys compared to girls in the Turkish minority group (Okur et al., 2015). The low prevalence of CSA among girls is contradictory to the international trend, in which CSA ranges 6%–62% among females and 3%–31% among males (Alami & Kadri, 2004). Overall, an equal or higher prevalence of CSA among males compared to females was also reported by other investigators, who conducted studies in Arabic countries such as Palestine, Egypt, and Kuwait (Afifi, El Lawindi, Ahmed, & Basily, 2003; Al-Fayez et al., 2012; Haj-Yahia & Tamish, 2001). The unexpected lower prevalence of CSA among females could be attributed to cultural factors in Arabic societies that may influence their reporting, such as family honor and reputation, family cohesion, female virginity, patriarchy, and honor killing (Haboush & Alyan, 2013). No studies were found that examined the role of culture on coping and psychological outcomes among CSA female survivors of Arabic descent.

Social Reactions to CSA Disclosure

Disclosure of CSA and seeking support are active ways of coping (Jonzon & Lindblad, 2004). Disclosure refers to telling anyone about the abuse either accidentally or purposefully, formally or informally during childhood or adulthood (Ullman, 2003). Despite the deleterious effects of abuse, many survivors have never disclosed their CSA or have delayed disclosure for years (Smith et al., 2000; Tener & Murphy, 2014; Ullman, 2003). For instance, the National Women's Study of childhood rape survivors reported that 28% of the women never disclosed their

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CSA, while 47% disclosed the encounter five years after the rape (Smith et al., 2000). Another study conducted among 122 adult female CSA survivors reported that 32% of the women disclosed their abuse during childhood and 68% during adulthood, with an average delay of 21 years between the CSA and disclosure (Jonzon & Lindblad, 2004). Similarly, Hébert, Tourigny, Cyr, McDuff, and Joly (2009) reported that 1 in 5 survivors had never disclosed abuse, while 58% delayed disclosure for more than 5 years after the first CSA experience. Thus, avoiding or delaying disclosure is very common among CSA female survivors (Fontes & Plummer, 2010; Ullman, 2003; Ullman & Filipas, 2005b).

There are multiple factors that impact the survivors' decision to disclose or conceal CSA during childhood or/and adulthood. For instance, survivors who experienced violent CSA with physical abuse by multiple perpetrators made CSA disclosure during childhood (Jonzon & Lindblad, 2004). On the other hand, early age of abuse onset and the absence of violence were significant predictors of delayed CSA disclosure. Furthermore, it was found in another study that family relationship with the perpetrator, early age of onset, and multiple rape episodes were associated with delayed disclosure of more than one month among female survivors of childhood rape (Smith et al., 2000). Delayed disclosure in cases of familial abuse or abuse by a relative could be attributed to the survivor's fear of exclusion and abandonment by family members who might take the side of the perpetrator (Hébert et al., 2009; Tener & Murphy, 2014). Repressing CSA memory, severity of CSA, duration of abuse, number of perpetrators, feelings of shame, fear of blame and disbelief, fear of the perpetrator, identity of the perpetrator, anxiety, and protecting the family were all identified in the literature as factors that impact disclosure (Alaggia, 2005; Hébert et al., 2009; Tener & Murphy, 2014; Ullman, 2003). Recipients of the CSA disclosure varied among the survivors depending on the time of disclosure. Interestingly, in a study by Smith et al.

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(2000), friends were the most common receivers of disclosure. This contrasts with the findings of other studies in which the most common receiver of childhood disclosure were mothers or a family member (Jonzon & Lindblad, 2004; Mason & Kennedy, 2014; Ullman, 2003). It is noteworthy that Smith et al. only focused on childhood rape characterized by force or threat, while the other studies included CSA with and without force or threat. During adulthood, the most common recipients of CSA disclosure were therapists, partners, and close friends, but not family members (Jonzon & Lindblad, 2004; Tener & Murphy, 2014; Ullman, 2003).

Although non-disclosed CSA and delayed disclosure can lead to negative outcomes such as PTSD and psychological distress (Hébert et al., 2009), the therapeutic effect of disclosure depends on the reaction the survivors received (Ullman, 2003). According to Tener and Murphy (2014), CSA survivors reported more positive reactions to disclosure during adulthood compared to childhood. Negative reaction to disclosure during childhood was found among survivors who were abused by relatives (Smith et al., 2000; Ullman, 2007). Some researchers reported that negative reaction and lack of support for CSA disclosure were correlated to PTSD and depression (Gries et al., 2000; Ullman, 2007; Ullman, Townsend, Filipas, & Starzynski, 2007).

Coping With CSA

Coping has been identified in the literature as a significant factor in understanding the long-term functioning of CSA survivors (Walsh et al., 2010). Coping is a dynamic cognitive and behavioral process to manage internal or external events appraised as stressful by individuals (Folkman & Moskowitz, 2004). Coping with CSA is a dynamic process that changes over the survivor's lifespan (Phanichrat & Townshend, 2010). Theoretically, coping strategies can be classified as problem-focused or emotion-focused. Furthermore, coping has been classified as avoidance/approach, cognitive/behavioral, and emotion/problem-focused coping. In addition to

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the variation in definition and categorization, the association between CSA and coping has been studied from different perspectives (Walsh et al., 2010). For instance, some studies examined coping strategies of CSA survivors and the relationship between coping strategies and psychological outcomes, and others examined coping as a mediator between CSA and psychological outcomes. The next section will provide an overview of the literature about coping.

Coping Strategies With CSA Among Adult Survivors

Several studies that examined coping among CSA adult survivors were identified in the literature. Most used a retrospective qualitative method and open-ended interviews. Although the studies varied by sample size, nature, definition of CSA, and coping assessment, they collectively indicated that CSA survivors employed a wide range of cognitive and behavioral coping strategies (Barker-Collo et al., 2012; Draucker et al., 2011; Ligiéro et al., 2009; Paige & Thornton, 2015; Phanichrat & Townshend, 2010). In their qualitative study, Phanichrat and Townshend (2010) found that CSA survivors employed an array of coping strategies in their journey of recovery during adulthood. Avoidant coping strategies including suppression of thoughts and feelings, escapism, and dissociation were initially employed by the survivors. Nonetheless, avoidant coping gradually evolved into problem-focused coping such as seeking support, cognitive engagement, acceptance, and seeking meaning. Another qualitative study of 95 adult survivors of CSA that aimed to construct a model of healing (i.e., coping) identified four stages of healing (Draucker et al., 2011). The stages were: (1) grappling with the meaning of CSA, (2) figuring out the meaning of CSA, (3) tackling the effects of CSA, and (4) laying claim to one's life. In the grappling stage, the survivors were normalizing CSA and blaming themselves for it. In the laying claim stage, the survivors gained control of their lives and empowered other survivors by sharing their stories and being advocates. Some of the factors that facilitated the survivors moving from one stage to another

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included ongoing support, affirming message, and commitment to transcend the CSA. Not all the survivors moved through the stages in a linear stepwise fashion, but all of them had experienced the first stage. In contrast to studies that focus on coping solely during adulthood, the findings of the PI's pilot study among Arab American female survivors illustrated that some females' coping strategies had evolved from childhood to adulthood (Timraz et al., 2018). For instance, some survivors used drugs, blocked out the abuse memories, did not disclose the CSA, and attempted suicide during childhood whereas other survivors approached others for help, disclosed their CSA, and became an advocate during adulthood. Some investigators (Draucker et al., 2011; Phanichrat & Townshend, 2010) illustrated that coping with CSA is not static and that adult survivors employ different coping strategies that may change over time.

Some studies examined the influence of CSA characteristics and culture on adult CSA survivors' coping strategies. In a study of adult male and female survivors of CSA, Steel et al. (2004) reported that abuse characteristics including age of onset, force, relationship to the perpetrator, and participation were associated with accepting responsibility (i.e., self-blame, criticizing self) means of coping. Furthermore, resistance during the abuse was associated with confrontive coping (e.g., using aggressive and risky efforts to alter the situation). Filipas and Ullman (2006), in a study of 577 undergraduate female CSA survivors, reported that severity of abuse was associated with maladaptive coping such as acting out aggressively and sexually, using drugs and alcohol, and withdrawing from others. Thus, abuse characteristics and severity can predict coping strategies and improve our understanding of the coping variation among survivors. In a small qualitative study of nine Latina female CSA survivors, Ligiéro et al. (2009) found that women employed a variety of coping strategies to relieve negative emotions and feelings and to protect self from further abuse. These strategies included isolating self from others; using drugs

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and/or alcohol; avoiding abuse thoughts; attempting suicide; doing artwork; seeking professional help; talking about the abuse to friends, family, or professionals; learning martial arts; running away from surroundings; and deviation from the female role expectation. Furthermore, coping with CSA was influenced by some cultural norms, beliefs, and expectations such as viewing women as property of men, determining whom they should obey, lack of talking about sexual matters, importance of virginity, blaming the survivors for the abuse, and maintaining the secrecy of abuse within the family. A quantitative study that examined the coping strategies employed by 290 female CSA survivors across four cultural groups (European Canadians, Native Canadians, European New Zealanders, Maori New Zealanders) found significant differences between the groups concerning logical analysis, positive reappraisal, problem solving, cognitive avoidance, acceptance, seeking alternative rewards, and emotional discharge coping (Barker-Collo et al., 2012). Overall, studies have concluded that coping with CSA is a complex and dynamic process and that many survivors continued to employ avoidance coping during their adulthood. Furthermore, the studies showed that abuse characteristics and culture are critical constructs that influenced coping with CSA.

Coping Strategies With CSA and Psychological Outcomes

In addition to studies that described the survivors' coping strategies with CSA, some studies examined the relationship between specific types of coping and psychological outcomes. The Brand and Alexander (2003) study of 101 adult female CSA survivors found that avoidant coping during childhood was very common and related to adult distress and depression. Interestingly, distancing coping (e.g., denial) was associated with less adult distress while social support coping was associated with more distress. Keeping in mind that Brand and Alexander's study examined coping during childhood when abuse was ongoing, distancing might be a

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protective factor at that time, especially in cases of familial abuse. On the other hand, seeking support through disclosure during childhood might not be positively perceived by others, eventually leading to adulthood distress. Similarly, the study by Wright, Crawford, and Sebastian (2007) explored how coping strategies facilitate or hinder long-term adjustment among female CSA survivors. The researchers reported that avoidant coping was significantly associated with greater depressive symptoms among survivors who had a poorer resolution of the abuse issue. Furthermore, coping by seeking social support was not related to better resolution or adjustment. The relationship between avoidant coping, PTSD, and personality disorder (i.e., dependent, avoidant) were also found among a treatment-seeking sample of female CSA survivors (Johnson, Sheahan, & Chard, 2004). In another study that examined the relationship between religious coping and psychological outcomes among African American female survivors of sexual assault occurring after the age of 14, researchers found that survivors who employed religious coping reported higher PTSD and depressive symptoms (Bryant-Davis, Ullman, Tsong, & Gobin, 2011). Accepting one's destiny, believing that CSA is a punishment from God, and praying to avoid thinking of the abuse were all negative religious coping strategies that might be adopted by survivors and in turn exacerbate negative outcomes (Bryant-Davis, Chung, & Tillman, 2009). Although the samples and settings vary across studies, findings from the literature suggest that avoidant coping, seeking social support, and religious coping during adulthood led to the development of negative psychological outcomes.

Coping as a Mediator of CSA and Psychological Outcomes

Some researchers have proposed that coping strategies could mediate the relationship between CSA and psychological outcomes (Walsh et al., 2010). For example, a study that tested the relationship between CSA characteristics and psychological distress mediated by coping found

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that confrontive coping, accepting responsibilities, and internalizing the CSA experience mediated the relationship between CSA characteristics (i.e., relation to the perpetrator, force, resistance, age of onset, participation, and frequency of abuse) and psychological distress in adulthood (Steel et al., 2004). In other words, females who experienced CSA over a long duration tended to internalize their CSA experience, leading to poor psychological adjustment. Furthermore, women who experienced CSA at an older age were more likely to accept responsibility for the abuse and have psychological distress. Resistance at the time of abuse was associated with negative psychological outcomes through the employment of confrontive coping. Other researchers found that maladaptive coping (i.e., cognitive and behavioral disengagement, denial, substance use) and emotion regulation mediated the relation between CSA severity and the psychological outcomes of PTSD and depression among adult survivors of sexual assault (Ullman et al., 2014).

CSA disclosure might be considered as a problem-focused coping, and non-disclosure or delayed disclosure might be considered as emotion-focused coping; the latter is associated with negative psychological outcomes in adulthood (Sciolla et al., 2011). In a large-scale study of 733 college students, disclosure of CSA was found to be related to PTSD. Furthermore, delayed CSA disclosure was associated with PTSD, especially among survivors of CSA perpetrated by relatives. This is not surprising considering the stress of withholding CSA disclosure for a long period and the trauma of being betrayed and abused by someone known to the survivor (Ullman, 2007). In addition to examining the mediational role of coping among CSA survivors, some studies examined coping among survivors of multitype abuse, which helped to delineate the differences in the coping strategies based on the abuse type. For example, in a study of 294 undergraduate women of child abuse (sexual, physical), cognitive coping strategies, particularly peritraumatic dissociation, was found to mediate the relationship between the type of abuse and posttraumatic

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stress symptoms (Wilson & Scarpa, 2012). More specifically, survivors of CSA and combined abuse, physical and sexual, reported significant peritraumatic dissociation and posttraumatic stress compared to survivors of physical abuse only. The study by Rosenthal, Hall, Palm, Batten, and Follette (2005) found that avoidance coping mediated the relation between CSA severity and psychological distress in adulthood. Similar findings were reported in the study by Cantón-Cortés and Cantón (2010), in which avoidance coping was associated with PTSD. This association was stronger among survivors of familial and continuous abuse compared to isolated extrafamilial CSA and non-CSA survivors.

Despite the variation in the definition and measurement of coping, multiple conclusions can be drawn. First, the qualitative studies illustrated that coping is a dynamic, ever changing process, and when resources like social support were available, survivors had gradually substituted avoidant coping with problem-focused coping to recover from their trauma (Draucker et al., 2011; Phanichrat & Townshend, 2010). Thus, the generalization that all CSA survivors employ avoidant coping is inaccurate. Nonetheless, cross-sectional studies that examined the relation between coping and psychological outcomes (Brand & Alexander, 2003; Bryant-Davis et al., 2011; Johnson et al., 2004) or coping as a mediator (Cantón-Cortés & Cantón, 2010; Rosenthal et al., 2005; Sciolla et al., 2011; Steel et al., 2004; Ullman et al., 2014) found that avoidant coping was common and associated with negative outcomes. Avoidant coping might buffer the trauma of CSA in the aftermath of abuse, but the psychological impact is deleterious because it prevents reappraisal of the traumatic experience and distorts the worldview. This leads to an array of psychological outcomes like PTSD, depression, poor adulthood adjustment, and personality disorder (Walsh et al., 2010). Although two studies (Barker-Collo et al., 2012; Ligiéro et al., 2009) examined the impact of culture on coping, the ethnic background of the survivors was not Arabic. Furthermore,

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I found no studies that examined abuse characteristics, cultural values and beliefs, acculturation, social reaction to abuse disclosure, coping, and psychological outcomes among CSA female survivors of Arabic descent.

Arabic Culture

Culture is the norms, values, and traditions of the members of society that are transmitted from one generation to another (Haboush & Alyan, 2013; Kolhatkar & Berkowitz, 2014). Arab refers to anyone who has an origin from the 22 countries belonging to the Arab State League: Jordan, Lebanon, Syria, Iraq, Palestine, Morocco, Algeria, Tunisia, Libya, Saudi Arabia, Qatar, United Arab Emirates, Oman, Yemen, Bahrein, Kuwait, Somalia, Sudan, Mauritania, Djibouti, Comoros and Egypt (Beitin & Aprahamian, 2014). Arabic culture is the values, traditions, and norms of the countries in which Arabic is the official language. Despite the variation in the Arab world, Arabic language, costumes, cuisine, history, literature, and culture bind the nations together (Nassar-McMillan et al., 2013).

Arabic Values and Beliefs

Collectivism. Arabic culture is characterized by collectivism that is represented by family cohesion and unity. Collectivism emphasizes that loyalty and benefits of family take precedence over the individual's benefits and preferences (Haboush & Alyan, 2013; Nydell, 2012). Honor, dignity, and the reputation of the family are of paramount importance, and no effort should be spared to maintain these attributes (Nydell, 2012). Family honor and reputation are reflected in the modesty and behavior of the family's females (Haboush & Alyan, 2013).

Patriarchy. In Arab context, Joseph (1996) defined patriarchy as "the prioritizing of the rights of males and elders (including elder women) and the justification of those rights within kinship values which are usually supported by religion" (p.14). In Arab families, authority and

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responsibility for the family comprises the father's role, and father's respect and total obedience are expected by family members. The patriarchal hierarchy (i.e., male domination and control) not only prevails in Arab families but also at work, school, and social associations (Barakat, 1993).

Virginity. From Arabs' perspective, virginity is the presence of the hymen and the abstinence of premarital sex (Abu-Odeh, 2011; Amer, Howarth, & Sen, 2015; Awwad, 2001). Virginity is socially constructed to also include the woman's behavior and modesty, and it is broader than the biological presence of the hymen. Moreover, it sets the boundaries of what is acceptable and not acceptable for a female. In other words, any act that may threaten a female's virginity prior to marriage should be discouraged such as riding a bicycle, certain sports, and using tampons (Amer et al., 2015). In general, being a virgin represents not only the purity of the female but also the purity and honor of the Arab family and society in general (Amer et al., 2015; Beitin & Aprahamian, 2014; Odeh, 2010).

Family honor. Family honor is the good name and reputation of the family (Beitin & Aprahamian, 2014). Virginity, behavior, and females' reputation represent the family's honor in Arab culture. Hence, protecting and defending family honor is of paramount importance, and no effort is spared to preserve it (Abu-Odeh, 2011). Losing virginity prior to marriage for any reason will lead to distortion of the female's reputation and family honor. Moreover, losing virginity will bring shame to the family and threaten its existence in the community (Amer et al., 2015).

Honor killing. Honor killing is the killing of a female by male kin for engaging or being suspected of engaging in sexual activity prior to marriage (Abu-Odeh, 2011; Awwad, 2001; Kulczycki & Windle, 2011). Other causes of honor killing may include being a victim of rape, marital infidelity, initiating divorce, and improper female sexual acts (Kulczycki & Windle, 2011). Honor killing is performed to restore family honor, reputation, and social status in the community,

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and the decision is taken after a family council (Abu-Odeh, 2011; Awwad, 2001). Kulczycki and Windle (2011) conducted a systematic review of 40 studies of honor killing and concluded that the tradition has long existed in the Middle East and North Africa, but the prevalence rate is inconsistent and cannot be generalized. In the end, family honor displays the patriarchal and patrilineal characteristics of Arabic culture, including male dominance and power over the female.

Mental health. Acknowledging psychological or mental health problems is an essential step in seeking mental care. In Arabic culture, there are many people who believe that mental illness is some sort of possession or evil spirit, so symptoms are not acknowledged as mental illness (Abu-Ras, 2007; Youssef & Deane, 2006). Lack of acknowledgment results from either denial or lack of knowledge of mental illness; both lead to the underutilization of mental health care services. Furthermore, mental illness is considered as a stigma that brings shame and embarrassment not only to the battered women, but to their family, too. In other words, having a family member with a mental illness or seeking mental health care can impact the likelihood of female members getting married (Abu-Ras, 2003; Al-Krenawi & Graham, 2000; Youssef & Deane, 2006). Holding these beliefs by the survivors or their families may prevent them from seeking professional help, which is one way of coping with CSA effectively. In the pilot study I conducted, some participants were explicit in stating that their families did not support their decision, either financially or emotionally, for seeing a therapist (Timraz et al., 2018). Nonetheless, those who sought support from professionals for their abuse found it helpful.

Acculturation

Acculturation is a process of adapting to a new culture over time; the process may entail maintaining the traditional culture or completely participating in the mainstream culture (Goforth, Oka, Leong, & Denis, 2014; Haboush & Alyan, 2013; Kolhatkar & Berkowitz, 2014; Nassar-

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McMillan et al., 2013). Multiple factors exist and influence the process of acculturation, such as generational status, length of residence in the United States, age at immigration, connection to the Arab world, religious affiliation, reasons for immigration, gender, level of education, language proficiency, attitudes toward living in the United States, and attitudes of external societies toward Arabs (Faragallah, Schumm, & Webb, 1997; Nassar-McMillan et al., 2013). Exploring Arabic female survivors' experiences of navigating Arabic and American culture is useful to understand their coping strategies with CSA. Acculturation level can influence the survivor's coping in multiple ways. Negative stereotypes of Arabs represented by the U.S. media and the discrimination against this minority group (Haboush & Alyan, 2013) likely make the survivors reluctant to report child abuse to an authority, fearful of a negative representation of Arabs. Nonetheless, a means of coping depends on the survivor's level of assimilation to the Western culture and willingness to be more open to disclose the abuse and seek professional help.

Arab American

There is no specific definition of *Arab American*. Hence, the terms Arab American and Middle Eastern are used interchangeably in the literature. In this paper, the term *Arab* refers to individuals who are of Arabic descent from any of the 22 Arab countries (Nassar-McMillan et al., 2013). Arab American is a heterogeneous group; self-identification is important because some Arab Americans have reported both Arabic and White identities, while others prefer to identify themselves as White (Goforth, Pham, & Oka, 2015). The preference depends on the acculturation level and generation (Nassar-McMillan et al., 2013). It is well known that the U.S. population is diverse and multicultural. The number of Arabs living in the United States is approximately 3.7 million (Haboush & Alyan, 2013). Michigan has 191,607 individuals reporting Arabic descent, second only to Los Angeles (Arab American Institute, n.d.).

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An Overview of CSA Among Arabs

Prevalence of CSA Among Arabs

No data on CSA were found among Americans of Arabic descent because they are usually considered as Caucasian by the federal standard definition of race and ethnicity (Nassar-McMillan et al., 2013). However, a small number of studies have focused on CSA and survivors of abuse in general in Arabic countries such as Kuwait, Egypt, Morocco, Bahrain and Palestine (Afifi et al., 2003; Al-Fayez et al., 2012; Al-Mahroos & Al-Amer, 2011; Alami & Kadri, 2004). Despite the variation in country, sample size, and population among these studies, findings have indicated that CSA is an existing problem among Arabs. Although the studies from Arabic countries are limited compared to the CSA research from Western and European nations, they have contributed to our understanding of the scope of the problem of CSA among Arabs.

In one study from Bahrain, according to the retrospective data of medical records from 2000-2009, approximately 49.5% of the sample (n = 440) were female victims of CSA (Al-Mahroos & Al-Amer, 2011). In another study conducted among 555 Egyptian male and female school adolescents to identify the prevalence and risk factors of child abuse, 7%, 3.8%, 0.7%, and 0.5% of the sample experienced sexual abuse; emotional and sexual abuse; physical and sexual abuse; and emotional, sexual, and physical abuse, respectively (Afifi et al., 2003). The multivariate analysis yielded that boys were more likely to be victims of CSA compared to girls. Another recent study examined the prevalence of child abuse among college male and female students (n = 963) in Egypt and found that 13% of the sample had experienced CSA (Mansour et al., 2010). The abuse was significantly higher among males ($p = 0.018$) compared to females. Similar findings were found in a study conducted in the Kingdom of Saudi Arabia among male and female adolescents (n = 16963) (Al-Eissa et al., 2015). Ten percent of Saudi adolescents experienced

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CSA, and the rate was higher among boys compared to girls. In a national study conducted among 4,467 Arab high school male and female students in Kuwait to identify the prevalence of child abuse (physical, sexual, and emotional), the prevalence of CSA, specifically sexual attacks and someone threatening the child with sex, was not significantly different between girls and boys (Al-Fayez et al., 2012). On the contrary, CSA that included unwanted touching of sexual parts and someone sexually exposing themselves to the child was higher among boys compared to girls. Yet a study in Palestine among college male and female students found the CSA rate was similar between the genders. (Haj-Yahia & Tamish, 2001). Findings of similarity between boys and girls were also reported among children in Lebanon for CSA occurring before and after the 2006 Hezbollah-Israeli war (Usta & Farver, 2010). Nonetheless, boys reported more CSA during the war than girls. Interestingly, in a retrospective study of 128 cases in Egypt, prevalence of CSA was higher among girls (54%) compared to boys (43%) (Hagras, Moustafa, Barakat, & El-Elemi, 2011). Although the above studies varied in their sample size, the age of the sample, and country, all except the study by Hagras et al. (2011) reached a consensus that CSA is more common among Arabic boys than girls. These findings contradict those from other international studies where CSA is more prevalent among females than males (Finkelhor, 1994b; Steel et al., 2004; Stoltenborgh, van IJzendoorn, Euser, & Bakermans-Kranenburg, 2011).

Gender variation in the prevalence of CSA between Arab survivors and survivors from other ethnic groups diminished in studies that focused on female survivors only. For instance, the study among Moroccan females (n = 728) found that 9% of the sample had experienced some form of CSA (Alami & Kadri, 2004), while in the study conducted in Palestine, 31% of adolescent females (n = 217) in a Bedouin-Arab community reported CSA (Elbedour, Abu-Bader, Onwuegbuzie, Abu-Rabia, & El-Aassam, 2006). The prevalence results in the Moroccan and

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Palestinian studies confirm that found among European female college students (11.5%) (Cantón-Cortés & Cantón, 2010) and Western female CSA survivors (28%) (Ullman, 2007).

The contradiction in the prevalence findings between the genders could be attributed to multiple factors. First, CSA is a cultural taboo and highly sensitive topic that is discouraged by many people (Timraz et al., 2017). Second, the survivors' feelings of shame and the stigma of being abused may hinder their disclosure. Third, the fear of being forced to marry the rapist or binge killed (i.e., honor killing) to restore family honor or conceal the abuse strongly impacts disclosure (Elbedour et al., 2006; Polonko et al., 2010). Fourth, girls have less freedom than boys, and girls are protected by social norms and closely observed (Al-Eissa et al., 2015), which minimizes their risk of being sexually abused by non-family members. Nonetheless, these norms might contribute to the high prevalence of familial abuse among Arabic females, as found in the pilot study conducted among Arab American females (Timraz et al., 2018). Lastly, being perpetrated by someone known to the victims and their families, including relatives and/or family members (Al-Fayez et al., 2012; Alami & Kadri, 2004; Haj-Yahia & Tamish, 2001), increases the victim's chance of not being believed by the family or being blamed for the abuse.

CSA Characteristics Among Arabs

Only a few studies conducted among Arabs provided information on CSA characteristics, including type of sexual abuse, age of onset, frequency, and relation to the perpetrator (Al-Eissa et al., 2015; Al-Fayez et al., 2012; Alami & Kadri, 2004; Elbedour et al., 2006; Haj-Yahia & Tamish, 2001; Saad, Hashish, Abdel-Karim, & Mohammed, 2016; Usta & Farver, 2010). This section provides an overview of the abuse characteristics found in these studies.

Type of CSA. In a study from Morocco, the prevalence of contact CSA with/without penetration and non-contact CSA was approximately similar among the female survivors (Alami

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& Kadri, 2004). Unfortunately, the authors did not provide any further description of what constitutes contact and non-contact CSA. In a study by Elbedour et al. (2006), the authors found that the most common types of abuse experienced by the women were sexual requests (53.3%), someone exposing his/her sexual parts to the women (16%), and fondling (13%). Sex with and without penetration, forcing the woman to show her genitals, and being forced to fondle the other person were the least common types of abuse reported. On the contrary, 51%, 34%, and 15% of survivors in Lebanon experienced sexual attempts, sexual acts, and exposure to sexually explicit media, respectively (Usta & Farver, 2010). Sexual attack and threatening the survivors with sex were found among Kuwaiti high school students (Al-Fayez et al., 2012). Interestingly, unwanted touching of sexual parts and someone sexually exposing themselves to the survivor were more prevalent among boys compared to girls; similar results were found in the study by Haj-Yahia and Tamish (2001). Additionally, in the latter study, touching the survivors against their will, kissing or hugging them in an upsetting way against their will, and exposing the perpetrator's genitals were prevalent among the survivors. Despite the commonality of one type of CSA or another, the studies showed that survivors experienced a wide range of contact and non-contact CSA.

Age of CSA onset. The mean age of CSA onset among Moroccan survivors was 14.5 ± 2.3 years, and approximately 67% were 13-19 years old at the time of CSA (Alami & Kadri, 2004). The study by Saad et al. (2016) had similar findings; CSA was more common among older children between 12 and 18 years old. Furthermore, 88% of CSA survivors in Egypt were between 10 and 18 years old (Hagras et al., 2011). Older age of CSA onset with mean age of 10 years was also found in a study conducted in the United States (Steel et al., 2004).

Relationship to the perpetrator. CSA can be perpetrated by family members, non-family members, friends, and/or strangers. In the study of Moroccan female survivors of CSA, 56% were

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sexually abused by someone known to them but not a family member, and 20% were abused by a family member (Alami & Kadri, 2004). In the study among Kuwaiti high school students, a large number of the survivors had been abused by relatives in the extended family (Al-Fayez et al., 2012). The study conducted with Palestinian university students found that perpetration was commonly committed by a stranger (46%) or a relative outside the home (36%) versus a family member since early childhood (19%) (Haj-Yahia & Tamish, 2001). Similar results were found in the studies conducted among Lebanese, Egyptian, and Palestinian survivors; that is, the CSA was commonly perpetrated by a stranger or someone known to the victim (e.g., a relative), followed by family members (Elbedour et al., 2006; Saad et al., 2016; Usta & Farver, 2010). In the study conducted by the PI among Arab American female CSA survivors, 9 of 10 were abused by someone known to them: 70% were abused by family members including father, uncle, and cousin, and 20% were abused by a friend (Timraz et al, 2018). Perpetration by relatives (i.e., family member/intimate partner) was also common among survivors from ethnic minority groups such as African American, Hispanic, and Asian American (Ullman, 2007). The high prevalence of being perpetrated by a family member or stranger was also documented in the studies conducted among CSA survivors from other cultural backgrounds (Berliner & Elliott, 2002; McLean, Morris, Conklin, Jayawickreme, & Foa, 2014; Ullman, 2007). The survivors' fear and reluctance to report a family member as the perpetrator might explain the low prevalence. Overall, being of Arabic descent and part of a collective society does not preclude perpetration by a family member or by someone known to the survivors and their families.

Arabs' Social Reactions to Abuse Disclosure

Only three studies addressed the social reaction to abuse disclosure among Arabic survivors (Abu-Baker, 2013; Shalhoub-Kevorkian, 1999; Usta & Farver, 2010). The first study

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was qualitative and conducted among two groups who attended therapy (27 adult survivors of CSA and eight families of CSA children) to explore parental reactions to CSA and the factors that influenced their reaction (Abu-Baker, 2013). Parental reactions to abuse was categorized by the functionality of the family and relationship to the perpetrator. Functional families' reactions were (1) seeking therapy for both the survivors and perpetrator in cases of familial abuse; (2) seeking help for the victim and removing the perpetrator from the family and community when the abuser was from the extended family; (3) disconnecting any relations with the perpetrator and forcing him to move from the community in the case of non-familial abuse; and (4) taking care of the survivor physically and emotionally and punishing the perpetrator when he/she was a stranger. On the other hand, dysfunctional families' reactions were (1) blaming the survivor in cases of familial abuse; (2) forcing the survivors to marry the perpetrator or a cousin in cases of familial abuse by extended family; (3) covering up CSA when the perpetrator was a community member; and (4) getting revenge or enforcing marriage when the perpetrators were strangers (Abu-Baker, 2013). As seen by these reactions, seeking therapy for the survivor and perpetrator in some instances was the family priority in functional families. Nonetheless, it is worth noting that reporting to authority was infrequent for familial abuse except in the case of stranger CSA. Thus, it can be inferred that cohesion with the extended family and community was highly valued, and reporting to authority may threaten this relationship and publicize the abuse, leading to family crisis.

Another qualitative study found that Palestinians' social reactions to abuse disclosure included acknowledgement of the abuse in various ways, such as providing psychological support to the victim; imprisonment and institutionalization of the survivors (to protect them from being killed or ostracized by family); termination of pregnancy; femicide (i.e., honor killing); hymen reconstruction; and forcing the survivor to marry her perpetrator (Shalhoub-Kevorkian, 1999). The

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main reasons for disclosing CSA were (1) terminating a pregnancy; (2) loss of virginity; and 3) fear of losing virginity. Disclosure of CSA was delayed by some survivors due to the feelings of shame and guilt, the taboo of talking about sexual matters, and the fear of losing their lives. In a third study addressing social reactions to disclosure conducted by Usta and Farver (2010) in Lebanon, the authors found that only 54% of their sample disclosed abuse to their parents, whose reactions included listening to the child (43%), telling the child it was not important (14%), avoiding talking about the abuse (14%), scolding the child (6%), and not reacting (23%). Children withheld their disclosure because of their fear of the perpetrator and/or parents and shame. Although the Palestinian studies by Abu-Baker (2013) and Shalhoub-Kevorkian (1999) were conducted more than ten years apart, social reactions to CSA disclosure remained the same. Thus, the sociocultural values and beliefs of women's purity, chastity, family honor, and collectivism frame social reaction to disclosure, which is geared toward restoring family and societal stability and harmony (Shalhoub-Kevorkian, 1999). Although the study in Lebanon did not provide further details of social reaction, more than half of the children received passive reaction to their disclosure (Usta & Farver, 2010). It is critical to acknowledge that parental and societal reactions to abuse disclosure can contribute to either revictimization or healing from the trauma (Ullman, 2003). In studies that illustrate Arabic parental reactions to CSA, the findings cannot be generalized and should be interpreted cautiously. In other words, the political issues in Palestinian and Lebanese society may contribute to the survivors' disclosure and parental reactions, which could be different in Arabic societies in more politically stable conditions.

Arabs Coping With CSA

Although no studies were found that focused on examining coping among Arabic CSA female survivors, it can be argued that disclosure of CSA and seeking therapy or nonprofessional

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help either during childhood or adulthood are considered ways of coping. For instance, in the study by Elbedour et al. (2006), 43% of the female survivors coped with their abuse by seeking help from family, friends, and teachers. On the other hand, Palestinian female survivors coped with CSA via disclosure and/or seeking therapy from professionals (Abu-Baker, 2013; Shalhoub-Kevorkian, 1999; Usta & Farver, 2010). Coping with CSA can take many forms, so to obtain a complete understanding of the survivors' coping, it is imperative to consider other factors such as characteristics of abuse, Arabic culture values and beliefs, acculturation, and social reactions to disclosure – all of which influence coping and long-term psychological outcomes.

Psychological Outcomes of CSA Among Arabs

Negative psychological outcomes of CSA have been documented among Arabic survivors. Some studies identified the relationship between abuse characteristics and psychological outcomes, and others only examined CSA outcomes. For instance, CSA psychological outcomes including anxiety, depression, psychosis, hostility, somatization, phobic anxiety, paranoid ideation, psychological distress, and obsessive-compulsiveness were found among Palestinian survivors; the severity of the outcomes varied among the survivors depending on their relationship to the perpetrator (Haj-Yahia & Tamish, 2001). Similar results were found between continuous familial abuse and PTSD among European college students (Cantón-Cortés & Cantón, 2010). Furthermore, a positive relation between PTSD and abuse by a relative was found among a diverse population of CSA survivors (African American, Hispanic, Asian American, White) (Ullman et al., 2007). Depression, anxiety, and sleep disturbance were reported by a large number of Moroccan females who were abused between the ages of 6 and 10 (Alami & Kadri, 2004).

The debilitating effects of experiencing CSA at early ages by someone known to the survivors are well documented in the literature (Cantón-Cortés & Cantón, 2010; Sciolla et al.,

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2011). In Egypt, relationships between childhood abuse and psychological outcomes that included low self-esteem, dissociation, self-harm, impulsivity, and aggression were reported by the survivors (Mansour et al., 2010). Child abuse was also significantly related to depression, phobia, somatization, obsessive-compulsive disorder, and anxiety among Egyptian survivors (Saad et al., 2016). Reporting of trauma symptoms including depression, PTSD, sleep disturbance, anxiety, and dissociation were at higher rates among CSA survivors than non-CSA participants in Lebanon (Usta & Farver, 2010). Furthermore, CSA female survivors reported higher trauma symptoms than their male counterparts. The high trauma symptoms among females could be attributed to the societal taboo and suppression of discussing sexuality in general and CSA in particular (Fontes & Plummer, 2010; Polonko et al., 2010). Additionally, females' fear of disclosure and the subsequent outcomes of doing so, including blame, disgracing the family name, ruining one's reputation, and honor killing, might hinder disclosure (Fontes & Plummer, 2010; Haboush & Alyan, 2013). Another explanation for not disclosing is that the CSA perpetrators in the conducted studies were mainly someone known to the victims, including relatives and family members (Al-Fayez et al., 2012; Alami & Kadri, 2004; Haj-Yahia & Tamish, 2001), so the chance of not being believed by the family and being blamed for the abuse could be a barrier to disclosure. Furthermore, the victim's fears of destroying family ties and parental divorce were found as barriers to disclosure in the pilot study conducted among Arab American female survivors of CSA (Timraz et al., 2018).

That CSA is a strong predictor of psychological problems in childhood and adulthood and abuse characteristics account for some of the outcomes are consistent findings in studies conducted in Arabic countries including Kuwait, Egypt, Palestine, and Morocco and those conducted in Western and European countries (Al-Fayez et al., 2012; Alami & Kadri, 2004; Felitti et al., 1998; Haj-Yahia & Tamish, 2001; Walsh et al., 2010). To obtain a better understanding of the

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relationship between CSA and psychological outcomes, the survivors' coping strategies must be explored. Even though survivors of CSA consistently had negative psychological outcomes, there was some variation in the findings, which could be attributed to the different coping strategies employed. The sociocultural context (i.e., social reaction to CSA, cultural values and beliefs) of the survivors must not be ignored, as this is one of the factors that impacts coping with CSA.

Conceptual Framework

Overview of the Framework

Two approaches of coping theories exist in the literature: trait-oriented and process-oriented. The trait-oriented approach posits that coping consists of individual dynamics with some environmental influence on coping. An example is Selye's general adaptation syndrome (Krohne, 2001). On the other hand, the process-oriented approach posits that an individual's coping depends on the psychological and environmental demands of a situation. An example of this approach is the transactional model of stress and coping theory developed by Folkman and Lazarus (Folkman, Lazarus, Dunkel-Schetter, DeLongis, & Gruen, 1986; Krohne, 2001). The majority of studies that addressed coping with CSA have adopted the process-oriented approach (Asberg & Renk, 2013; Cantón-Cortés & Cantón, 2010). Furthermore, a process-oriented approach may expand our knowledge of factors that account for coping variations among survivors. Thus, to fulfill the aims of the present study, a process-oriented approach such as the stress and coping model is ideal. An overview of the model and its constructs will be presented in the next section.

Transactional Stress and Coping Model

Psychological Stress

Folkman and Lazarus (1984) defined psychological stress as the "relationship between the persona and the environment that is appraised by the person as taxing or exceeding his or her

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resources and endangering his or her well-being" (p. 19). Thus, it can be inferred that the degree of stress experienced by individuals depends on their appraisal and evaluation of the encounter. The relationship between the person and environment is dynamic, mutually reciprocal, and bidirectional. The relationship is mediated by two processes: cognitive appraisal and coping (Folkman & Lazarus, 1984; Folkman, Lazarus, Gruen, & DeLongis, 1986). There are two types of stress stimuli: daily hassles and major life events. Some might assume that major life events have a greater impact on health than daily hassles. Nevertheless, DeLongis, Coyne, Dakof, Folkman, and Lazarus (1982) concluded that the correlation between daily hassles and somatic health was greater than the correlation between life events and somatic health. Furthermore, the intensity and frequency of hassles are significantly related to health outcomes. Major concepts of the model (e.g., coping, cognitive appraisal, emotion) and their relation to stress are described next.

Cognitive Appraisal

According to Folkman and Lazarus (1984), cognitive appraisal is defined as "the process of categorizing an encounter, and its various facets, with respect to its significance for well-being" (p. 31). Cognitive appraisal is essential for individuals to determine if the encounter is stressful or benign and to mediate their behavioral and emotional responses (Aldwin, 2007; Folkman & Lazarus, 1984). There are two types of appraisal: primary and secondary. Primary appraisal refers to individuals' evaluation of what is at stake and its significance to their well-being in the specific encounter (Folkman, 2008; Folkman, Lazarus, Dunkel-Schetter, et al., 1986; Krohne, 2001). Secondary appraisal refers to individuals' evaluation of their coping options to overcome or prevent harm (Folkman & Lazarus, 1984; Folkman et al., 1986; Krohne, 2001).

Overall, stressful encounters or situations do not predict stress or individuals' coping processes. Instead, they trigger cognitive appraisal that in turn evaluates the encounter as

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threatening, harming, or challenging (Lazarus, 1993). There are three types of primary appraisal: irrelevant, benign appraisal, and stressful. When the transaction between the person and environment has no impact on the person's well-being, it is appraised as irrelevant. On the other hand, if the transaction leads to favorable outcomes or enhances the individual's well-being, then it is appraised as benign-positive. Stressful appraisal includes three types: harm, threat, and challenge appraisals. In harm appraisal, the psychological damage and loss have already taken place, and the appraisal is accompanied by negative emotions such as sadness and anger. Threat appraisal refers to damages or losses that have not yet occurred, but they are anticipated. Uncertainty in such circumstances leads to feelings of fear and anxiety. The challenge appraisal is positive and accompanied by pleasurable emotions, such as excitement, eagerness, and confidence, because it focuses on the individual's gains and growth (Folkman & Lazarus, 1984).

It can be noted that each type of stressful appraisal is accompanied by different emotions. Thus, emotions are interrelated with cognitive appraisal, and as they change, the appraisal of an encounter changes (Folkman & Lazarus, 1984). It is important to understand that threat and challenge appraisals can occur simultaneously (Folkman & Lazarus, 1984, 1985). For instance, a study completed by Folkman and Lazarus (1985) examined the complexity of coping and contradictory emotional states among undergraduate college students in three stages of college examination. The researchers concluded that students employed contradictory emotions (e.g., threat and challenge) during every stage of the examination. However, what is considered challenging at one point in time may be considered threatening at another point (Folkman, 2008; Folkman & Lazarus, 1984; Krohne, 2001).

Cognitive appraisal is influenced by individuals' characteristics, such as motivation, beliefs about self and the world, values, commitments, and recognition of personal resources (Folkman &

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Lazarus, 1988; Folkman, Lazarus, Gruen, et al., 1986). Additionally, some environmental factors affect appraisal of the stressful encounter as threatening, challenging, or harmful, such as novelty of the encounter; event uncertainty; imminence; ambiguity; duration of the event; timing over the life cycle; and social support resources (Folkman & Lazarus, 1984, 1988). Coping processes heavily depend on an individual's cognitive appraisal of an encounter.

Coping

Coping is defined as "constantly changing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person" (Folkman & Lazarus, 1984, p. 141). From this definition, it can be inferred that coping is process-oriented rather than trait-oriented because it is dynamic and changes continuously depending on the appraisal and reappraisal of the person-environment relationship. Reappraisal is a consequent appraisal that follows the initial appraisal and is influenced by new environmental and/or personal information. Coping occurs in response to demands that are evaluated cognitively as harmful, challenging, or threatening, which explains the variation among individuals regarding the employment of different coping strategies for the same encounter. A clear distinction should be made between coping function (i.e., what the individuals do or think to manage their demands) and coping outcomes because coping function is dynamic and context-dependent (Folkman & Lazarus, 1984, 1988). Moreover, coping function or process is more diverse than stable across different encounters (Folkman et al., 1986). For instance, employing denial after a major examination may decrease the level of distress and help an individual move forward. On the contrary, employing denial for chronically ill individuals who experience chest pain may lead to health complications and hospitalization (Folkman & Lazarus, 1984).

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Types of coping. There are two forms of coping functions: problem-focused and emotion-focused. When individuals regulate their emotional responses to a problem that is appraised as non-modifiable, they are employing emotion-focused coping. However, if individuals manage and alter an encounter that is appraised as modifiable and causes stress, they are employing problem-focused coping (Folkman & Lazarus, 1984, 1985, 1988). There are several types of emotion-focused coping, including distancing, escape-avoidance, accepting responsibility, exercising self-control, positive reappraisal, and seeking social support. On the other hand, problem-focused coping includes confrontive and planful-problem solving coping (Folkman & Lazarus, 1988).

Problem-focused coping and emotion-focused coping occur simultaneously. In other words, individuals can employ both emotion- and problem-focused coping to deal with demands that are appraised as stressful (Folkman & Lazarus, 1984). For instance, a study that aimed to analyze how middle-aged men and women cope with the stressful events of everyday life over one year found that for every stressful encounter, both problem-focused and emotion-focused coping were employed by a majority of participants. Nevertheless, 18 out of 100 participants employed only one type of coping (Folkman & Lazarus, 1980). Another study that investigated the coping processes of undergraduate college students undergoing examinations found that the students combined both problem-focused and emotion-focused coping during the three examination stages (anticipation, the waiting stage after the exam before grading, and after receiving the grade) (Folkman & Lazarus, 1985). Thus, it can be concluded that there is no good or bad coping and individuals can employ both emotion- and problem-focused coping concurrently or subsequently to deal with encounters. A good example of employing the two types of coping in a subsequent manner is the phenomenological study by Phanichrat and Townshend (2010) that explored the coping strategies of adult CSA survivors. The authors found that female survivors of CSA tend to

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initially employ avoidance coping, a type of emotion-focused coping, in the aftermath of CSA; this gradually changes to problem-focused coping, such as seeking support and self-acceptance. Most of the survivors (n = 7) were White British, and the rest were from other ethnic groups that were not identified.

Antecedent Factors and Outcomes

Certain factors, including resources and constraints, determine the individual's way of coping with specific encounters (Folkman & Lazarus, 1984). Resources facilitate an individual's coping, while constraints hinder the individual from using these resources. Some resources are properties of the individual like health and energy, positive beliefs, commitments, problem-solving skills, and social skills; others are environmental such as social support and material resources. Personal constraints include cultural values and beliefs. Environmental constraints include competing demands for the same resources. A good example that illustrates the competing demands between coping resources and constraints is the pilot study conducted among Arab American female survivors of CSA (Timraz et al., 2018). The researchers found that Arabic female CSA survivors were hesitant to disclose their abuse and seek social support from family due to their fear of being blamed and stigmatized by the family and society. Regardless of the factors that influence cognitive appraisal and coping, both processes strongly impact adaptational physical, social, and psychological outcomes. Folkman and Lazarus (1984) indicated that adaptational outcomes include short- and long-term social functioning, morale, and somatic health. Social functioning refers to individuals' roles, satisfaction with relationships, or the skills required for maintaining roles and relationships. Morale reflects individuals' feelings about themselves and the world around them. Lastly, somatic health is the physiological changes that result from a stressful encounter. Coping impacts health through three pathways: (1) changing the frequency, intensity,

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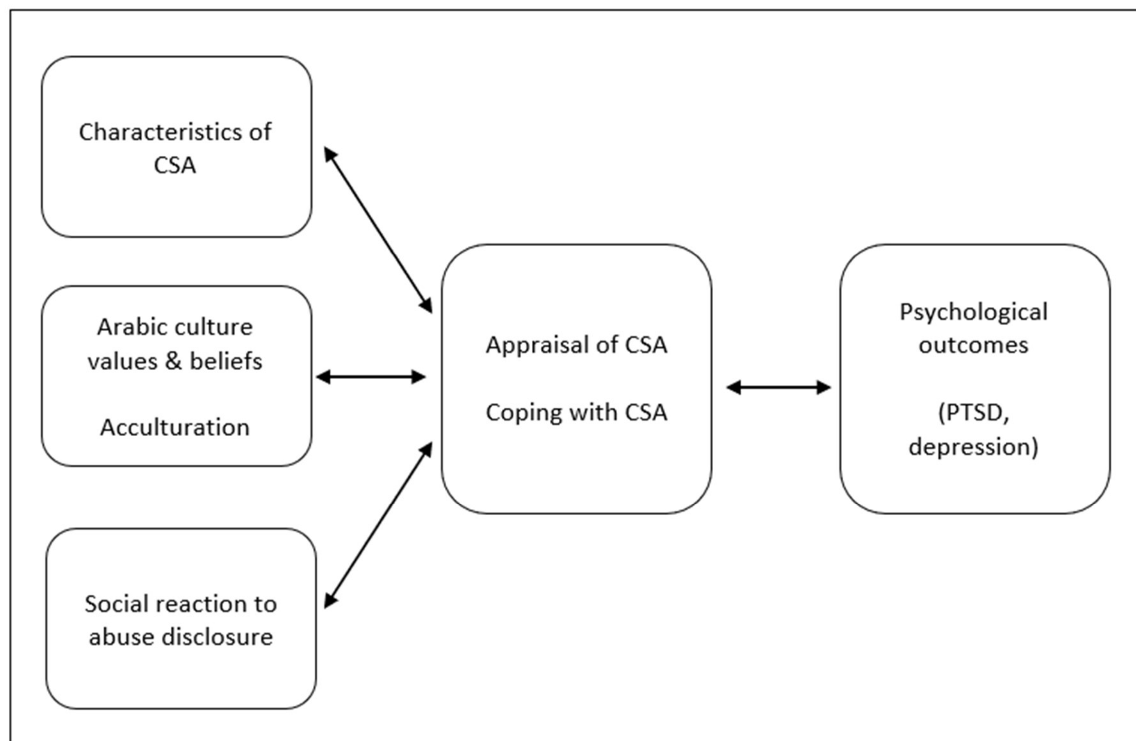
duration, and pattern of the physiologic stress reaction; (2) engaging in risky behavior, such as substance abuse and self-harm; and (3) hindering adaptive health/illness-related responses.

Description of the Study Concepts

The study's conceptual-theoretical (CT) model for understanding the coping and psychological outcomes among CSA survivors of Arabic descent is derived from the Transactional Stress and Coping Model (Folkman & Lazarus, 1984). The model consists of five major variables: stress, appraisal, coping, antecedents of stress and coping, and short- and long-term adaptational outcomes. In this study, CSA represents the source of stress. CSA characteristics, Arabic culture values and beliefs, acculturation, and social reactions to abuse disclosure represent the antecedent factors (Figure 1).

Figure 1. Conceptual-Theoretical Model of Coping With CSA



Folkman and Lazarus (1984) placed a great emphasis on cognitive appraisal (i.e., primary and secondary) because it reflects the individuals' evaluation of the stressful encounter and the

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subsequent coping strategies. Thus, the female survivors' appraisal of their CSA experience as stressful (i.e., harm, threat, challenge) or benign will be explored qualitatively. Upon those findings, the female survivors' coping strategies including emotion-focused and problem-focused will be explored. To meet the purpose of this study, only the psychological domain of the long-term adaptational outcomes will be addressed. To obtain a better understanding of coping among CSA female survivors of Arabic descent, some of the variables will be explored both qualitatively and quantitively. These variables are acculturation, social reactions to abuse disclosure, coping, and long-term psychological outcomes (e.g., PTSD, depression).

Summary

It is well acknowledged that CSA is a widespread problem that violates children's right to protection. Although children are resilient, many adult CSA survivors have developed negative psychological outcomes resulting from their sexual abuse (Felitti et al., 1998; Walsh et al., 2010). Coping with CSA is one of the factors that strongly predicts the post-abuse adjustment and negative psychological outcomes in adulthood, as presented in the studies discussed above. Avoidant (i.e., emotion-focused) coping is predominant among CSA female survivors and has been associated with an array of psychological outcomes like PTSD, depression, and personality disorder (Brand & Alexander, 2003; Johnson et al., 2004; Wright et al., 2007).

It is well documented in the literature that CSA characteristics can predict CSA-negative psychological outcomes either directly or indirectly through coping (Cantón-Cortés & Cantón, 2010; Steel et al., 2004; Ullman et al., 2014). In addition to CSA characteristics, a relationship between culture and coping has been established in a small number of studies (Barker-Collo et al., 2012; Ullman & Filipas, 2005a). In other words, the cultural values and beliefs held by the survivors and their community can determine the type of coping strategies employed by female

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survivors (e.g., the disclosure of abuse, confrontation, seeking support) and the social reaction to disclosure. Unfortunately, no studies were found that explored coping with CSA among Arabs or Americans of Arabic descent. The only studies available among Arabs are those conducted in Arabic countries; these mainly examined the prevalence and negative outcomes of CSA. Interestingly, the prevalence of CSA was higher among males than females, which indirectly illustrates the impact of culture on disclosure and reporting CSA by female survivors. Reactions to CSA disclosure among some Arabs can go beyond blaming the victims to include femicide or exclusion from the family. On the other hand, withholding disclosure can exacerbate the negative CSA outcomes. Considering the large number of Arabs living in the United States, it is imperative to understanding the coping strategies and psychological outcomes influenced by CSA characteristics, cultural values and beliefs, acculturation, and the social reactions to CSA of female survivors of Arabic descent.

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CHAPTER 3 METHODS

This chapter provides an overview of the study's design, sample and setting, instruments, procedure and data collection, data management and analysis, rigor of qualitative analysis, validity approach, and ethical consideration. In addition, an overview of the pilot study that was used as guide for the current study is presented.

Pilot Study

Design

In 2014, the PI conducted a pilot study in Metropolitan Detroit, an urban community in the U.S. Midwest, to explore coping with CSA and long-term psychological outcomes among Arab American female survivors of CSA (Timraz et al., 2018). The study design was a descriptive exploratory qualitative design. This design was selected to fulfill the aim of exploring and describing the survivors' experiences in their own words. In addition, the qualitative descriptive design enabled the researcher to elicit more information about the phenomenon, which was not explored previously among this population.

Procedure and Data Collection

After obtaining the university Institutional Review Board approval, ten women who identified themselves as Arab American and who were between 18-40 years old with a history of CSA and fluent in English were recruited in the study in the years 2014-2016. The women were recruited through the university webpage, at a community center frequented by Arab American, and by candidate word of mouth.

The data were collected through individual semi-structured interviews that lasted for approximately 45 minutes. The interview guide was developed by the researcher guided by the Lazarus and Folkman Stress and Coping model (Folkman & Lazarus, 1984), existing literature,

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and input from experts in child sexual abuse and qualitative methodology. The interview guide consisted of open-ended questions about the CSA characteristics, social support, Arabic culture, coping, and long-term psychological outcomes. The interviews were conducted either in-person, by phone, or by email depending on the women's preferences. All interviews except the email interview were audio recorded. The women received a $25 gift card as an appreciation for their time and a list of resources that had numbers of hotlines and centers for survivors of abuse and violence. The PI conducted a debriefing follow-up by phone or email within a week after the interview to ensure the women's emotional stability.

Data Analysis

The qualitative data were analyzed using content analysis. The recorded interviews were transcribed verbatim and double-checked for their accuracy by the researcher. The transcribed data were coded by two independent coders until the interrater reliability reached 95% by the sixth interview. The coding book was developed based on the theoretical framework and existing literature on CSA. A descriptive summary of each coded interview was provided. The case summaries then were entered into an Excel spreadsheet for across and within case analyses. Themes were developed by aggregating the codes into broad categories to provide a clear description of the experience of Arab American female survivors of CSA.

Results

Most of the women in the study (n = 9) had experienced contact CSA by family members. Most of the women disclosed their CSA prior to the study to a parent, friend, cousin, sibling, partner, therapist, and/or police officer and had received supportive and unsupportive reactions. Arabic culture values and beliefs about sexuality, CSA, CSA survivors, disclosure, men, mental illness, and seeking professional help were identified by the women as influencing their CSA

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experiences. The women employed an array of coping strategies including seeking support, avoidance, protective coping, accepting responsibility, and positive reappraisal. The negative long-term psychological outcomes identified by the women were CSA flashbacks, difficulty falling asleep and maintaining sleep, low self-esteem, lack of empathy, anger, paranoia, depression, anxiety, difficulties with trust, and sexual issues. The findings of the pilot study helped the researcher to initially understand the CSA experience of Arab American women. Furthermore, the researcher utilized the findings of that study to build upon and carefully design the current study.

Dissertation Study

Design

This study was conducted using a mixed-methods design (MMD). According to Creswell (2014), MMD is defined as "an approach to inquiry involving collecting both qualitative and quantitative data, integrating the two forms of data, and using distinct designs that may involve philosophical assumptions and theoretical frameworks" (p.4). Convergent MMD, which is one of three basic MMD, was selected to guide the current study.

The proposed study was conducted using the mixed-methods design to fulfill the aim of complementarity by gaining a comprehensive understanding of the phenomenon using both qualitative and quantitative methodology (Creswell, 2013). One of the hallmarks of MMD is that the strengths of one method outweigh the weaknesses of the other (Bryman, 2006; Carr, 1994; Creswell & Clark, 2011; Johnson & Onwuegbuzie, 2004). Other advantages of mixed methods include: (1) theory and knowledge development; (2) qualitative data (words) used to add meaning to the numerical quantitative data; (3) numbers used to confirm the words; (4) generalizability of the findings; (5) instrument development; (6) answering complex questions that cannot be addressed by a single method; and (7) practicality, in that researchers have the choice to use

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different methods best suited to answer their questions. It is important to acknowledge the value and uniqueness of the three existing approaches, qualitative, quantitative, and MMD, and to recognize that no specific approach is superior to the other (Foss & Ellefsen, 2002).

Convergent MMD was selected because it is characterized by (a) collecting qualitative and quantitative data concurrently, giving equal emphasis to both methods; (b) analyzing the two data sets independently; and (c) merging the two sets together during the interpretation (Creswell & Clark, 2011). (See Figure 2.)

As a further advantage of convergent MMD, both types of data can be collected from the same sample, an important consideration given that the Arabic population is a difficult to reach minority group in the United States (Timraz et al., 2017). Additional challenges for recruiting this population include the sensitive nature of the topic, females' fear of disclosing CSA, the influence of a female's companion (i.e., male, senior female) regarding consent for the study, and language barriers. In the present study, some strategies, including those informed by Timraz et al. (2017), were implemented to overcome these challenges, such as assuring potential participants that their confidentiality and privacy were maintained within the legal limits, providing a description of how the study data would be protected, describing how the study data would be disseminated and distributed to the public, establishing a relationship with the potential participant and her family member to build trust, explaining the purpose of the study in lay language privately, asking participants for language preference, and having a bilingual recruiter fluent in English and Arabic.

When recruiting stigmatized or hard to reach persons, it was imperative to have a well-designed study flyer and/or advertisement. For this study, careful attention was made toward the language, text, font size, color, picture, and credibility of the brochure /advertisement following recommendations in the literature (Hershberger et al., 2011). Brochure refers to the printed

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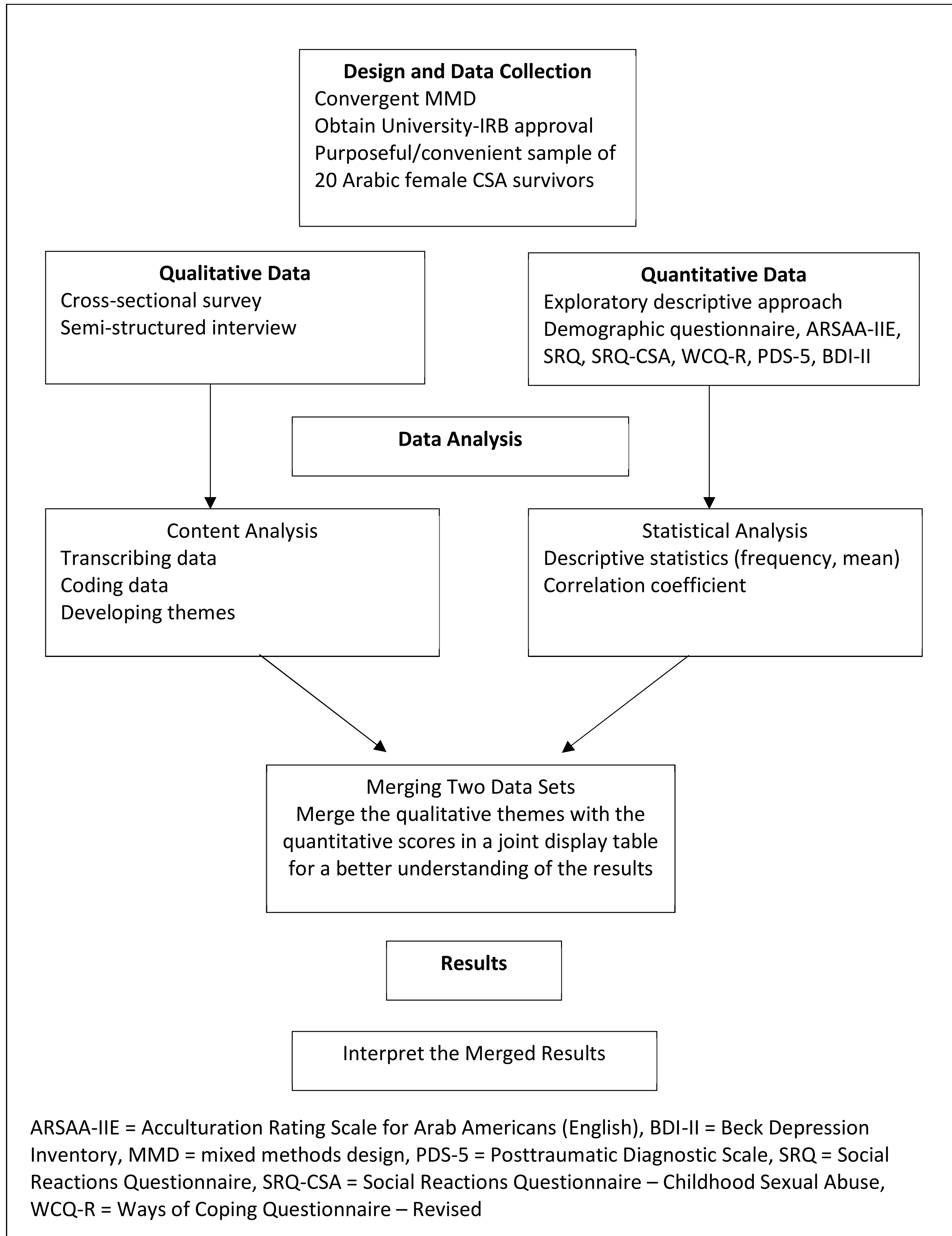
Figure 2. Convergent Mixed-Methods Design



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description of the study, while advertisement refers to the electronic description of the study posted in web pages and social media. Because CSA is a hidden topic and not well perceived by a large number of Arabs, the PI ensured that the language was culturally appropriate and did not antagonize the interested women. Also, the pictures/clip art were culturally appropriate and reflected the aim of the study and the targeted population. To increase the credibility, the university logo, IRB protocol number, and study approval date were included in the flyer. The study advertisement included the same information as the flyer and was created on the university server to increase credibility. To facilitate communication, a hyperlink of the PI's university email was embedded in the advertisement, a strategy used successfully by Hershberger et al. (2011).

Sample and Setting

Setting. Multiple sites were approached to recruit participants using active and passive approaches. The sites were health and counseling centers, universities, and social media sites.

The health and counseling centers posted the study advertisement on their web pages for one time only, and this approach did not yield any participants. On the other hand, the study advertisement was posted on a weekly basis at the university webpage for nine months. Sixteen women were recruited through the university webpage. Additional recruitment methods included social media tools such as Facebook and WhatsApp. Using social media only yielded one participant.

The study flyer was distributed by the PI at a medical center, university campus and counseling center, and university campus health clinic. No participants were recruited from the above sites with the exception of the university campus, which yielded two participants. In addition, one participant was recruited via word of mouth. Other sites like mosques, churches, colleges, and universities were approached by the PI, but potential candidates were either reluctant

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to provide their approval due to the sensitive nature of the topic, or they never responded to the PI's email requests.

Sample. A purposeful convenience sample of 20 Arabic female CSA survivors participated in the study. Purposeful sampling enabled the researcher to select information-rich cases to fulfill the purpose of the study (Patton, 2014; Streubert & Carpenter, 2011). Creswell and Clark (2011), recommended using the same participants to collect qualitative and quantitative data when the aim of the study is corroboration, comparison, or relating findings of the two datasets. Thus, to achieve the study aim of complementarity, a single sample, or what Collins, Onwuegbuzie, and Jiao (2006) called "identical," was considered.

To obtain in-depth understanding of Arabic females' coping with CSA and psychological outcomes, the sample size of 20 participants was determined. Having a large sample size would not serve the purpose of the study and would result in fewer details (Creswell & Clark, 2011); on the other hand, a smaller sample studied extensively may generate rich data (Curtis, Gesler, Smith, & Washburn, 2000). Additionally, the design of the qualitative and quantitative methods was exploratory descriptive and descriptive, respectively. According to Burns and Grove (2008), the sample size of most descriptive studies is usually small because the aim is to gain a greater understanding of the phenomenon and not a generalization. In qualitative approaches, the sample size depends on the aim of the study, its design, and the researcher's credibility and expertise (Patton, 2014; Sandelowski, 1995). Based on the researcher's previous experience conducting an exploratory qualitative study with Arab Americans (Timraz et al., 2017), 20 participants was sufficient to complete the study.

Inclusion and exclusion criteria. Women who participated in the study (1) were 18 years and older, (2) were of Arabic descent, (3) had a history of sexual abuse prior to the age of 17, (4)

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had at least one explicit memory of CSA, and (5) were fluent in English. Fluency in English was needed to maintain the credibility of the transcribed data. Women were excluded if they had a history of CSA after the age of 17 years, were not fluent in English, and/or were not Arabs. The cut-off age of CSA was determined to be 17 years to minimize overlapping between CSA and intimate partner violence/adult sexual assault. The cut-off age of CSA experience varied among the studies that explored coping strategies and ranged from 14 to 18 years (Asberg & Renk, 2013; Cantón-Cortés & Cantón, 2010; Ullman, 2007).

Measures

To fulfill the purpose of complementarity, data were collected by qualitative and quantitative measures. These measures an included in-depth individual semi-structured interview and five quantitative surveys that measured acculturation, social reaction to abuse disclosure, coping, PTSD, and depression (see Table 1).

Qualitative individual interview. Data was collected during an in-depth individual interview which was congruent with the descriptive qualitative methodology (Creswell & Clark, 2011; Sandelowski, 2000). The interview enabled the researcher to understand and describe the participants' CSA characteristics, cultural values and beliefs, social reaction to abuse disclosure, coping, and psychological outcomes. The interview guide consisted of semi-structured open-ended questions to allow participants the freedom to control pacing and to allow the researcher to elicit comprehensive information about the subject matter (See Appendix B). The interview guide was a modified version of a guide developed and tested for the future pilot study (Timraz et al., 2017) among Arab American female CSA survivors. The guide was based on the available literature and Lazarus and Folkman's transactional stress and coping framework. Additionally,

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Table 1. Measurements Table

	Constructs	Qualitative	Sample questions	Quantitative	Sample questions
Antecedent factors	CSA characteristics	Individual semi-structured interview	Can you tell me about the time you were abused? How old were you when the abuse started?	None	None
	Cultural values and beliefs	Individual semi-structured interview	Do you think being of Arabic descent influences your decision to disclose abuse? How?	None	None
	Acculturation	Can you tell me how important it is to you to follow or honor Arabic values? What are the reasons?		ARSAA-IIE	I enjoy listening to Arabic language music.
	Social reaction to abuse disclosure		Have you ever disclosed your abuse to anyone?	SRQ	1. Told you it was not your fault.
			What were the reasons for the disclosure?	SRQ-CSA	1. Reacted to your story with disbelief.

(continued)

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Table 1. Measurements Table (continued)

	Constructs	Qualitative	Sample questions	Quantitative	Sample questions
Mediating process	Cognitive appraisal	Individual semi-structured interview	Can you tell me, what does the abuse mean to you? How do you feel about being abused?	None	None
	Coping		What do you do to deal with the abuse? How do you think being abused by a stranger or family member influences your way of dealing with CSA?	WCQ-R	1. Just concentrated on what I had to do next – the next step. 33. Tried to make myself feel better by eating, drinking, smoking, using drugs or medication, etc.
Long-term psychological effects	Psychological outcomes	Individual semi-structured interview	How do you feel when you remember the abuse?	PDS-5	3. Reliving the traumatic event or feeling as if it were actually happening again (0 = not at all, 4 = 6 or more times a week)
			How has the abuse influenced your view of yourself and the world around you?	BDI-II	9. Suicide thoughts or wishes (0 = I don't have any thoughts of killing myself, 3 = I would kill myself if I had the chance)

Note. ARSAA-IIE = Acculturation Rating Scale for Arab Americans (English), BDI-II – Beck Depression Inventory, CSA = child sexual abuse, PDS-5 = Posttraumatic Diagnostic Scale, SRQ = Social Reaction Questionnaire, SRQ-CSA = Social Reactions Questionnaire – Child Sexual Abuse, WCQ-R = Ways of Coping Questionnaire – Revised.

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the questions in the guide were aligned with the study's aims (Castillo-Montoya, 2016). The topics in the modified interview guide were (1) antecedent factors of CSA characteristics; Arabic culture values and beliefs, acculturation, and social reaction to abuse disclosure; (2) appraisal and coping processes; and (3) psychological outcomes. In addition to the these questions, there were some closing questions at the end of the interview that intended to assess the psychological well-being of the participants and provide them an opportunity to raise questions that were not addressed during the interview (Castillo-Montoya, 2016).

Sociodemographic questionnaire. Participants completed a sociodemographic questionnaire, including questions about age, marital status, religion, income, health status, educational level, parental education level, employment, type of medical insurance, country of origin, and length of stay in the United States.

Acculturation Rating Scale for Arab Americans-IIE (ARSAA-IIE). ARSAA-IIE is a modified version of the Acculturation Rating Scale for Mexican Americans (ARSMA-II) developed in 1995 by Cuellar, Arnold, and Maldonado (Jadalla, Hattar, & Schubert, 2015; Jadalla & Lee, 2015). The scale was translated into English and validated in a large sample of 297 Arab Americans (Jadalla & Lee, 2015). ARSAA-II is a 28-item self-report measure that assesses acculturation on different dimensions including language use and preferences, ethnic identity and classification, ethnic behavior and interaction, and cultural heritage (Jadalla et al., 2015).

Scoring. The measure is a 5-point Likert scale (1 = not at all, 2 = very little/not very often, 3 = moderately, 4 = much/very often, 5 = extremly often/almost always). Attraction to one culture more than another is indicated by a higher mean score for attraction to Arabic culture (AArC) or attraction to American culture (AAmC). The AArC score ranges from 15-75. The score of AAmC ranges from 13-65.

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Reliability and validity. Factor analysis was run on the ARSAA-II using principal axis factoring and direct Oblimin rotation that yielded two factors: attraction to American culture (AAmC), which has 13 items, and attraction to Arabic Culture (AArC), which has 15 items (Jadalla et al., 2015; Jadalla & Lee, 2012, 2015). The correlation between the two factors was negative (r = -0.33). Cronbach's alpha for AAmC was 0.89, and for AArC, 0.85, in a sample of 297 adult Arab-Americans (Jadalla et al., 2015; Jadalla & Lee, 2015).

Social Reactions Questionnaire (SRQ/SRQ-CSA). SRQ is a 48-item self-report instrument that is designed to assess diverse reactions received by female sexual assault survivors (SAS) upon disclosure (Ullman, 2000). SRQ was initially developed from the literature and pilot-tested on a convenience sample of 155 female SAS (Ullman, 1996). SRQ demonstrated a good validity and reliability when revised and pilot-tested in ethnically diverse samples (i.e., community, college, mental health agencies) of female SAS (Ullman, 2000). SRQ consists of 3 primary scales (turning against, unsupportive acknowledgment, positive reaction) and 7 subscales that measure positive (i.e., beneficial) and negative (i.e., harmful) reactions (Relyea & Ullman, 2013; Ullman, 2000). The validity and reliability of the SRQ has not been established among Arab American female survivors of CSA.

Because the scale was not primarily developed for reaction to CSA disclosure, an additional 12 social reactions questions for CSA disclosure (SRQ-CSA), developed by the SRQ author and used in multiple studies (Ullman, 2007; Ullman et al., 2007) will be administered along with the SRQ (Ullman, 2007; Ullman & Filipas, 2005a).

Scoring. Participants will be asked about how often they receive the 48 reactions from others using a 5-point Likert scale (0 = never, 1 = rarely, 2 = sometimes, 3 = freqeuntly, 4 = always) (Ullman, 2000). The 48 items represent two positive reaction subscales (emotional support and

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tangible aid) and five negative reaction subscales (victim blame, stigma/treat differently, take control, egocentric responses, and distraction). To compute the total score, a mean score is computed for each scale. An alternative scoring is available to identify the percentage of each reaction by dichotomizing participants who received (1-4) versus not received (0). The 12-supplementary CSA questions are measured with a 5-point Likert scale (0 = never, 1 = rarely, 2 = sometimes, 3 = freqeuntly, 4 = always) and scored independently by their average (reversing the score of the 11th question because it measures a positive reaction). SRQ does not have a specific timeframe, and it varies among the studies depending on their needs (Ullman, 2000). For this study, the participants will report any reactions they have received upon CSA disclosure with no time constraint.

Reliability and validity. SRQ had good concurrent validity, construct validity, convergent validity, internal consistency with Cronbach's alpha of the seven subscales ranging from 0.77 to 0.93, and test-retest reliability (r = 0.68-0.77) when tested in a diverse sample of female SAS (Ullman, 2000). Cronbach's alpha for the total scale is 0.91 as demonstrated in a recent study of adult female survivors of CSA (Asberg & Renk, 2013).

Ways of Coping Questionnaire-Revised (WCQ-R*).* WCQ-R is a 66-item self-report scale that measures a wide range of cognitive and behavioral coping strategies used by individuals to deal with internal and/or external demands in a specific stressful encounter (Folkman et al., 1986). The original WCQ-R was 68-items, developed from the literature and Lazarus and Folkman's theoretical framework (Folkman et al., 1986). Redundant and unclear items were deleted or reworded in the revised scale. WCQ-R is designed to assess coping in particular stressful encounters and not coping style or trait. The stressful encounter can be determined by participants

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or the researcher. In this study, CSA is identified as the stressful encounter and the focus of the questionnaire.

WCQ-R has 8 scales that describe a variety of cognitive and behavioral coping strategies. Coping is identified as either problem-focused or emotion-focused (Folkman & Lazarus, 1984). Of the 8 scales, five measure emotion-focused coping (self-controlling, distancing, positive reappraisal, accepting responsibility, and escape-avoidance); two measure problem-focused coping (i.e., confrontive coping, planful problem-solving); and one scale measures both problem and emotion-focused coping (i.e., seeking social support) (Wilson, Vidal, Wilson, & Salyer, 2012). The scale takes about 10 minutes to be completed.

Scoring. The questionnaire is a 4-point Likert scale (0 = not used, 1 = used somewhat, 2 = used quite a bit, 3 = used a great deal). To score the WCQ-R, the raw score for each item on each scale will be added to obtain the total score, which describes the amounts of each type of coping used by the individuals. A high raw score indicates that individuals frequently use this strategy to cope with the stressful encounter.

Reliability and validity. Cronbach's alpha of the 8 scales in a community sample were 0.70 for confrontive coping, 0.61 for distancing, 0.70 for self-controlling, 0.76 for seeking social support, 0.66 for accepting responsibility, 0.72 for escape-avoidance, 0.68 for planful problem-solving, and 0.79 for positive reappraisal (Folkman et al., 1986). The internal consistency scores ranged from 0.61 to 0.79 (Wilson et al., 2012). Cronbach's alphas ranged from 0.40-0.82 in a sample of 101 female survivors of childhood incest (Brand & Alexander, 2003).

Posttraumatic Diagnostic Scale (PDS-5). PDS-5 is a 24-item self-report scale that measures PTSD symptom severity in the past month according to the latest criteria of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) (Foa et al., 2016).The scale starts

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with two sets of questions to assess the presence of trauma history and to determine the current traumatic experience that currently bothers the participant. The PDS-5 assesses the severity and presence of symptoms through 20 items, and the distress and interference caused by the PTSD symptoms through 4 items. The PDS-5 takes 5-15 minutes to be completed.

Scoring. Frequency and severity are scored on a 5-point Likert scale (0 = not at all, 1 = once per week or less/a little, 2 = 2-3 times per week/somewhat, 3 = 4-5 times per week/very much, 4 = 6 or more times a week/severe). PTSD severity is determined by the total score that ranges from 0-80 for the 20 items. Severity of symptoms is determined as follows: 0-10 minimal, 11-23 mild, 24-42 moderate, 43-59 severe, and 60-80 very severe. The cutoff point for probable PTSD diagnosis is 28 (Foa et al., 2016).

Reliability and validity. The PDS-5 demonstrated good psychometric properties when tested on 242 participants from the community, veterans, and college sites who had traumatic experience identified by DSM-5 criterion A (Foa et al., 2016). The measure had good internal consistency ($\alpha = 0.95$); test-retest reliability ($r = 0.90$); and 0.90 convergent validity with both PTSD Checklist-Specific Version and PTSD Symptom Scale-Interview for DSM-5. Additionally, PDS-5 had good discriminant validity with Beck Depression Inventory-II scale (Foa et al., 2016).

Beck Depression Inventory (BDI-II). BDI-II is a 21-item self-report scale that measures depression symptoms and severity in individuals aged 13 years and older in the past two weeks. BDI-II assessments of the symptoms correspond to the DSM-IV criteria for major depressive disorder (Beck, Steer, & Brown, 1996; Smarr & Keefer, 2011). BDI-II differs from the original BDI and BDI-IA by substituting four items (weight loss, body image change, somatic preoccupation, and work difficulties) with newly revised items (agitation, worthlessness, concentration difficulties, and loss of energy) to identify the symptoms of severe depression or

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depression that requires hospitalization. Additional changes included rewording of the statements and changing the sleep and appetite items to include increase and decrease in the symptoms (Beck et al., 1996). BDI-II takes 5-10 minutes to be completed.

Scoring. Participants typically respond on a 4-point Likert scale ranging from 0-3 (Beck et al., 1996). Nonetheless, two items (16 and 18) have seven options to reflect the increase and decrease in sleep and appetite. BDI-II score is obtained by summing the items ratings, with the higher score indicating more depression. The maximum score is 63 indicating severe depression. According to the BDI-II manual, the score of 0-13 denotes minimal depression, 14-19 mild, 20-28 moderate, and 29-63 severe. It is recommended in the manual that the cut scores are based on the sample characteristics (Beck et al., 1996). Since BDI-II only provides an estimate of depression severity, the 9th and 12th items of suicide ideation and hopelessness should be monitored closely, especially if scale responses are 2-3 (Smarr & Keefer, 2011).

Reliability and validity. The Coefficient Alpha is 0.92 for the outpatient and 0.93 for college students (Beck et al., 1996). BDI-II test-retest reliability was established by studying the responses of 26 outpatients who attended therapy at the first and second sessions, which were one week apart. The test-retest correlation was 0.93, which was significant at $p < 0.001$ (Beck et al., 1996). For construct validity, convergent validity was examined by administering the earlier BDI-IA and BDI-II to 191 outpatients during their initial evaluation. The correlation between BDI-IA and BDI-II was 0.93 ($p < 0.001$) (Beck et al., 1996).

Procedure and Data Collection

The study was submitted to the Institutional Review Board of Wayne State University. Flyers about the study and the researcher's contact information were posted in university buildings and nearby restaurants and grocery stores. Flyers were also posted at locations in the surrounding

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community that has a large number of Arabs, including grocery stores and a health center. Other university and health center locations provided their approval to post the electronic study advertisement on their web page for a specific period of time. Moreover, the PI was actively recruiting participants on a weekly basis by handing the flyers to females at the Wayne State University campus, including the campus health clinic and a student health center that serves Arabic women. Additionally, a description of the study was posted on social media (e.g., Facebook, Instagram) and the university webpage, which helped in disseminating information about the study and approaching a larger number of Arabic women. Furthermore, the WhatsApp social media application was used to disseminate the study advertisement. The researcher implemented some of the strategies that were successful in recruiting females of Arabic descent for the pilot study (Timraz et al., 2017, 2018). These strategies included building rapport and trust with females by explaining the study's aim and process in lay language, having female recruiters of Arabic descent who were fluent in Arabic and English, addressing prospective participants' concerns appropriately, and engaging the females' companion in decision making for participation in the study.

Although face-to-face interview is the gold standard data collection method for qualitative inquiry (McCoyd & Kerson, 2006), for this study phone and email interview were available to maximize recruiting Arabic female CSA survivors. Offering phone or email interview was imperative especially for those who wished to maintain their anonymity and/or who might be geographically beyond reach for in-person interview (Burns, 2010; McCoyd & Kerson, 2006). As another advantage of email interview, it was practical and convenient especially for participants with families or busy schedules. Furthermore, participants had the opportunity to write their responses in a stream of consciousness-manner that increased the credibility and richness of the

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data (McCoyd & Kerson, 2006). Finally, email interview minimized social pressure and increased the sense of privacy and safety that supports disclosing stigmatized or sensitive information.

Women who contacted me in-person, by phone, or by email and expressed their willingness to participate in the study were screened for their eligibility for the study. If they met the inclusion criteria, a full description of the study was provided either personally, by phone, or by email. Women who agreed to participate in the study were scheduled for a face-to-face individual, phone, or email interview depending on their preference.

Face-to-face interview. The in-depth face-to-face interview was conducted in a private office at the university to give participants the opportunity to speak freely about their experience. Women who were scheduled for a face-to-face interview were informed a few days prior about the location and room number. At the time of the interview, the women completed the information sheet and received the list of survivor resources prior to starting the qualitative questions. Upon completing the qualitative questions, the participants were asked to complete the five surveys for ARSAA-IIE, SRQ, WCQ-R, PDS-5, and BDI-II electronically through Qualtrics. A tablet or laptop was available at the time of the interview for the participants to complete the quantitative surveys. However, all of the women who did the face-to-face interview preferred to complete the surveys later at their convenience. The women had 72 hours to complete the surveys. The gift card was sent electronically to the women's preferred email address upon completing the surveys.

Participants' preferences and convenience of the settings was considered. The individual interview lasted 45-120 minutes. The time limit of the interview was two hours to avoid emotional exhaustion of the participants. All interviews were audio digitally recorded except email interview. The PI used strategies to minimize harm during the interview (Kavanaugh & Ayres, 1998). For instance, during the pilot study that was conducted among Arab American women (Timraz et al.,

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2018), some participants had experienced emotional distress. In such cases, the PI offered the women an opportunity to pause the interview, change the subject to a less emotional one, or stop the interview. All of the women voluntarily chose to complete the interviews, and no adverse effects were encountered during or after the interview. In the present study, the PI followed the same protocol and provided the participants with a list of the appropriate resources to reach in case of crisis. At the end of the interview, the participants received a $75 gift card as an appreciation for their participation. The PI conducted a brief follow-up phone or email interview (with participant permission) for the purpose of debriefing with all of the participants within a week to ensure their emotional stability and well-being.

Phone interview. Women who chose a phone interview had received a gentle reminder for the date and time of the interview a few days prior to the meeting time. At the time of the phone interview, verbal consent was obtained and the resources list was sent to the participant's email address. Next, the participants responded to the sociodemographic questions followed by the qualitative questions. Upon completing the qualitative part, a Qualtrics link that had all of the quantitative surveys was sent to the participant's preferred email address. The participants were instructed to complete the surveys within three days after the phone interview to receive the compensation. Upon completing the quantitative part, participants received the gift card electronically by email.

Email interview. Email interview consisted of multiple email exchanges between the participants and the researcher (Cook, 2012; McCoyd & Kerson, 2006). These emails consisted of the screening questions, information sheet, list of resources, interview questions, and follow-up questions. The estimated number of emails ranged from 10-20. The PI's university email was used throughout the interview to increase the credibility of the study. In addition, I created an email

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address for each participant to use for these electronic interviews. The women were instructed to use the designated email for the interview and not their personal email to maintain the confidentiality of the data. The email address and password were sent to each woman's preferred email address on the day of the interview. The researcher changed the participant's password of their assigned email address immediately after the completion of the qualitative interview. Women who contacted me via email were screened for their eligibility. If they were eligible, an email interview was scheduled. At the time of the interview, the information sheet was pasted in the body of the email and sent to the participant. To reflect participation agreement, participants had to respond to the consent email by stating "I read the information sheet and agree to participate in the study. My email responses confirm my ongoing agreement" (McCoyd & Kerson, 2006). After obtaining the participant's agreement, the resources list and a brief description of the interview process was provided by email. For instance, participants were informed that the interview would consist of multiple email exchanges and that it would start with open-ended (qualitative) questions followed by the surveys. Because written responses take longer than the verbal ones, participants were informed that they could complete the interview within three days after the initial email and that they had the right to pause the interview and take a break whenever they needed. The qualitative questions were divided among separate emails to elicit more information and avoid overwhelming the participants.

All of the emails were encrypted and required the participant's log-in information to access the messages. A new email would begin when replying to participants to avoid a thread and maintain confidentiality of the given information in case the woman left the email accessible (Cook, 2012). The received messages were copied in a word document without any identifying information other than the participant's assigned identification number (ID). All of the emails were

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deleted from the inbox folder and then deleted from the trash folder (McCoyd & Kerson, 2006) once each set of questions was completed. Each email's password was changed immediately after the qualitative interview was completed, and the women were instructed to use their personal emails to complete the surveys and for the follow-up. Upon completion of the qualitative questions, the Qualtrics link of the five surveys was sent to the participant's preferred email. At the end of the interview, the gift card was sent via email. As the study aims to explore the women's CSA experience in their own words, the interview started with the qualitative questions followed by the quantitative surveys to minimize bias.

Data Analysis

Qualitative data analysis. To fulfill the qualitative aims of the study (aims 1-6), qualitative data analysis was performed using one type of content analysis, termed conventional qualitative content analysis (Hsieh & Shannon, 2005). This analysis method was congruent with the descriptive nature of the study and achieves the aim of the study in providing a comprehensive description of Arabic women coping with CSA. All the recorded interviews were transcribed verbatim by a certified transcriptionist. The researcher checked the received transcripts for accuracy. A coding list was developed from the pilot study for investigating coping of Arab-American women and long-term psychological outcomes (Timraz et al., 2018). The coding list was slightly modified according to the present study's generated data. The interview transcripts were entered into the computer to facilitate data analysis and management using Nvivo 11 (Creswell, 2013). Double coding and verification of the data were conducted to ensure trustworthiness. To double code the interviews, a PhD candidate student and the PI read and coded each transcript independently using the initial coding list. After coding separately, both coders met to review coded passages until intercoder reliability reached at least 80% by the tenth transcript.

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Dr. Kavanaugh, a committee member, oversaw the development of the coding schema and the application of codes. Upon completion of the coding process, a descriptive summary of the main concepts in the study (i.e., CSA characteristics, cultural values and beliefs, social reaction to abuse disclosure, coping, and long-term outcomes) was provided for each participant in an Excel spreadsheet.

Quantitative data analysis. Descriptive statistics (i.e., mean, standard deviation, frequency) of the sample was generated using the IBM-SPSS 23. Additionally, the relationship between the variables of acculturation, social reaction to abuse disclosure, coping, PTSD, and depressive symptoms was examined using Correlation Coefficient. A summary of the scores of the five measures (ARSAA-IIE, SRQ/SRQ-CSA, WCQ-R, PDS-5, BDI-II) for each participant was entered to an Excel spreadsheet to be combined later with the qualitative data for across and within data analysis.

Integrated mixed-methods analysis. In MMD, data analysis should stem from the purpose of the study independently from the epistemological orientation of a single method (Onwuegbuzie & Teddlie, 2003).Thus, to achieve the aim of complementarity (i.e., obtaining an elaborate and comprehensive understanding of the phenomenon), the qualitative and quantitative data were integrated into the early phases of analysis using joint display (Creswell, 2013; Giurgescu et al., 2013; Lee & Greene, 2007). Joint display (i.e., matrix) or Excel spreadsheet presented the two data sets at the same time to identify the relationship between and across cases (Creswell & Clark, 2011; Lee & Greene, 2007). The spreadsheet arrayed the raw scores of the quantitative measures along with the qualitative summary for each participant. Qualitative and quantitative data were compared across the main concepts to note similar themes. Patterns were

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noted for similarities and differences between participants. Written reports were generated for collective descriptions of the participants according to the themes.

Rigor of Qualitative Analysis

Attention to rigor was implemented (Lincoln, 1995). The credibility of the study was achieved by thick description, triangulation, double coding, reflexivity, and peer review. Thick description refers to a comprehensive description of the collected data involving the demographic data. Triangulation was achieved by mixing the qualitative and quantitative data of the same concepts (acculturation, social reaction to abuse disclosure, coping, PTSD, and depressive symptoms) and by corroborating the available literature and the expertise of Dr. Kavanaugh, who is expert in qualitative methods, and Dr. Patterson, who is expert in mixed-methods, in the process of code development and analysis. Peer review was achieved by having the faculty sponsors provide feedback on the analysis and description of themes to ensure credibility.

Validity Approaches

In order to minimize validity threats when combining the two data sets, one convenient sample was drawn for both qualitative and quantitative methods, and that data were collected separately from the same sample to facilitate comparison and merging of the results (Creswell & Clark, 2011)

Ethical Consideration

The institution's IRB approval was obtained prior to conducting the study. The potential risks of taking part in the study were minimal and included the emotional distress of recalling a traumatic childhood experience. Five participants experienced some emotional distress when they recalled unpleasant memories during face-to-face interview. Although the researcher made it clear that the women can take a break at any time or stop the interview without any obligations, all five

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chose to continue the interview. The women were doing well when the researcher followed up with them by email a few days after the interview. Participants were informed that participation in the study was voluntary and that they could withdraw at any time with no obligation or cost. Participants had the right to skip any question/s that they were not willing to answer. The researcher did an email follow-up with the participants within a week after the interview to ensure their emotional stability and well-being. A list of resources that included hotlines and help centers for victims of violence in Michigan was provided at the beginning of the interview. For those who had any history of suicide attempts or ideation, the researcher emphasized the need of calling 911 or going to the hospital emergency department (ED) if she experienced any suicidal thoughts. Furthermore, the PDS-5 item 16 that assesses risky behavior and BDI-II item 9 that assesses suicidal thoughts and wishes were checked before ending the interview. If one or both items were scored high, the researcher sent an email to the woman to emphasize the need of calling 911 or going to the ED if she felt that she wanted to harm herself or someone else. For women who scored high on BDI-II and PDS-5, the researcher ensured at the time of the follow-up that they knew the resources available for them to approach if they needed counseling. Although emotional distress of recalling traumatic experienced was encountered by some participants, crisis intervention was not required.

Participants were identified by numbers. Upon completing the follow-up, all names, phone numbers, and emails were deleted. Although there was no direct benefit for participating in the study, valuing the participants and asking them about their traumatic experience in a non-judgmental manner has been found to be beneficial among trauma survivors (Cromer & Newman, 2011). In this study, when participants were asked how they felt about the interview, the majority stated that it was helpful to talk about their trauma and to be heard to in a respectful, neutral way.

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An additional benefit is that the results will inform future research in developing a culturally sensitive interventional program for Arabic female survivors of CSA.

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CHAPTER 4 RESULTS

This chapter describes and summarizes the findings of the study guided by the Lazarus and Folkman Transactional Stress and Coping Model and the specific aims of the study. The quantitative findings include descriptive statistics of the sample and surveys, in addition to the relationship among the five variables: social reaction, acculturation, coping, posttraumatic stress disorder and depressive symptoms. The qualitative findings consist of themes that include quotes from the survivors. The mixed-methods findings include a combination of the quantitative raw scores, descriptive statistics, and correlation coefficient findings with the qualitative themes.

Sample Demographics

A total of 20 women of Arabic descent participated in the surveys and interviews; however, only the data of 19 participants were analyzed (Table 2). All of the data of the excluded participant were eliminated from the study to avoid inconsistency. More than half of the women (57.9%) were between 18-24 years. Seven women earned a high school diploma (36.8%), five had an associate degree (26.3%), and seven had a college degree (36.8%). The majority of women were Muslim (73.7%) and unmarried (63.2%). The women's countries of origin were mainly Lebanon (31.6%), Iraq (21.1%), and Yemen (15.8%). More than half of the women were employed (63.2%) and had an annual income of more than $20,000 (68.4%). Eleven women described themselves as healthy (57.9%), and nine indicated that they had psychological and/or physiological health issues (42.1%). All of the women in the study had health insurance. The women's average length of stay in the United States was 16 years (*SD* = 6.44). The mean of their families' length of stay in the United States was 22 years (*SD* = 19.07). More than half of the women's parents had some college education or a college degree (73.7% of mothers and 63.2% of fathers).

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Table 2. Descriptive Statistics of the Participants (N = 19)

Variable	Mean (Standard Deviation), range, or attribute	Frequency (%)
Women's length of stay in the U.S.	16.68 (6.44)	
Families' length of stay in the U.S.	22.26 (19.07)	
Age in years	18-24	11 (57.9)
	25-44	8 (42.1)
Level of education	High school diploma	7 (36.8)
	Associate degree	5 (26.3)
	College degree	7 (36.8)
Country of origin*	Lebanon	6 (31.6)
	Yemen	3 (15.8)
	Iraq	4 (21.1)
	Saudi Arabia	2 (10.5)
	Jordan	1 (5.3)
	Kuwait	1 (5.3)
	Palestine	1 (5.3)
Marital status	Single	12 (63.2)
	Married	5 (26.3)
	Divorced	2 (10.5)
Religion	Muslim	14 (73.7)
	Christian	3 (15.8)
	Jewish	1 (5.3)
	Catholic	1 (5.3)

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Table 2. Descriptive Statistics of the Participants (N = 19) (continued)

Variable	**Mean (Standard Deviation), range, or attribute**	**Frequency (%)**
Employment	Employed	12 (63.2)
	Unemployed	7 (36.8)
Health issues	Yes	8 (42.1)
	No	11 (57.9)
Health insurance		19 (100)
Annual income	< $10,000	2 (10.5)
	10,001-20,000	4 (21.1)
	20,001-30,000	6 (31.6)
	≥ $30,001	7 (36.8)
Mother's level of education*	Less than high school diploma	2 (10.5)
	High school diploma	1 (5.3)
	Some college/ community college	6 (31.6)
	Bachelor	7 (36.8)
	Master	1 (5.3)
Father's level of education*	Less than high school diploma	1 (5.3)
	High school diploma	4 (21.1)
	Some college/ community college	3 (15.8)
	Bachelor	5 (26.3)
	Master	4 (21.1)

* Numbers do not add up to 19 due to missing data.

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Quantitative Results

Descriptive Statistics

Descriptive statistics (mean, standard deviation) were used to calculate the levels of acculturation (ARSAA-IIE); social reaction to CSA disclosure (SRQ, SRQ Child Sexual Abuse [SRQ-CSA]); coping (WCS-R); PTSD (PDS-5); and depressive symptoms (BDI-II) for the sample (Table 3). The analyses revealed that the women were more attracted to Arabic culture (52.84 ± 10.08) than American culture (52.68 ± 5.59) and received more positive ($2.03 \pm .99$) than negative ($1.33 \pm .90132$) reactions to their CSA disclosure. Self-controlling (16 ± 4.31), distancing (15.24 ± 7.8), and positive reappraisal (13.21 ± 5.17) were the most frequent coping strategies employed by the women followed by escape-avoidance (12.59 ± 4.56), accepting responsibilities (12.42 ± 6), planful problem-solving (12.24 ± 5.1), confrontive coping (9.33 ± 3.99), and seeking social support coping (8.82 ± 5.71), respectively. The women reported mild symptoms of depression (16.63 ± 17.07) and moderate (34.95 ± 24.51) symptoms of PTSD.

Relationships Among Variables

Pearson *r* correlation was used to analyze the relationship between acculturation, social reaction to CSA disclosure, coping, depression, and PTSD (Table 4). Attraction to Arabic culture was significantly correlated with attraction to American culture ($r = -.545$, $p = .016$); self-controlling ($r = -.531$, $p = .019$); escape-avoidance ($r = -.551$, $p = .015$); and positive-reappraisal coping ($r = .591$, $p = .008$). Attraction to American culture was significantly correlated with PTSD ($r = .498$, $p = .030$). Furthermore, positive social reactions to adult sexual assault were significantly correlated with negative social reactions to adult sexual assault ($r = -.629$, $p = .012$); social reactions to CSA ($r = -.817$, $p = .000$); and escape-avoidance coping ($r = -.560$, $p = .030$). Negative

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Table 3. Descriptive Statistics for Acculturation, Social Reaction to Abuse Disclosure, Coping, Depressive Symptoms, and PTSD (N = 19)

Variable (instrument)	**Mean (*SD*)**
Attraction to Arabic culture (AArC)	52.84 (10.08)
Attraction to American culture (AAmC)	52.68 (5.58)
Social reactions—positive (SRQ)	2.03 (.99)
Social reactions—negative (SRQ)	1.33 (.90)
Social reactions to childhood sexual abuse (SRQ-CSA)	1.25 (1.05)
Confrontive coping (WCQ-R)	9.33 (3.99)
Distancing coping (WCQ-R)	15.23 (7.79)
Self-controlling coping (WCQ-R)	16.10 (4.31)
Seeking social support coping (WCQ-R)	8.82 (5.70)
Accepting responsibilities coping (WCQ-R)	12.42 (5.99)
Escape-avoidance coping (WCQ-R)	12.58 (4.56)
Planful-problem solving (WCQ-R)	12.24 (5.10)
Positive reappraisal (WCQ-R)	13.20 (5.16)
Depressive symptoms (BDI-II)	16.63 (17.07)
Posttraumatic stress disorder (PDS-5)	34.95 (24.51)

Note. AAmC = attraction to American culture, AArC = attraction to Arab culture, BDI-II = Beck Depression Inventory, CSA = child sexual abuse, PDS-5 = Posttraumatic Diagnostic Scale, SD = standard deviation, SRQ = Social Reactions Questionnaire, SRQ-CSA = Social Reactions Questionnaire Child Sexual Abuse, WCQ-R = Ways of Coping Questionnaire Revised

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Table 4. Correlation Among Acculturation, Social Reaction to CSA Disclosure, Coping, Depressive Symptoms, and PTSD ($N = 19$)

Variable	1	2	3	4	5	6	7	8	9	10	11	12	13	14
Attraction to Arabic culture	—													
Attraction to American culture	-.545*	–												
Positive social reaction- ASA	.087	.078	–											
Negative social reaction - ASA	-.507	.255	-.629*	–										
Social reaction to CSA	-.419	.287	-.817**	.871**	–									
Confrontive	-.182	.437	.028	.045	.119	–								
Distancing	.213	-.354	.194	-.017	-.240	-.639**	–							
Self-controlling	-.531*	.255	.188	.391	.138	-.140	.423	–						
Seeking social support	.131	.194	.139	-.405	-.106	.450	-.718**	-.476*	–					
Accepting responsibilities	-.147	-.110	-.344	.076	.218	-.130	-.291	-.430	.007	–				
Escape-avoidance	-.551*	.251	-.560*	.688**	.624*	.003	-.095	.520*	-.339	.133	–			
Planful problem-solving	.199	.069	.185	-.548*	-.351	.311	-.602**	-.595**	.595**	-.022	-.471*	–		
Positive reappraisal	.591**	-.421	.109	-.077	-.186	-.373	.448	-.202	-.257	-.376	-.490*	-.050	–	
Depression	-.438	.352	-.228	.139	.293	.056	-.211	.274	.134	.191	.550*	-.026	-.785**	–
PTSD	-.217	.498*	-.458	.327	.517*	.172	-.401	-.058	.094	.325	.522*	.089	-.527*	.729**

* Correlation is significant at the 0.05 level (2-tailed).

** Correlation is significant at the 0.01 level (2-tailed).

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social reactions to adult sexual assault were significantly correlated with social reactions to CSA (r = .871, p = .000); escape-avoidance (r = .688, p = .005); and planful-problem solving coping (r = -.548, p = .034). Social reactions to CSA disclosure was significantly correlated with escape-avoidance (r = .624, p = .013) and PTSD (r = .517, p = .048).

Qualitative Results

Five categories of Arabic women's CSA experience emerged from the coded interviews. The categories are CSA characteristics, social reaction to CSA disclosure, CSA experience in Arabic context, coping with CSA, and long-term outcomes of CSA.

Characteristics of CSA

This category describes the nature of CSA; number of perpetrators and perpetrators' gender, ethnicity, and relationship to the women; CSA age of onset, frequency, and duration; and age and power differential (physical force and threat) (see Table 5).

Nature of CSA. Sixteen women reported contact CSA and three reported contact and non-contact CSA. Contact CSA included oral, vaginal, and/or anal penetration (n = 7) and fondling (e.g., kissing, touching the survivor's private). As one woman said, "she [half-sister] lays me down and then she puts like, a toy basketball in her pants and starts fondling me in my lower area with it" (P6). Non-contact CSA included sexual requests, sexual comments, and watching the women while dressing as exemplified by one woman who stated, "he [half-brother] would kind of inappropriately grab me and make it seem like it was a joke or ask me to like show him my breasts and stuff like that" (P15).

Number of perpetrators, perpetrators' gender, ethnicity, and relationship to the women. Seventeen perpetrators were males, and two were females (i.e., sibling, cousin). The majority of the perpetrators (n = 23) were of Arabic descent, and three were of non-Arabic

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Table 5. CSA Characteristics of the Women ($N = 19$)

P	Age of onset in years	Type of CSA	Relationship to the perpetrator	Frequency	Duration	Age difference (perpetrator's age)	Number of perpetrators	Perpetrator ethnicity	Gender of perpetrator
1	9	Contact Vaginal/anal/oral penetration	Familial Step brother	Frequent	Continuous* 1 y	> 5 years (15 years)	1	White	Male
2	14	Contact Vaginal penetration	Familial Aunt's husband	Frequent	Continuous 3 y	> 5 years (30s)	1	Arab	Male
3	15	Contact Vaginal/oral penetration	Non-familial Friend	Frequent	Intermittent**	< 5 years (18 years)	1	Arab	Male
4	11	Contact Fondling Non-contact Sexual requests	Familial Nephews Non-familial House tenant	Frequent	Intermittent	> 5 years (27 years) (unknown)	3	Arabs	Males
5	6	Contact Fondling	Familial Cousin	Frequent	Continuous 2 y	> 5 years (16 years)	1	Arab	Male
6	6	Contact Vaginal penetration	Familial Half-sister	Frequent	Continuous 2 y	> 5 years (17 years)	1	White	Female
7	6	Contact Fondling	Non-familial neighbor	One-time	Intermittent	< 5 years (10 years)	1	Arab	Male
8	8	Contact Fondling	Familial Uncle	Frequent	Intermittent	> 5 years (40s)	1	Arab	Male
9	15	Contact Fondling Vaginal penetration	Non-familial Classmate	Frequent	Continuous 3 months	< 5 years (19 years)	1	Arab	Male
10	7	Contact Oral-penetration	Familial Uncle	Frequent	Continuous 3 months	> 5 years (30 years)	1	Arab	Male

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Table 5. CSA Characteristics of the Women ($N = 19$) (continued)

11	9	Contact Fondling	Familial Uncle Brother	Frequent	Continuous 1 year	> 5 years (30 years) < 5 years (12 years)	2	Arabs	Males
12	5 10	Contact Fondling	Familial Uncle Sister-in-law's brother	Frequent One-time	Continuous 3-4 y Intermittent	> 5 years (20s) (19 years)	2	Arabs	Males
13	15	Contact Vaginal penetration	Non-familial Friend	One-time	Intermittent	< 5 years (17 years)	1	Arab	Male
14	9	Contact Fondling	Non-familial Teacher	Frequent	Continuous 1.5 y	> 5 years (in his thirties)	1	Arab	Male
15	7 13	Contact Fondling Non-contact Sexual requests/comments	Familial Half-brother Non-familial Family's friends	One-time Frequent	Intermittent Continuous Months/years	> 5 years (16 years) (40s)	4	1 non-Arab 3 Arabs	Males
16	16	Contact Fondling	Familial Grandfather	Frequent	Continuous until today	> 5 years (70s)	1	Arab	Male
17	6	Contact Fondling	Familial Cousin	Frequent	Continuous 6 y	< 5 years (9 years)	1	Arab	Male
18	14	Contact Fondling Non-contact Sexual comments	Non-familial Family's friend	Frequent	Continuous Less than a year>	> 5 years (40s)	1	Arab	Male
19	4	Contact Fondling	Familial Cousin	Frequent	Continuous	< 5 years (8 years)	1	Arab	Female

*Continuous: CSA that occurred on a regular daily, weekly, or monthly basis.
**Intermittent: CSA that occurred sparingly.

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background. The number of perpetrators ranged from one to four. Fifteen women were abused by one perpetrator, and four women were abused by two to four perpetrators during their childhood. Thirteen women described being abused by a family member including father figures (i.e., uncle and grandfather) (n = 5); siblings (n = 3); and relatives (e.g., nephews, cousins, aunt's husband) (n = 7). Eight women experienced CSA by a non-family member including family friends, teachers, classmates, friends, and neighbors.

CSA age of onset, frequency, and duration. The women's age when they first experienced CSA ranged from 4-16 years. Twelve women were younger than 10 years old, and seven were older at the time of the abuse. Fifteen women reported frequent abuse that occurred more than once by either one or more perpetrators. Two women who were abused by two perpetrators reported both frequent and one-time CSA. Two women reported one-time contact CSA that was perpetrated by non-family members. Continuous CSA that lasted from 3 months to 6 years was reported by 11 women. In addition, one woman reported an ongoing CSA at the time of the interview as she said, "it [CSA] keeps – it's still going" (P16). Four women experienced intermittent CSA, and two experienced both continuous and intermittent. Eleven women reported that continuous and frequent duration of CSA was perpetrated by family members. Only four women reported frequent and continuous duration of CSA perpetrated by non-family members.

Eight survivors of familial CSA reported that their abuse stopped when the perpetrators moved from the survivor's house: "It probably ended when I turned 8, when she moved out" (P6). Furthermore, some women reported that their abuse stopped when they refused to comply with the perpetrator's requests and avoided being around them. One survivor (P12) said, "it stopped because I refused to be alone with him and I would, like panic if I was home alone. I would make my dad or somebody take me wherever they were going."

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Age and power difference (physical force and threat*).* The age difference between the women and their perpetrators ranged from 2 years to more than 20 years. Twelve women repored that the age difference was more than 5 years. Six women reported an age difference of less than five years and one woman, who was abused by two perpetrators, reported having an age difference of both more and less than 5 years. Twelve women reported that the perpetrators used physical force such as slapping, hitting, tying them up, ignoring requests to stop, and hold ing them down as exemplified by one woman (P1) who stated, “I mean, there were things like tying me up or tying me to things or like hitting me and like slapping me and stuff and choking me.” Another survivor (P3) of non-familial contact CSA stated,

> The first time, he held both my arms against my chest, and if I tried to move them, he would push them back up against my neck and tell me not to move. I had my face turned to the side and my eyes closed because I didn't want to see what was happening, but he would grab me by my jaw and forcefully turn my face towards him. He forced his fingers into my mouth at some point, but he pulled them out when I bit down and grabbed my jaw even harder. He slapped me a few times whenever I'd make a sound and he'd tell me to stay quiet or we would get caught.

In contrast to the use of physical force, three women reported the use of persuasion to abuse them as one woman (P14) stated, “He’s a lovely teacher and he liked to be close to his students.” Another survivor (P8) of familial abuse said, “He tried to keep continuing laughing, smiling with me, talking with me, being more friendly, you know.”

Eight women were verbally threatened by their perpetrators to comply with their sexual requests or not to disclose the abuse. Six women were threatened by family members like a sibling, cousin, or uncle. Some threats included describing the physical harm that could happen or the threat of telling others about the abuse. One woman (P1) said, “He threatened to come find me and kill me. I guess I mean he had choked me before so that’s what he threaten to do again.” Of the 11 women who were not threatened by their perpetrators, three explained that their perpetrators never

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threatened them because they knew that the women would never disclose the abuse. One woman (P2) said, “No, I think he knew I would never tell anyone.”

Social Reactions to CSA Disclosure

The social reaction category describes dynamics of CSA disclosure and outcomes as perceived by the women. The majority of the women (n =15) in this study disclosed their CSA prior to the study interview.

Dynamics of CSA disclosure. The dynamics of the disclosure describe the timing, recipients of disclosure, and the reasons for disclosing the abuse. Nine women disclosed their abuse during childhood, six disclosed it during adulthood two to 20 years after it ended, and four had never disclosed their abuse prior to the study. For those who disclosed their abuse during childhood, only two of the women disclosed it immediately (i.e., 24 hours), and eight delayed their disclosure more than one month to four years while the abuse was ongoing or after it ended. Two of the women who never disclosed their CSA, five who disclosed it later during childhood, and five who disclosed it during adulthood were all abused when they were nine years old or younger. The first recipients of childhood disclosure were friends (n = 5), mothers (n = 4), and law enforcement officers (n = 1). On the other hand, the recipients of adulthood disclosure were often friends (n = 5), followed by partners (n = 3) and professionals (n = 3), mothers (n = 2), and siblings and cousins (n = 2).

The women disclosed their CSA during childhood because they wanted the abuse to stop as described by P11: “I eventually told my mom about my brother because I would wake up in the middle of the night thinking that I felt a weight on me.” Some women realized that it was wrong or inappropriate and that they needed to talk about the abuse with a trusted person. One participant stated, “For my friends, because I needed someone to talk to and like, I knew that they were there

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for me. I knew they wouldn't say anything" (P13). One woman looked for advice on how to handle the abuse: "I told my friend in high school because I was seeking for help and advice on what I should do" (P3). On the other hand, the reasons for disclosure during adulthood were to be understood by close friends and partners: "I wanted her [friend] to understand why I decided not to be in a relationship or get married. I wanted her to stop nagging me about it" (P17). Another woman wanted to share her personal story with others when the abuse topic was brought up: "It's kind of like you know when you talk to somebody sometimes those things come up so it's just you know when we've been talking" (P1). Some women who disclosed during adulthood wanted to warn family members about the perpetrators, and they wanted to be able to talk about the abuse with someone and get professional help. One survivor (P2) of familial CSA stated, "My cousin she lives in Canada…and I knew her mom was going to be like let me introduce you to him [perpetrator] and that was like the main reason I told her don't let your sister be there." Another survivor (P6) stated,

> She [mother] was like, the number one person that I thought of telling…it's something that is in your head that's in your subconscious forever. So, I just I wanted to get it out finally and I ended up getting shut down.

Several reasons were endorsed by the women for not disclosing the abuse prior to the interview, or for disclosing it to certain people like friends but not parents. Fear of others' reactions such as blame, disbelief, humiliation, and anger were endorsed by 11 women. One of the survivors of familial abuse (P3) stated, "If I had told my parents hell would have broken loose of course." The second common reason reported by five women was protecting loved ones (i.e., parents, siblings, grandparents) from taking the responsibility for the CSA or from becoming overwhelmed by the abuse disclosure. One survivor (P1) of familial CSA said, "I could just never disclose this

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because my mom would feel so guilty." Other reasons included fear from the perpetrators and further abuse, such as: "Disclosing the abuse can affect the perpetrators to abuse me again. If I get the words out then they might attack me again and people will blame me for the things I didn't do" (P4). Other women felt ashamed and wanted to preserve family ties and reputation.

Received reactions. Women received diverse reactions upon disclosure. These reactions are categorized into supportive and unsupportive.

Supportive reactions to CSA disclosure. Supportive reactions reflect the positive reactions received by the women upon disclosure. Supportive reactions include emotional support and instrumental support. The most common supportive reaction endorsed by the women was emotional support that included believing the survivors: "She believed me over him and comforted me when I needed it" (P18) and feeling sorry for the survivors: "She felt so bad. She's like, I'm so sorry. I can't believe that happened" (P13). One woman described that showing understanding and caring was supportive: "His [fiancée] reaction made me feel so much better about it all. The way he responded to the story made it much easier for me to move on from the pain" (P3). Another survivor (P1) stated, "My husband totally believes me. He's really supportive. He's been the best one about this. He totally understands and is fine about it."

In addition to emotional support, instrumental support (i.e., taking action and seeking therapy for the survivor) was endorsed by three women who disclosed their abuse during childhood. Instrumental support provided by the parents included confronting the perpetrators, expelling them from the family's house, and seeking professional help for the survivors. One of the survivors (P18) explained her mother's reaction as follows: "I called my mom immediately. She left work early to come home and confront him in the basement…My mom was going to call the police but she gave him mercy because he was close to the family."

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Despite the supportive reactions to CSA disclosure, unsupportive reactions were endorsed by the women. Several of the women (n = 11) reported receiving supportive and unsupportive reactions like believing the women for the abuse encounter but telling them to keep it as a secret, getting angry at the perpetrators, remaining passive and not taking an action toward the perpetrator, telling others about the abuse without the women's permission, blaming the women for the abuse, treating the women differently, and getting angry at the women for not disclosing the abuse earlier.

Unsupportive reactions to CSA disclosure. Unsupportive reactions reflected the negative reactions received upon disclosure. These reactions did not support the women's needs and contributed to additional trauma and self-blame. Women endorsed a wide array of negative reactions. The first reaction was recipient's anger and revenge against the perpetrator, as described by one survivor (P10) of familial abuse: "He [father] stormed into our house with a baseball bat and beat my uncle to an inch of his life. I think if my mother hadn't pulled him off, my father would've killed him." The second reaction endorsed by the women was the survivor being blamed for the CSA: "A lot of the reaction was why didn't you scream?" (P9). Another survivor of rape stated, "My parents didn't believe it was rape. They told me I wanted it. You're the one who was coming on to him" (P13). The third negative reaction included disbelief or denial of women's encounter of familial CSA: "I told her [mother], and she just stopped and said, that sounds ridiculous. You know, that probably never happened." (P6). The fourth negative reaction was telling others about the CSA without the women's permission, as one survivor of non-familial abuse stated, "She [friend] was the only one I talked to about it, and then she told her mom, and her mom came and talked to my mom." Another survivor (P3) of non-familial rape said, "She told everyone we knew that I had tried to ruin someone's life by claiming rape, when it didn't even happen." The fifth negative reaction was being treated differently by others (i.e., parents, friends)

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like calling names and pulling away from the survivors. One survivor (P3) of non-familial rape said, "A few months after I shared the incidents with him, he lashed out at me and called me a slut." Additionally, four women described their social reactions as passivity (i.e., not taking action against the perpetrators) and minimizing the abuse experience. One of the survivors (P5) of familial abuse stated, "They [mother and brother] didn't tell anyone. I feel like they were supposed to tell his parents." Another survivor (P17) of familial abuse stated, "My friend made sure I wasn't raped, but I think she still expects me to get over it, 'there are people with worse experiences'." Finally, another negative reaction that was endorsed by the women was getting angry at the women for not disclosing the abuse earlier, as one survivor stated, "My friend was very mad, very, very mad. He started asking why didn't you tell me?" (P3). Another woman (P16) of familial and non-familial abuse state, "She [mother] told me, "Why? Why didn't you tell me anything? I would have put them all in jail."

Some of the unsupportive reactions were found to be related to the age of perpetrators, type of abuse, and relationship to the perpetrators. For instance, remaining passive was reported by three women who were abused by family members; two of the perpetrators were children, and one was an adult. Furthermore, blaming the women for the CSA, treating differently, and/or telling them to keep the abuse a secret from friends, family members, or future husband were common among survivors of familial abuse and/or rape. One survivor (P13) of non-familial rape said, "my dad was telling me that when you get married, you are not telling him [husband] about this." Another survivor (P10) of familial abuse gave this account:

> She [mother] explained to me that if I told anyone else about my uncle, that he would go to jail… She reminded me that he has helped our family a lot, she told me that he was paying the mortgage at the moment while my mom and dad were going through their divorce proceedings, and she reminded me how much my brothers especially needed him since boys need a male figure in the house. With tears in her eyes she begged me not to tell

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> anyone else and that she would deal with her brother on her own. She promised me that after she talked to him, the abuse would stop.

Women's Experience of CSA in Arabic Context

The second aim of the study was to explore the impact of Arabic culture on female survivors of CSA. This section describes the Arabic culture norms and values perceived by the women to impact their experience of CSA. The Arabic values and beliefs identified by the women included cultural norms and beliefs about sexuality, men and women, family honor and reputation, family ties, CSA and survivors of CSA, and mental illness and seeking professional help.

Arabic norms and values about sexuality. Seven women endorsed that they never had a sex talk (i.e., inappropriate touch, body changes and development) with their parents because sex was considered a taboo subject that people were not open to talk about or teach. One woman (P13) said,

> My parents never sat me down and talked to me about sex. I had to learn about it from a white lady in my health class. I signed it [permission form] without them knowing, because I wanted to learn about it.

Three survivors of continuous familial abuse described that their lack of knowledge about sex hindered them from recognizing the abuse early and stopping it. One survivor (P11) of familial abuse stated the following:

> I was never educated. I didn't know what it was, just that I was helping and that it would be over soon. I thought I was doing something good the first few times and I would sit on the dresser very patiently and wait for it to be over. To me, that is the worst part about the situation because I was so unaware of what was happening. If I had prior sex education I probably would've realized what was happening sooner and maybe prevented further abuse.

Another survivor (P2) of familial abuse stated,

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> I didn't know what was going on because it was my first sexual experience ever. You know as an Arabic we don't date that much we're not allowed to do those things. We're not that open, I've never had that sex talk with my parents and I didn't know exactly what was going on and I couldn't do anything.

Women talked about virginity prior to marriage and how it is highly valued by Arabs. One woman (P1) said, "my mom was very um; like you cannot you know you can't have sex until you leave this house...she really wanted us to stay virgins until 18." According to the women, those who lost their virginity regardless of the context or if it was consensual or not prior to marriage are seen as dirty, impure, and damaged goods. One survivor (P13) of non-familial rape stated, "My dad was telling me…no one's going to want you if they know that [rape] happened if you're not pure."

Arabic norms and values about family's reputation. According to the women, a family's reputation goes hand in hand with female behavior (i.e., modesty) and reputation, and it is the woman's responsibility to preserve that reputation. One woman (P4) said, "Family reputation always matters to me because if I do something wrong, then I feel like the society will look down on my family and try to destroy my family reputation." In addition, some women endorsed that it is very important for them and their families to keep the family's reputation clean under any circumstances. For instance, some of the women whose families are well known in the community opted to not disclose their abuse to protect their family's business and reputation. In addition to hindering the women from disclosing their abuse, preserving family's reputation also influenced some of the reactions that were received by the families upon disclosure. For example, one survivor of non-familial rape (P13) reported that her family did not report the perpetrator to the police to preserve her reputation and that of her family along with their status in the community. She stated,

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"They [parents] didn't want to pursue an investigation. Or they didn't want to go after the guy because they knew it would stay with me" (P13).

Arabic norms and values about family ties and trust. Family ties and trusting others were two of the Arabic values that the women reported to influence their experience of CSA. "Close-knit family" was a term used by some of the women to describe the relationship between their family members. Many women stated that they were close to their family and extended family members (e.g., cousins, aunts), which was something they highly valued. Maintaining the solidarity of the family and not tearing it apart was reported and emphasized by five women to influence their decision to disclose the abuse. For those who disclosed their abuse, family ties also influenced the reactions they had received from their families upon disclosure. For example, in cases of familial abuse or abuse by close family friends, maintaining family ties by keeping the abuse secretive took precedence over reporting to the police, as one woman (P10) said,

> She [mother] explained to me that if I told anyone else about my uncle, that he would go to jail. Not only that but he'd never get his citizenship, and he'd have to go back to Gaza and never be allowed to come back to the U.S. ever again.

The values of trusting and respecting family members and close family friends are rooted in Arabic families and are passed on to their children. These values were endorsed by two women to be one of the reasons for their abuse by family members. One survivor (P8) of familial CSA said, "In our culture, I think trusting relatives is the common reason for sexual abuse. And I believe a relative is the number one abuser." Another survivor (P2) of familial rape said,

> I don't believe anymore that family is the most important thing because the people that you trust the most can actually hurt you. Yes, I love my parents we're very close, very close in

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many ways but other than that the way they think of family like we should be together we should always support each other. I just can't support someone because he's a family.

Trusting family members and close friends by the survivors and their families was noted to be one of the reasons that all of the familial abuse occurred at the family's house or properties (i.e., backyard): "I was there to visit my dad at his house that I spent the whole summer there that year" (P1). Another survivor (P10) stated,

> One day I was studying for a spelling test, and my uncle invited me into his room to help me study. We were going over my practice test when suddenly he took his penis out of his pants and invited me to touch it. I didn't want to, and I began to cry because I knew what he was doing was inappropriate. He told me to shut the fuck up, grabbed me by my hair, and forced my head down to give him oral sex. When it was over I said I wanted my mom, and he condescendingly dared me to tell my mother about the incident. It was like he knew he could get away with it.

Arab perception of CSA and CSA survivors. Most of the women described that CSA is a silent issue that Arabic individuals and families avoid addressing or handling: "It's terrible no one talks about it, no one actually mentions it" (P2). Denying the existence of CSA by Arabs was also reported by two women, one of whom stated, "Arabic culture doesn't admit or talk about such issues, it just doesn't exist" (P7). Four women endorsed that their families' inadequate knowledge about CSA (i.e., types, signs) impeded their families from identifying CSA and intervening properly: "They [family] don't understand these things sometimes or they don't know about these things" (P5). Denying the existence of CSA, lack of knowledge about the subject matter, and not having an appropriate sex talk between the women and their parents during childhood were reported by some survivors of continuous familial CSA to be contributing factors for being abused over a long period of time. As one survivor (P11) said,

> I was 9 years old. At the time, my parents finally felt comfortable leaving my siblings and I alone when they would go shopping. My brother was the first person to touch me inappropriately. And shortly thereafter my uncle who would stay with us when my parents weren't around. I didn't know that it was wrong. I was told that it would only be a few

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> minutes. My uncle would kiss me and rub his genitalia on me. My brother would also rub his genitalia on me.

In addition, lack of family's knowledge about CSA and how to handle it influenced two families in their attempts to minimize and deny the abuse by not talking to the perpetrators or trying to stop the abuse. One of the survivors (P11) stated, "My mom would ask me if I had self-control before leaving me with my brother and uncle again. She made it seem like their advances were due to my behavior." When it comes to acknowledging the abuse, one of the women stated that only severe cases of CSA like rape are acknowledged as abuse. She (P17) explained,

> Growing up my mom used to say, if you think your dad is mean just be glad he doesn't sexually assault you like some dads do. Unless something extreme like that happened, then you have no complaints. Incidents that are not extreme are nonexistent so reacting to them is not, dare I say, allowed.

The majority of the women reported that survivors of CSA are always blamed and/or disbelieved for being abused. Not wearing modest clothes (Abaya), headscarf (Hijab), and having a relationship prior to marriage were the reasons for survivor's blame as noted by five women. One survivor (P9) of non-familial rape stated, "I don't really know how to explain it very well, but a lot of times I was blamed for the incident. Because I did not wear the hijab... it was basically I seduced him and everything was my fault." Another survivor (P13) stated, "My parents didn't believe it was rape. They told me, you wanted it you talked to him…He wouldn't have done that if you never texted him" (P13).

Eight women reported that Arabic CSA survivors are seen by their families and communities as dirty, not pure, and damaged goods regardless of the context of abuse. One survivor (P7) of familial abuse said, "Arabic women are treated as a whore for being abused or

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even divorced." Another survivor (P4) stated, "I didn't share it with anyone because I have seen people in my society to always blame the women for no reason even if it's not her fault."

Arab perception of mental illness and seeking professional help. Seven women talked about their families' perception of mental illness and seeking professional help. Mental illnesses were seen as stigmatizing and shameful. In addition, mental illness were not well acknowledged by the survivors' families and in some instances were denoted as some kind of "craziness." Furthermore, two women stated that behaviors as a result of mental illnesses (e.g., suicide) were perceived either as a sin or a reason for misbehaving, as one of the women (P9) said, "If a person is depressed or suicidal, especially suicidal, it's looked upon negatively, that you're committing sin. It's always you're committing sin if you feel suicidal and it's never, 'how can I help you?'."

In addition to the above mentioned factors, the cultural perception that mental illness is a personal matter that can be solved without involving an outsider (e.g., professional) was an additional factor for not seeking professional help or not supporting the survivor's decision to seek help. One survivor (P1) of severe familial abuse stated,

> I don't know if its Arabic culture, but my family doesn't like mental illness: they think you can just kick in the butt and be sane again; like if you just snap yourself out of it you'll be fine. So I don't know what kind of culture that is but that seems to be the mentality in my family.

Another survivor (P13) of non-familial rape who urged her family to seek therapy stated,

> I asked my parents to put me in therapy and they told me no: You don't need therapy. You're fine. There's nothing wrong with you. They believe that we should be able to fix our own family problems, and we don't need someone that we don't know to get involved in our business.

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All of the norms and values rooted in the survivors, their families, and communities impacted the women's experiences of CSA including victimization, reactions received upon disclosure, and the women's perception of their experience in Arabic and non-Arabic context.

Acculturation and women's perception of their experience in Arabic versus non-Arabic context. Thirteen women endorsed that their experience of CSA would have been different if they were of a non-Arabic background. The women reported that being of Arabic descent inhibited them from disclosing their abuse or even talking about it to others due to the fear of not being believed, being blamed for the abuse, and to preserve family reputation and ties. One survivor (P4) stated,

> Yes, that would be different if I were from a western background because western cultures don't care about the society or what other people will say to them. They can share about the abuse to others like their family or friends because they grew up with a culture that lets them share things they need to share with someone else. Our culture cares about what others think of them and what might happen to our reputation if someone else finds out about this.

Furthermore, Arab perceptions of mental illness and professional help hindered some of the women from seeking professional help to avoid the embarrassment and stigma of having a mental illness. Lastly, some of the women endorsed that if they were of a non-Arabic background, they might have received more supportive reactions from their families like reporting the abuse to police or seeking therapy for them. A survivor (P19) of familial abuse stated,

> Arabic culture hinders dealing with the abuse because it has restricted me from being open about it. Whereas my friends who come from Western culture openly talk about the sexual abuse they have faced in their lives and how they are seeking therapy to deal with the consequences. I do not want to seek therapy about it because I finally feel content with where I am mentally, but I feel it would have helped me a lot in high school and the beginning of college if I was able to speak to someone about what I was going through.

Despite the women's length of stay in the U.S., they identified Arabic norms and values that they honor and followed and other values that they disagree with. Nine women identified the

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sense of belonging and connectedness with their family members as part of the culture that they highly valued, as one woman (P11) said,

> I honor Arabic values because that is how I was raised. I love my family and I love my brother very much and I believe that he honestly didn't know what he was doing either. (my uncle can go to hell) I think that some traditions are outdated but I value them because they are a part of who I am and how I identify myself in America. I value family and respect as the most important because all I have at the end of the day is my family. Blood is thicker than water.

Other values embraced by the women included modesty, respect, and hospitality. In addition, six women identified religion as an important part of Arabic culture as one woman (P4) stated,

> Since I am from a Muslim country, the Arabic traditions that I tend to follow is the religion, learning what Islam is, drinking tea, celebrating national holidays, fasting in Ramadan, reciting Quran, and having the goal to go to Hajj. I follow my culture by dressing up with Abaya and being modest.

Seven women disagreed with the Arabic norms and values of a female's virginity, the taboo of having a relationship prior to marriage, the negative perception of CSA and survivors, and female's inferiority and dependence because these codes impacted them negatively as survivors of CSA. As one survivor (P10) of non-familial rape stated,

> Family ties probably impacts me the most. My mom became Facebook friends with my uncle's wife a few years ago. She cried when she saw pictures of him and his children. Even after everything he did to her daughter, she still missed him and loved him. I believe that's a very specific sentimentality to Arabic culture. It doesn't matter if they did something terrible, family is family.

Coping With CSA in the Arabic Context

The survivors employed different strategies to cope with their CSA experience. Nonetheless, these coping strategies were employed to a different extent by the women depending on their appraisal of CSA. In other words, the women varied in their appraisal of CSA and some

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women appraised it as more stressful than others. The strategies include seeking social support, positive reappraisal, planful-problem solving, self-blame and assuming responsibility, self-controlling, confrontive coping, and avoidance-distancing coping. The impact of CSA characteristics, social reaction, and Arabic culture on coping is also presented.

Women's appraisal of CSA experience. All of the women in the study appraised their CSA experience as stressful (i.e., harmful), as one survivor (P6) said,

> I feel like it completely ruins who I am as a person. I feel like my developmental stages were completely messed up to say the least, because of what happened to me. I feel like when it was happening to me, I knew what was going on. Even though I was younger and I didn't know what sex really was yet or what abuse really was yet or what consent really was yet. I knew what was going on. I hated it.

Appraising the abuse experience also encompassed the women's feelings of being abused. Most of the feelings expressed by the women were negative and included feelings of shame, humiliation, violation, hurt, unfairness for being abused. Furthermore, anger, shock, and betrayal were also experienced. The majority of these women were abused by a family member or a trusted person (i.e., friend), as one survivor (P8) of familial CSA said, "How could he [uncle]? How he was able to do this! Like I was like his daughter." Another survivor (P19) of non-familial abuse by a close family friend stated,

> You are being attacked by someone who your parents (usually the people who care the most about you) trust. It is different because the person who is abusing you is someone who is trustworthy in the eyes of the people you love. Whereas, with a stranger, you can be angry about it because it does not feel like betrayal as much as when it is someone who you trust.

Seeking social support. Seeking social support involved behaviors that were commonly described by the women such as disclosing the abuse to others, seeking professional help, and taking part in this study. For instance, fifteen women coped with their experience through disclosure of CSA at varying times during their lives. Disclosing the abuse during childhood was

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mainly to stop it or to get advice from a trusted person of how to handle the situation. On the other hand, talking about the abuse with a trusted person for support and acknowledgment was a way of coping with it during adulthood. In addition to disclosure, six of the 15 women sought professional mental health services to be able to cope with their CSA and the aftermath.

Taking part in this study was considered another form of seeking social support. The most common reasons for participating in the study were trying to seek help with coping with the CSA experience and being able to talk about it anonymously without being judged. One survivor (P15) said, “I feel empowered for the first time about the abuse because this is my first time really addressing it as an adult and recalling the situation.” Another survivor (P9) said, “It [participating in the study] was in a sense really therapeutic because I don’t talk about this very often and it makes me think that maybe even going to CAPS [Counseling and Psychological Services] once a month talking to someone.”

Positive reappraisal. The women employed multiple forms of positive reappraisal such as focusing on personal growth, praying, and finding benefits from their experience. Focusing on personal growth and continuing education to become an advocate to help other survivors of abuse was reported by five survivors of CSA abuse (i.e., rape); three of them were survivors of contact CSA with penetration and had received unsupportive reactions upon disclosure. One of the survivors (P9) stated, “I would like to help these girls. And me going to school and finishing school. My objective is to be an advocate for human rights. Specifically, I’d love to help these girls get through this.” Another survivor (P1) stated, “I really want to become a lawyer and I really want to work in like child sexual abuse prosecution or something related to child abuse.”

Praying to cope with the CSA was found to be helpful by two women, as one (P3) said,

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> I pray a lot more now. I didn't pray much before or even after the incidents occurred. It was more that I started praying more and putting my faith in God after I pulled myself back up from the destructive path I had gone down because of the incidents.

In addition to focusing on personal growth and praying, finding benefit from the CSA experience, such as becoming aware of the CSA issues and perpetration, was reported by the women. As one survivor (P4) of familial abuse stated, "I gained many experience like what types of gestures or facial expression they might make or personality they show towards me to abuse me." Other benefits of being abused were having empathy toward survivors of abuse and becoming empowered and a stronger person: "I feel like if I didn't go through that, I wouldn't be as strong as I am today" (P9). Furthermore, some used the CSA experience as a guide to raise their own children, as one survivor (P14) of non-familial abuse explained,

> Since I went through this experience, I'm watching my kids really close. People are not maybe in this situation will not think about it. No, but I will think about it more and more. Whenever I see my kid around with older kids … I would think about it more and more. Why? Because I've been in this situation.

Praising self was expressed by three women for being able to stop the abuse, as one (P5) of them said, "I'm very glad that I was able to stop it. To a certain point and not let it just happen so many times after that." In addition, two of these women were grateful that their abuse did not include any type of penetration.

Planful-problem solving. The women endorsed using multiple planful-problem solving strategies to cope with their CSA experience. Writing in various forms like short stories, poems, and letters was reported by some women. One woman stated, "I also express myself a lot through my poems, and that helps tremendously as well" (P3). Writing about the CSA experience (e.g.,

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letter to the perpetrator) helped some of the women to process their experience and to express their anger toward the perpetrators without confronting them in public. One survivor (P1) stated,

> Well after the abuse happened around 10 or 11-years-old I wrote down everything that happened to me and that was very helpful. I felt it implanted what happened into my brain I don't' know if it's because of that I remember everything or I just remember everything because I was conscious; I was 9 or 10-years-old I was not a young child so I pretty much remember everything. So the journaling, I felt like it helped me process things a little bit.

Recognizing the need for help and seeking it, and talking to a friend, spouse, or therapist about the CSA was endorsed by two women: "If I ever don't feel good or feel like I'm worried, I just schedule a session with my psychologist and just go talk it helps" (P2). Avoiding the perpetrators and limiting any contact with them was endorsed by nine women who were abused by family members and one who was abused by non-family member. One woman (P16) said,

> I had learned to avoid the situation. Definitely just being too close to him he's sitting on a couch at my grandma's but it can only fit like, two people. I definitely, used to sit by him, all the time, and, read. I definitely learned to avoid that if my grandma's not in the room.

Other planful-problem solving strategies include exercising, listening to music, doing art, joining self-defense classes, reading self-healing books, and learning a deep breathing exercise to manage the negative feelings when CSA is triggered. One survivor (P19) of familial abuse stated,

> Often when I feel restless about what I had gone through, I go for long runs on a trail near my home until I get to the waterfall. If it is too cold, I like to take a little drive to be on the open road with good music and a breeze.

Confrontive coping. Coping by letting feelings out, especially when the topic of abuse was brought up, was noted by one woman (P2):

> I lost a lot of; some people they're not friends there were some people who I talk to in general like yeah I stop talking to them in general because I can't talk to someone who

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thinks this way. I got so many arguments with people about that subject because everyone has their own point of view.

Although not directly reported by the women, it was noted by the PI that those who used confrontive coping to a greater extent were all abused by family members and disclosed their abuse at varying times during their lives. Disclosing the abuse, taking into account the outcomes of disclosure and the mentality of Arabs, might have been perceived by the women as something risky, but they did it anyway.

Self-blame and assuming responsibility. Thirteen women coped with their CSA by self-blame and assuming the responsibility for being abused. Self-blame was present when the women trust the perpetrators and were alone with them, went out without the family's permission, did not wear headscarf, did not take action to stop the abuse, and kept silent about the abuse. One survivor (P15) of familial and non-familial continuous CSA said,

> I feel like disgusted. As I got older, like right now, as I think back on it, it's like disgusting to me, like, "oh my god, how did that happen? How did I not scream? How did I not like run away at the moment? How could I just keep frozen? Why didn't I say anything? Why I just keep quiet?"

A survivor (P13) of non-familial rape by a friend said,

> The only reason I broke up with my boyfriend of six months at the time was because I felt like my parents would accept him [perpetrator] more, because he was a family friend, and he was older than me and he was more mature. In the long run, he would be the better guy to be with. So, I did it for all the right reasons, but you know, that just blew up in my face.

Two survivors of non-familial rape explained that their use of self-blame coping contributed to the negative reaction (i.e., blame) they had received from their families upon

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disclosure. One survivor (P9) explained, "It was your fault, it was your fault. It kept me in this hole of self-blame for so long." The two women disclosed their abuse during childhood immediately after the rape and were blamed for it by their families.

Emotional-control. Emotional-control coping that included controlling self from expressing CSA feelings, letting these feelings interfere with other things, and disclosing the abuse were reported by the women. Controlling self from expressing feelings was adopted by 15 women. Ten of the women were abused by family members and five by non-family members. Controlling self from expressing anger toward the perpetrator and acting normal during family gatherings and special occasions were reported by survivors of familial abuse. This form of self-controlling was greatly influenced by the Arabic values and beliefs of family ties and family reputation, as one survivor (P19) of familial abuse said,

> Family reputation and family ties have kept me from being able to move on in my life and leave the negativity behind because I have to face my abuser at all of our family gatherings and act as if nothing has happened to maintain good relations with my family.

Another survivor (P12) of familial abuse explained,

> My uncle is still around – is still at every family event, He was at my wedding. He was at my engagement, like as when the guy, my husband, came to ask for my hand. Every time I look at him, it reminds me of who he really is, but I just can't say anything because it'll just tear the family apart.

Controlling the abuse feelings from interfering with other things like personal growth was reported by the women: "I kept it to myself so that I could focus on my other goals" (P18). In addition, controlling self so as to not disclose the abuse to others was reported by 13 women: "I just feel like most people can't handle the experience of hearing about of the abuse and I can't

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really tell anyone besides my husband because it's just not something that should be in people's brains" (P1). All of the women except two (P4, P19) disclosed their abuse either during childhood, adulthood or both and had received supportive and unsupportive reactions. However, non-supportive reactions like survivor's blame, minimization, and asking the survivors to keep the abuse secretive from others (e.g., father, future husband, friend) were more prevalent and contributed to employing this type of coping. The reasons for not disclosing the abuse immediately in the aftermath of CSA or later were to preserve family ties, especially in cases of familial abuse, preserve family reputation from being ruined, and the fear of not being believed or blamed for the abuse. One survivor (P11) stated,

> I was continuously forced to recall a bad memory that only I knew. Even my closest friends didn't know, and I couldn't tell them because if they told their parents it would ruin my parent's relationship with them or it would "embarrass" my parents. I was continuously reminded to control myself even though I was a child who had no idea what sex even was.

Furthermore, two of the women (P6, P15) stated that the unsupportive reactions (i.e., disbelief, blame) they had received from others (e.g., parents) upon childhood disclosure inhibited them from any further disclosure. One of the women (P6) said,

> She [her mom] is like, "Yeah, I understand that, you know, she [her sister] is part of the LGBT community, but I don't think that she'd ever do that to her sibling." I tried to explain to her over and over again that it can happen, but she kind of shrugged me off, and that was the last time I spoke about it.

Escape-avoidance coping. In this study, women used a variety of escape-avoidance strategies such as smoking, drinking, using drugs, cutting oneself, overeating, and starving oneself to get some relief from the negative feelings of CSA and/or to mentally evade thinking about the

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experience. One survivor (P9) of non-familial rape stated, "I still continue to self-harm and I feel like that was a way to instead of thinking of the mental, you know, whatever I was going through in my head, I would, you know, guard it to the self-harm." Another survivor (P15) of familial and non-familial abuse said,

> Most of the time when I get really stressed out just in general in life, not just the sexual abuse, but just in general as far as like what I've been through, even as an adult with sexual abuse, because sexual abuse, not just childhood, but it's also for people who are adults too, they have to deal with sexual harassment. I would sometimes try to get away to get pills or something to get high just to forget about it.

Other coping strategies included sleeping more than usual to escape thinking about the abuse: "After we moved here [U.S.] I started sleeping a lot. A lot, a lot because it's like he's not here it's not going to happen" (P2); refusing to believe that the abuse happened: "I try to avoid it. Like never happened" (P8); and avoiding or withdrawing from people. One survivor (P17) explained,

> I am isolating myself except from close friends. I don't know if I can make a direct connection between the abuse and isolating myself, there are other factors, but I am justifying by using the abuse. I have been pulling back from people for a long time.

Using wishful thinking (i.e., wishing the CSA would go away) and hoping for a miracle to happen were commonly employed by survivors of rape, familial, frequent, and continuous CSA. One survivor (P2) of familial rape said,

> I used to fight him a lot. But eventually, I started feeling empty. Feel numb like there's nothing you can do – just let go. I remember just letting go. And it's just a terrible feeling because like I felt worthless, sometimes I just felt nothing. Like I would just go into a totally different world while this is happening because I knew there was nothing else I can do.

Distancing coping. Survivors of CSA used a variety of distancing strategies to cope with their experience of abuse. Trying to forget the CSA experience and to not dwell on it were

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commonly used, as one survivor (P4) explained, “As a survivor of CSA, I just try to not think of that moment and forget what really happened.” Furthermore, going with fate and going on as if the abuse never happened were also employed by the survivors of familial and non-familial contact CSA. Nonetheless, these two strategies were more prevalent among the survivors who were abused by family members or who received unsupportive reactions. One survivor (P16) who was abused by her grandfather and never disclosed the abuse to her parents said, “I can’t feel horrible about it. So, I have to be okay with it.” Another survivor (P18) of non-familial abuse said, “Now when I think about it I just accept that it happened and move on with my day.”

There were some women who coped with their CSA by looking to the bright side of their experience. More explicitly, three survivors of familial CSA (i.e., fondling) were thankful that their abuse did not include any forms of penetration or physical force: “I just try to relax think about something else. Think about other bad stories that might happen and/or actually happened to other victims that makes me feel better” (P8). An additional way of coping with CSA as noted among five women was minimizing the perpetrators’ abusive behaviors: “I understand what they were doing, but we all have moments of weakness. I didn’t want to ruin somebody’s life for something so stupid that they did in a moment of weakness” (P15). All of the women except one were abused by family members who were 3-20 years older than the woman. One survivor (P17) of familial CSA by young cousin said,

> I grew up thinking that he was the real victim, he has scars, emotional and physical, from his dad that he can show to everyone and people would recognize them as scars. I didn't go back home to a physically abusive father, he did. He needed to do what he did to survive.

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Long-Term Psychological Outcomes of CSA

All the women reported the debilitating impact of CSA on their lives and well-being. The impact was categorized into CSA recall, triggers, and reactions; sleeping issues; and interpersonal issues.

CSA recall, triggers, and reactions. Recalling the abuse memories and having flashbacks were reported by the women. Nonetheless, the frequency of recall, triggers, and reactions varied among them. For instance, some women only recall the abuse when it is triggered, while others recall it more frequently on a daily or weekly basis, as one survivor (P2) of familial rape said,

> I don't think there's a day that goes by that I don't have a glimpse and if I want to think about everything in detail unfortunately I can list everything about every single time and if I close my eyes I can actually see it in front of me.

The triggers for the women were seeing the perpetrators or hearing about them, especially in cases of familial abuse. Seeing people with the same physical features of the perpetrators was described: "seeing anybody that looks like her seeing anybody that she used to hang out with like her friends from high school and seeing my mom" (P6). Some women were triggered by watching or hearing child abuse news or advertisement on the media, being with men, or having sex: "I've lived the experience over and over again, and I don't mean to get really graphic here, but I just remember the way it felt. I just remember, like every time I've had sex" (P6). Furthermore, some survivors reported that certain smells, places (i.e., basement, school, forest), and postures (i.e., laying down) could trigger the CSA memories. One survivor (P3) of non-familial rape said,

> Driving by the library or the high school triggers me, and that's something that happens just about every day. Sometimes I'll see a car that resembles his, and that triggers me as well. I don't like going into forests or lying down in the backseat of any car for any reason.

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Some survivors experienced panic when they recalled the abuse: "When I remember the experience, it's as if there is a black filter on the whole world. Everything seems to be falling apart. I have a panic attack" (P11). Others described heart racing, feeling sick, irritable, anxious, suffocated, itchy, and scared. One survivor (P10) of familial CSA said,

> When I remember the abuse, it's visual and sensory. I can taste him, I can smell him, and I can see him. It's like I'm in his bedroom or hiding under my bed hoping he can't find me. But then I remind myself that was 20 years ago and you're not there anymore. You don't have to hide under any more beds.

Sleeping issues. Another psychological outcome of CSA was having problems falling asleep or maintaining asleep, as reported by two women. These women were survivors of rape that occurred more than once by a family member/non-family member (e.g., classmate). One of the women (P9) said, "sometimes I do have insomnia because of it."

Interpersonal issues. Interpersonal issues of CSA were reported by the women and included low self-esteem, lack of trust, and intimacy issues.

Low self-esteem. Six women expressed feelings of low self-esteem as a result of their abuse. All of these women except one were abused by family members, four experienced contact CSA with penetration (i.e., vaginal), and two experienced fondling. Four of the women disclosed their abuse during adulthood a long time after the abuse ceased, one woman disclosed during childhood, and one never disclosed it prior to the study interview. Women who disclosed their abuse had received supportive and unsupportive reactions like disbelief and minimizing the CSA. One survivor (P6) of familial abuse by her sister stated, "I have really, really low self-esteem. I think that has a lot to do with what happened to me." Another survivor (P15) of familial CSA who felt incompetent and unsuccessful although she had a degree and job explained,

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> I look at my brother, who used to have girls come over and he's successful. He has a Master's in electrical engineering. He has a good job and makes good money. I know that's my own brother. This is going to sound really bad, but I don't even like to talk to him or see him because it just makes me feel so bad about myself.

Lack of trust and feelings of insecurity. Lack of trusting others was described: "I have extreme trust issues, I could tell someone Yeah, like I trust you and I don't" (P13). Similarly, many other women expressed feelings of insecurity: "After the event, I was more careful around people in general because I realized everyone could be capable of harm, despite their harmless appearances" (P18). Being abused by family (e.g., uncle) and/or non-family (e.g., friend) members contributed to the women's inability to trust and their fear of being harmed by others. Difficulties to build or sustain relationships, having a pessimistic view of the world as a nasty place, and the unwillingness to have children were other negative outcomes of CSA reported by the women. One survivor (P15) of familial and non-familial abuse explained,

> It's a horrible world. It is a very evil world. People are just very bad; I would never want a child because it's too much like it's evil. People see that people are born good, like no. I feel like some people are born evil. Most individuals in this world are not going to do anything unless they benefit. They're not going to do anything for anybody unless they benefit directly from it. I see humans as very selfish.

Intimacy issues. Three women reported that sex was one of the triggers of CSA memories, and this influenced their satisfaction with intimate relationship, as one said, "My everyday life has been impacted because I fear that my sex life may be a trigger with my future husband" (P11). Another woman (P1) who was severely abused by a family member explained,

> It did affect the things that I'm interested in sexually. So the sadistic abuse really messed with my head and what gets me to be satisfied sexually. I kind of feel like I'm some kind of weirdo. I only get off on abusive stuff. That is a problem as well.

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Convergent Mixed-Methods Results

To achieve the last aim of the study to explicate a comprehensive description of coping and psychological outcomes of CSA, the quantitative and qualitative data were combined using joint display. In other words, the qualitative summaries of the interviews and quantitative raw scores were combined in an Excel spreadsheet (see Table 6) for across and within data analysis. Furthermore, the quantitative descriptive and correlation results were also combined with the qualitative themes.

Social Reactions to CSA Disclosure

Looking across and within cases and the SRQ/SRQ-CSA score provided a better understanding how the women perceived the reactions they had received upon disclosure. In this study, 15 women had disclosed their abuse prior to the interview, and four made their first disclosure during the study interview. Twelve of the 15 women who disclosed their abuse reported supportive and/or unsupportive reactions from the same individual and/or different individuals upon disclosure. These women had higher scores on the positive than negative SRQ subscale. Therefore, the women had perceived the overall reactions they had received during their lifetime to be more positive than negative. Furthermore, some of the unsupportive reactions like being passive and not reporting the abuse to the police were perceived by some of the women to be appropriate in Arabic culture, taking into account the values of family ties, reputation, and the lack of knowledge about CSA. One survivor (P18) of non-familial abuse by a close family friend explained, “If my mother took further action [report to the police] with our family friend, the community might have taken his side over mine and that would've led to additional problems.”

On the contrary, of the 15 who disclosed their CSA, 3 women who experienced vaginal penetration had high scores on the negative SRQ and on the SRQ-CSA. Two of the women had

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Table 6. An Example of Convergent Mixed-Method Design Data Analysis (N = 19)

Concept	Qualitative	Quantitative
Social reaction to CSA disclosure	"she believed me over him and comforted me when I needed it" (P18)	Positive SRQ = 3.15 Negative SRQ = 0.54 SRQ-CSA= 0.58
Acculturation	"There are definitely a lot of negatives regarding, uh, the subject of rape and abuse. I definitely don't agree with that, particular values or how they react to it. How Arabs react to that situation, but when it comes to family oriented and hospitality I definitely do" (P9)	AArC = 43 AAmC = 50
Distancing	"You don't want to even think about it or you-you don't want to even remember it, but sometimes even I forget that I've been in this situation" (P14)	WCQ-R relative score = 26.29%
Self-controlling	"I was continuously forced to recall a bad memory that only I knew. Even my closest friends didn't know and I couldn't tell them because if they told their parents it would ruin my parents relationship with them or it would "embarrass" my parents. I was continuously reminded to control myself even though I was a child who had no idea what sex even was" (P9)	WCQ-R relative score = 20.36%
PTSD	"Last year there was this guy I liked and I asked myself if I would even be able to kiss him. I closed my eyes and thought about it but then I 'smelled' my cousin and snapped out of it" (P17)	PDS-5 = 60 severe symptoms

Note. AAmC = attracted to American culture, AArC = attracted to Arabic culture, CSA = childhood sexual abuse, PDS-5 = Posttraumatic Diagnostic Scale, PTSD = posttraumatic stress disorder, SRQ = Social Reactions Questionnaire, SRQ-CSA = Social Reactions Questionnaire–Childhood Sexual Abuse, WCQ-R = Ways of Coping Questionnaire Revised.

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disclosed their abuse during childhood immediately after the rape to others (i.e., friends, parents), and the third disclosed her abuse during adulthood to her mother. All of them had received supportive (e.g., being believed and supported during the trial) and unsupportive reactions (i.e., disbelief and blame). Nonetheless, unsupportive reactions of blame and disbelief outweighed the supportive reactions. In other words, these women reported the overall reactions they had received during their lifetime to be more negative than positive.

Acculturation

During the interview, the women were asked to identify the Arabic values and traditions they honor and follow in their lives. The most common values and traditions reported were maintain close contact with family and extended family members, religion, hospitality, and respect. Furthermore, one woman identified Arabic/ethnic food and belly dance as Arabic traditions that she and her family honor. Quantitatively, the ARSAA-IIE intended to assess acculturation on different dimensions, including language use and preferences, ethnic identity and classification, ethnic behavior and interaction, and cultural heritage (Jadalla et al., 2015). Eight women scored high on the AArC subscale, nine scored high on the AAmC subscale, and two women had equal score on both subscales. Regardless of the women's attraction to Arabic or American culture, during the interview they identified certain values like family and religion to be part of their Arabic culture that they honored and followed.

Coping with CSA

During the interview, the women reported the coping strategies they were using since the abuse to cope with their CSA; some of them endorsed four or more strategies and others endorsed less than three. Nonetheless, completing the WCQ-R questionnaire broadened our understanding

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of the other current types of coping that were used during the last month by the women and the extent of each type.

CSA characteristics, social reactions, and confrontive coping. Although this type of coping was not commonly reported by the women in the study, two survivors of continuous familial CSA with penetration used this type of coping more often than other types. These two women reported the reactions they had received upon disclosure to be more positive than negative.

CSA characteristics, social reactions, and distancing coping. Seventeen women adopted distancing strategies to cope with their CSA. However, only six used these strategies more often than other types of coping, as indicated by their high scores on the distancing subscale. All of these women were survivors of contact CSA, mainly fondling by family members, expect one woman who was abused by a teacher. Furthermore, all of these women except one reported the social reactions they had received to be more positive than negative.

CSA characteristics, social reactions, and self-controlling coping. The majority of the women in this study used self-controlling to varying degrees to cope with their CSA. Nonetheless, ten of the women used these strategies very often as reflected in their high relative score in the self-controlling subscale. Seven of the 10 women reported receiving positive reactions as reflected in their SRQ score. Furthermore, five of the seven women were abused by a family member and two by non-family member. In contrast, three women had perceived the reactions they had received to be more negative; two were abused by family members and one by non-family member.

CSA characteristics, social reactions, and seeking social support. The majority of the women (n = 15) in the study had disclosed their CSA despite the fact that only a few of them sought professional help. The relative scores of the seeking social support subscale were low as reported by the women compared to other types of coping. Four of the six women who sought

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therapy were survivors of CSA with penetration by family or non-family member. Five of the women reported the overall social reactions to be positive.

CSA characteristics, social reactions, and assuming responsibilities. Eight women reported accepting responsibilities coping, and six of these women had high relative scores on the accepting responsibilities subscale. The reasons for self-blame and accepting responsibilities were trusting the perpetrator, going out with the perpetrator without family's permission, not wearing headscarf, not taking an action to stop the abuse, and not disclosing the abuse earlier when it happened. Four of the women were abused by family members and received positive reactions, one was abused by non-family member and received positive reactions, and one was abused by non-family member and received negative reactions as reported by the women.

CSA characteristics, social reactions, and escape-avoidance. More than half of the women reported during the interview their use of escape-avoidance strategies to cope with their CSA. This type of coping was used at great extent during adulthood by six women as reflected in their high relative score of the escape-avoidance subscale. Four of the six were survivors of familial abuse and two of non-familial abuse. Furthermore, all six women reported receiving supportive and unsupportive reactions. Nonetheless, four of them reported the overall reactions they had received to be more negative as reflected in the high scores on the negative SRQ subscale.

CSA characteristics, social reaction, and planful-problem solving. Planful-problem solving strategies were reported by some of the women during the interview. Nonetheless, five women had high relative score on the planful-problem solving subscale. Four women reported the reactions they had received upon disclosure to be positive. One of the women did not disclose her abuse prior to the interview. Furthermore, four women were abused by family members and one was abused by non-family member.

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CSA characteristics, social reactions, and positive reappraise. The majority of the women reported positive reappraisal strategies, but only five used it very often as shown in their high relative score. Four women were abused by family members and one by non-family member. Two of them had never disclosed their abuse prior to the interview, two had received positive reactions and one received negative reactions upon disclosure as perceived by the women and reflected in the SRQ.

Combining descriptive statistics with qualitative themes

When it comes to social reactions to CSA disclosure, the mean score of the positive social reactions to adult sexual assault was higher than the negative reactions. Combining the qualitative data with the quantitative data improved our understanding that despite the negative reactions the women had received, they identified the overall reactions to be more positive than negative. During the interview, the women endorsed the reactions they had received upon disclosure from recipients, and the majority of the recipients provided a combination of supportive/positive and unsupportive/ negative reactions (i.e., believe vs. treating differently, belief vs. being passive). Thus, the high mean score of positive social reactions indicated that a large number of the women had received positive reactions upon disclosure. It is worthwhile to mention that the SRQ and SRQ-CSA have not been used among Arabic female survivors of CSA before.

The women identified an array of coping strategies they employed to cope with their CSA experience, some of which were not reported in the quantitative survey (WCQ-R). However, the extent of using a specific type of coping over another was not identified. Furthermore, during the interview the women endorsed all of the coping strategies they employed to cope with their CSA during their lifetime. In contrast, the quantitative survey measured women's coping strategies in the last month. Thus, the quantitative results expanded our understanding that despite the women's

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employment of several coping strategies during their lifetime, self-controlling, distancing, and positive reappraisal were the most frequent methods used during adulthood to cope with CSA.

Correlation and Qualitative Themes

The correlation between the coping strategies and other factors including social reactions to CSA disclosure, acculturation, depressive symptoms, and PTSD was also combined with the qualitative data to understand the women's CSA experience. First, attraction to Arabic culture was positively correlated (r = .591**, p = .008) with positive reappraisal and negatively with self-controlling (r = -.531*, p = .019) and escape-avoidance coping (r = -.531*, p = .015). Although many women identified Arabic culture as a barrier for them to cope with their CSA, they identified family to be one of the values they highly honored. As discussed earlier under the culture theme, religion was identified by the women as an important value of the Arabic culture that they followed and honored. The positive reappraisal subscale has a religious dimension. The positive relation between attraction to Arabic culture and positive reappraisal along with the qualitative data indicated that Arabic women used religion to cope with their CSA as part of their identity as Arabs.

Escape-avoidance coping was positively correlated with negative social reactions to adult sexual assault (r = .688**, p = .005) and social reactions to CSA (r = .624*, p = .013), and negatively correlated with the positive social reactions to adult sexual assault (r = -.560*, p = *.030*). Qualitative data shows that women who received negative reactions to their CSA disclosure reported the use of escape-avoidance coping. Thus, the quantitative data improved our understanding that receiving negative reactions upon disclosure like blame and disbelief fostered the women's employment of escape-avoidance strategies (e.g., self-harm, eating, drinking, using drugs) to cope with CSA during adulthood. Furthermore, receiving negative reactions to CSA disclosure inhibited some of the women from any further disclosure and triggered escape-

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avoidance coping as a way to forget or avoid thinking about their CSA experience. In contrast, receiving positive reactions to CSA disclosure such as believing the survivor and seeking professional help may have helped to minimize the use of escape-avoidance strategies by the women. Furthermore, escape-avoidance coping was positively correlated with PTSD and depression.

Summary

This chapter presented Arabic women's experience of CSA. Continuous contact CSA was the most common type of abuse reported by the women. Furthermore, the most common perpetrators of CSA were family members. The women endorsed receiving positive and negative reactions upon disclosure, and some of these reactions were related to the type of abuse and relationship to the perpetrators. Survivors of non-familial rape received more negative than positive reactions. The women employed an array of coping strategies to deal with their CSA during their lifetime. The most common types of coping employed by the women during adulthood were self-controlling coping, distancing, and positive-reappraisal, respectively. The long-term outcomes of CSA were PTSD, low self-esteem, sleeping issues, sexuality issues, and lack of trust and feeling of insecurity.

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CHAPTER 5 DISCUSSION, LIMITATIONS, RECOMMENDATIONS, AND IMPLICATIONS OF THE STUDY

To date, this is the first mixed-methods study that explicates a comprehensive understanding of coping and long-term psychological outcomes of Arabic female survivors of CSA. This chapter includes a discussion of findings, limitations and strengths, recommendations, and implications of the study.

Summary of the Study

Nineteen women who identified themselves as Arabic survivors of CSA participated in the study's interview and online surveys. The most common type of abuse was contact CSA perpetrated by a family member. All of the women in this study except three had disclosed their abuse during their lifetime, and the most common recipients of the disclosure were friends. The women had received both supportive and unsupportive reactions to their disclosure, and the majority perceived the overall reactions they had received as positive. The cultural values and norms about sexuality; CSA; and CSA survivors, family ties, and honor all influenced the women's experience of CSA and coping with it. The women had adopted multiple strategies in the aftermath of the abuse and in adulthood to cope with CSA. The most common strategies reported by the women during adulthood were self-controlling, distancing, and positive reappraisal. The long-term psychological outcomes reported by the women were CSA recall, low self-esteem, lack of trust, feeling of insecurity, and problem building and maintaining relationships. Furthermore, the mean score of the PDS-5 was moderate and expected considering that PTSD is one of the most common negative outcomes of CSA.

CSA Characteristics

The most common type of abuse endorsed by the women was contact CSA without penetration (i.e., fondling) followed by contact with penetration (i.e., vaginal, oral, anal). The least

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common type of CSA was non-contact abuse (i.e., abuse that did not involve any physical contact with the women like sexual requests or comments). These findings were consistent with other studies conducted among Arabic (Timraz et al., 2018; Usta & Farver, 2010) and non-Arabic survivors of CSA (Negriff, Schneiderman, Smith, Schreyer, & Trickett, 2014; Shevlin, Murphy, Elklit, Murphy, & Hyland, 2018). Nonetheless, some studies of Arabic CSA survivors had different findings of the commonality of the type of abuse (Alami & Kadri, 2004; Elbedour et al., 2006). For instance, Alami and Kadri (2004) reported equal occurrences of contact CSA with (33.8%) and without (33.8%) penetration among Moroccan adult female CSA survivors. Furthermore, in a study of Arabic high school female survivors of CSA, the most common type of CSA reported was a sexual request (53.3%), someone exposing his/her sexual parts to the women (16%), and fondling (13%) (Elbedour et al., 2006). There are several differences among the studies that may account for the inconsistent findings. In the study by Alami and Kadri study, 33% of the women refused to continue the study when the topic of CSA was introduced to them by the researchers. The study by Elbedour et al. (2006) was conducted among Bedouin high school girls aged 14-18 years who were living in a traditional, tribal, and patriarchal community where sex and sexuality were unspoken subjects. Thus, one possible explanation of the differences among the studies is the women's perception of CSA as a taboo subject and their fear of the repercussion of reporting contact CSA such as dishonoring the family's name and honor killing. In the current study, more than half of the women elected to participate by phone or email to maintain their anonymity, which may have facilitated disclosure of contact CSA.

Eleven women were abused by family members, six by non-family members, and two by both family and non-family members. Perpetration by family members has been found to be common among Arabic (Al-Fayez et al., 2012; Timraz et al., 2018) and non-Arabic survivors of

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CAS (Finkelhor, 1994a; Jonzon & Lindblad, 2004). In the current study, all of the non-familial perpetrators were known to the women, which is consistent with another study conducted by the principal investigators among Arab American female survivors of CSA (Timraz et al., 2018). None of the women were abused by a stranger (i.e., someone unknown to them), in contrast to a study by Haj-Yahia and Tamish (2001), in which strangers were the number one perpetrators (45.6%) compared to relatives (36.2%) and family members (18.6%). One possible explanation of the inconsistent findings is the differences in defining the perpetrators of abuse among the studies. For instance, in the current study, perpetrators were categorized into family and non-family members. Furthermore, family members included blood related and non-blood related individuals like aunt's husband and sister-in-law's brother, whom are considered family members from an Arab perspective. On the other hand, Haj-Yahia and Tamish categorized the perpetrators into family, relative, and strangers without any further description of each category, which was considered by those authors as one of their study's limitations.

In the current study, survivors of familial CSA reported frequent abuse that lasted for a long period of time compared to survivors of non-familial abuse. This finding is not surprising taking into account the perpetrators' accessibility to the women. Consistent with other studies (McKillop, Brown, Wortley, & Smallbone, 2015; Timraz et al., 2018), all of familial CSA occurred in the family house or properties. Physical force was commonly reported by the survivors of contact abuse involving penetration, which was also reported by Ventus, Antfolk, and Salo (2017).

There are some Arabic cultural factors that may contribute to the women's victimization. First, multiple parenting is common among Arabic families (Haj-Yahia, 1995), in which the parents rely on relatives (e.g., aunt, uncle, grandparents) to help raise children (Haj-Yahia & Tamish, 2001). Thus, the interdependence on the family and extended family and having access to

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the child may contribute to the high prevalence of familial CSA. For example, in the current study, a large number of the women were abused by their uncles, a grandparent, or older siblings who lived in the family house or took care of the survivors. Second, hospitality is a common feature of Arabs and valued by a large number of people (Nassar-McMillan et al., 2013), including the women in our study. Hospitality and frequent gatherings with neighbors, relatives, and friends may also contribute to CSA by non-family members. For instance, two of the women were abused by close family friends; one lived in the family house temporarily, and the other frequently visited the family house to spend leisure time with the survivor's parents. Third, children's respect for their older family members is valued by Arabic families. This value becomes problematic when the perpetrator is an uncle or older siblings. In other words, being abused by a trusted person can delay a child's disclosure due to the fear of others' reactions of disbelief or blame (Fontes, 1995).

Social Reactions to CSA Disclosure

The majority of the women had disclosed their CSA prior to the study. In prior studies, a high prevalence of CSA disclosure was found among Arab American female survivors of CSA (Timraz et al., 2018) and non-Arabic survivors (Kogan, 2004; Smith et al., 2000). Despite the large number of women (n = 16) who disclosed CSA prior to the study, only two disclosed it within 24 hours of the abuse, and the rest waited months to years. Delay in disclosure is well documented in the literature among non-Arabic survivors of CSA (Hébert et al., 2009; Kogan, 2004; Smith et al., 2000). In the current study, nine of the women who delayed their disclosure had their first CSA experience at the age of nine or younger; all nine were abused by family members. Early age of onset (Jonzon & Lindblad, 2004; Kogan, 2004) and abuse by family members (Goodman-Brown, Edelstein, Goodman, Jones, & Gordon, 2003; Hébert et al., 2009; Kogan, 2004; Smith et al., 2000) were found in other studies to be barriers to early disclosure of CSA. The women's delays in

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disclosure were due to their lack of knowledge about the subject (e.g., sex talk with parents). Furthermore, Arabic families are considered to be the major sources of support to their members, and children are raised to respect and trust family members. Trust and respect could delay disclosure of abuse due to the fear of destroying the family. Furthermore, trusting family members could delay identifying the experience as abuse and disclosing it by the women, especially if it did not include any kind of physical force (Alaggia, 2004; Alaggia, Collin-Vézina, & Lateef, 2017).

The most common recipients of childhood disclosure were friends followed by mothers. Mothers were found to be a common recipient of CSA disclosure in a national study by Smith et al. (2000) of female survivors of CSA. In Smith et al.'s study, 86% of the women were Caucasian, 11% African American, and 3% from other categories. In the current study, the majority of the women who made their first disclosure to friends or a legal authority like the police were older in age (> 10.5 years) and had experienced contact CSA with penetration. Kogan (2004) found that adolescents (age 11-17) were more likely to disclose their abuse to friends than family members, relating that to the women's cognitive ability to identify the negative repercussion of disclosure to family members. Kogan also related the finding to the importance of friend relationships at that particular age (Arata, 1998; Lamb & Edgar-Smith, 1994). This same dynamic could be true in the present study in which CSA was negatively perceived by a large number of families. Thus, the women's fear of their families' reactions and their need for support and advice about how to handle the situation influenced them to go to friends first rather than to parents. The most common recipients of adulthood disclosure were friends, partners, and professionals, consistent with findings in other studies (Jonzon & Lindblad, 2004; Kogan; Smith et al., 2000; Ullman, 2003). As discussed earlier, the repercussion of disclosing familial CSA such as destroying family ties,

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overwhelming parents with the CSA, and the fear of not being believed influenced the women's decision to disclose their abuse to close friends rather than to family members.

Overall, there were intrapersonal and interpersonal factors that impacted the women to either not disclose their abuse or delay disclosure. Interpersonal factors such as feelings of shame, guilt, and minimizing the CSA experience were reported by the women in our study and found in the literature to be a deterrent to CSA disclosure (Collin-Vézina, De La Sablonnière-Griffin, Palmer, & Milne, 2015; Goodman-Brown et al., 2003; McElvaney, 2015). Feelings of shame, guilt, and minimizing the abuse experience could be attributed to the social expectations of female's virginity prior to marriage and to the survivor's lack of distinction between sex and CSA, especially contact CSA that did not involve penetration. Intrapersonal factors such as protecting loved ones from feeling guilty, protecting the integrity and cohesiveness of the family, fear of disbelief and blame, and the fear of further abuse were reported in this study and were congruent with other studies among Arabic (Timraz et al., 2018) and non-Arabic survivors of CSA (Fontes & Plummer, 2010; Ligiéro et al., 2009; McElvaney, Greene, & Hogan, 2014).

Receiving positive and negative reactions upon disclosure is commonly found among survivors of CSA, but the degree of support varies according to recipient of disclosure (Ullman, 2003). Receiving mixed reactions to CSA disclosure was noted in our study and other studies of Arabic female survivors of CSA (Abu-Baker, 2013; Shalhoub-Kevorkian, 1999; Timraz et al., 2018; Usta & Farver, 2010). In the current study, 16 of the 19 women perceived the overall reactions to CSA disclosure to be positive, including believing the women, seeking professional help for the women, feeling sorry for the women and showing understanding, and confronting the perpetrators. These positive reactions outweighed or buffered the negative reactions of minimization, passivity, secrecy, and telling others without the woman's permission. In other

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words, this study is retrospective and although the women had received mixed reactions to their disclosure, as adults they may have perceived their family's and friends' unsupportive reactions as acceptable, taking into account the cultural taboo of sex and the negative perception of CSA and survivors. None of the women endorsed extreme negative reactions such as honor killing, forcing the women to marry their perpetrators, or ostracizing the women from the family (Abu-Baker, 2013; Shalhoub-Kevorkian, 1999), which could be another reason that the women reported their overall reactions to be positive. Fatalism or the belief that God has the ultimate power to control all events is a strong part of traditional Arabic culture (Nydell, 1996). Although fatalism is more prevalent in uneducated than educated people, it is considered as a cultural factor that might influence others' reaction to CSA disclosure. For instance, a family's reaction of passivity toward the CSA and perpetrator could be attributed to their belief in fatalism and that CSA was an inevitable event beyond anyone's control (Fontes, 1995, 2007).

The women who perceived the reactions to their disclosure (e.g., blame, disbelief) as generally negative were all survivors of contact CSA with penetration by male non-family members, and in one case a female family member. Similar findings were found in the study by Timraz et al. (2018), in which survivors of contact CSA with penetration were blamed for the abuse by their families. Engaging in any sexual activity prior to marriage is considered sinful and can endanger the reputation and status of the family in the community, bringing shame and dishonor to the entire family (Abu-Baker, 2013). Thus, abused women are blamed for bringing shame and dishonor to the family regardless of the context of the abuse and the absence of consent. Furthermore, the social script of male dominance and the perception that perpetrators of CSA are only males (Sorsoli, Kia-Keating, & Grossman, 2008) might influence the negative reactions of disbelief or minimization when the abuse was perpetrated by female family members.

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Coping and Long-Term Psychological Outcomes of CSA of Arabic Women

Arabic women used an array of cognitive and behavioral strategies to cope with their CSA experience, which is consistent with other research studies of non-Arabic survivors of CSA (Barker-Collo et al., 2012; Draucker et al., 2011; Ligiéro et al., 2009; Phanichrat & Townshend, 2010). However, the extent of using numerous or few strategies varied among the survivors of the present research, a finding that was also reported in a mixed-method study of female survivors of CSA (Oaksford & Frude, 2003). Furthermore, some coping strategies were employed in the aftermath of abuse and others during adulthood, which supports the Folkman and Lazarus (1984) statement that coping is not a trait but a context-dependent process that changes over time. In their qualitative study of adult survivors of CSA, Phanichrat and Townshend (2010) found that escape-avoidance coping was initially adopted by the survivors of CSA and gradually evolved over time to a problem-focused coping.

In the current study, despite the women's level of acculturation, they and their families were impacted by the Arabic culture norms and values of sexuality, family ties and reputation; CSA and survivors; and mental illness and seeking professional help. The impact of these values was reflected in the women's decision to disclose their abuse, the reactions they had received, their appraisal of CSA, and their coping.

Confrontive coping was not reported very often by the women. In this study, most of the women were abused by family members and opted to disclose their abuse to friends. Confronting the perpetrators might not be possible when the survivors are controlled by the cultural norms of respect and preserving family ties and reputation. In addition, fear of not being believed and taking the perpetrator's side might also influence the women's decisions to confront their perpetrators.

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Furthermore, the Arabic women's inability to express their emotions as part of the Arabic culture expectation influenced their ability to let their feelings out and to confront their perpetrators.

Negative social reaction to CSA disclosure was found in the literature to be associated with self-blame (Ullman, 1996). This finding is consistent with the present study in which some of the women attributed their self-blame coping to the negative reactions they had received from their families. However, a large number of the women who reported self-blame had perceived the overall social reactions to be positive/supportive. It should be noted that all the women in this study appraised their CSA as stressful. Thus, feeling ashamed for experiencing a culturally taboo activity, failing the family's and societal expectations of not being virgin and pure prior to marriage, and having been abused by a known person might all be factors that lead the women to hold themselves accountable for the abuse (Fontes, 2007; Nassar-McMillan et al., 2013; Steel et al., 2004). The influence of culture on coping in general and self-blame in particular was found in the literature among Arabic and Latina female survivors of CSA (Ligiéro et al., 2009; Timraz et al., 2018).

Escape-avoidance coping is one of the strategies frequently employed by survivors of CSA and has been associated with negative psychological outcomes if used into adulthood (Cantón-Cortés & Cantón, 2010; Johnson et al., 2004; Wright et al., 2007). In our study, all survivors used some escape-avoidance strategies to cope with their CSA, but only a few continued to use it during adulthood. Those who still used escape-avoidance coping were mainly abused by family members or someone they knew and had received negative reactions from their families upon disclosure. Thus, it is possible that the feelings of betrayal for being abused by a trusted person and the disappointment of receiving negative reactions, especially from parents, may lead to additional trauma and the reliance on escape-avoidance coping to forget about the negative experience.

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Similarly, Ullman (1996) found that negative social reactions were correlated with avoidance coping in female survivors of sexual assault. In that study, avoidance coping mediated the relationship between negative social reactions and psychological outcomes.

In the current study, escape-avoidance coping was correlated with PTSD and depression, which is a common finding in the literature on CSA (Brand & Alexander, 2003; Cantón-Cortés & Cantón, 2010; Johnson et al., 2004; Walsh et al., 2010). It is well acknowledged that the employment of escape-avoidance coping in the aftermath of abuse could be beneficial, but if used over time it can lead to a deleterious effect (Resick & Schnicke, 1993). However, this association should be interpreted with caution in regard to the present study because there were other factors that might contribute to the PTSD and depression, such as the CSA characteristics, negative social reactions, and Arabic culture.

Self-controlling was adopted by a large number of the women to cope with CSA and used to a great extent during adulthood. The Arabic culture values and norms about sexuality, CSA, and family honor and ties had all influenced the women's decision to disclose their abuse, to select the recipients of disclosure, and to anticipate the reactions of the disclosure. For instance, the first recipients of CSA disclosure in childhood and adulthood were friends, not family members. Moreover, three survivors had never disclosed their abuse prior to the study, two of whom were abused by family members. Thus, it can be assumed that many family members including parents were not aware of the CSA. Controlling one's feelings and behaviors by forcing oneself to act normal in the presence of familial perpetrators during family gatherings and occasions in a collectivist society where the well-being of the family precedes the individual's well-being might foster the use of this type of coping frequently. Furthermore, the negative perception of CSA and the negative reactions received upon disclosure such as blame and disbelief influenced the

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women's willingness to disclose their abuse or to talk about it with others. In addition, the adoption of self-controlling coping could also be attributed to the Arabic communication style that is usually impersonal and restrained instead of expressive and personal (Al-Krenawi & Graham, 2000; Dwairy & Van Sickle, 1996). This dynamic may make it hard for the women to express their emotions or to feel comfortable doing so. Furthermore, self-expression and personal decision are not the norms in Arabic culture and individuals are raised to be submissive and dependent on their families and extended families as the core sources of support (e.g., emotional, financial) (Dwairy & Van Sickle, 1996). Thus, it can be hypothesized that self-controlling coping might be perceived by the women to be an efficient way to cope with their CSA in a way that does not jeopardize their relationship with their families and keeps the family dynamics under control. Another explanation is that the women may have difficulty expressing their emotions to others and prefer to keep their feelings to themselves.

Distancing coping such as trying to forget the abuse experience, going with fate, and minimization was endorsed by a large number of the women and used to a great extent during adulthood. As with the other coping strategies, Arabic culture might play a role in adopting this type of coping. Trying to forget about the CSA and moving along when it is not feasible to disclose the abuse or talk about it with others due to shame and fear of others' reactions might foster this type of coping among the women. Fatalism is another concept that is a strong part of Arabic culture. Nydell (1996) summarized that Arabs believe in God and acknowledge his power and that some events depend on God and cannot be controlled. Morling and Fiske (1999) found that fatalism (i.e., harmony control) was correlated with collectivism and interdependence. Therefore, one possible explanation is that the collectivist nature of Arabic culture and the belief in God as an external locus of control may foster the women's use of fatalism to cope with their abuse. In

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other words, fatalism might help the women to not blame themselves for the abuse and instead regard it as fate. Fatalism was suggested to be one of the barriers to seeking mental health services among Latinos with mental illness who strongly believed in fate (Kouyoumdjian, Zamboanga, & Hansen, 2003). It is worth mentioning that fatalism is a central construct in Latino culture (Greenwell & Cosden, 2009). Thus, it can be suggested that although fatalism might help the women to cope with their CSA, it could be a barrier to seeking professional help for the psychological outcomes of CSA. In a study by Khamis (2008) of 179 adolescent Palestinian boys who suffered Intifada-related injuries, fatalism, negative coping (e.g., wishful thinking), and geographical locations were found to be predictors of PTSD, depression, and anxiety. In that study, fatalism was considered as one type of distancing coping and not an independent factor. However, Khamis study showed that fatalism can predict psychological outcomes among trauma survivors and should be considered when working with Arabs. In the current study, minimizing the abuse experience could be attributed to the women's belief in fate and to the cultural perception of CSA. In other words, the notion of only acknowledging severe cases of abuse that involve penetration may lead to the minimization of other types of abuse such as fondling and non-contact abuse.

Although distancing and self-controlling may be considered to be emotion-focused strategies that can lead to maladjustment during adulthood (Leitenberg, Greenwald, & Cado, 1992), it is also possible that these strategies could have benefits for Arabic women and their families. In other words, the self-controlling and distancing coping might not endanger the women or jeopardize personal and family reputation and honor compared to confrontive or seeking social support coping in which disclosure of CSA is required. It is well documented that emotion-focused coping is employed when the stressful event is appraised as uncontrollable (Folkman & Lazarus, 1984). Thus, Arabic women's feelings of powerlessness and inability to control the CSA might

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foster their use of distancing and self-controlling coping in the aftermath and in adulthood. Brand and Alexander (2003) found that distancing coping was associated with better functioning in adulthood but inconsistent with the findings of Leitenberg et al. (1992), who found that self-controlling (i.e., emotion-suppression) and distancing (i.e., denial) were the most frequent method used by the survivors in the aftermath of abuse and in adulthood. Furthermore, Leitenberg et al. explained that the use of these two methods might be attributed to the women's lack of a concrete or direct method to cope with the abuse experience. The inconsistent results support the fact that coping is context dependent and varied among survivors of CSA.

Positive reappraisal is another cognitive coping strategy that was reported and used by the women during adulthood. Similar findings were found in the study by Oaksford and Frude (2003), in which positive reframing strategies were reported by the women to be used exclusively for the long-term. Another recent study by Timraz et al. (2018) of Arab American female survivors of CSA reported similar findings. In this study, focusing on personal growth and attaining proper education to help other survivors resulted from the women's CSA experience, especially those who had received negative reactions to their disclosure. All the participants were college students or graduates. Being at school and having the sense of achievement might help the women to regain their sense of self-worth. Praying was also endorsed by the women to help them cope with their CSA. The majority of the women were Muslims and Christians, and the women identified religion to be part of their culture. Thus, praying to cope with CSA might be attributed to the women's attachment to their culture.

Seeking social support was reported by a large number of the women, but it was the least frequent strategy to be used during adulthood. Survivors of continuous abuse by a family member had a greater need to talk about their experience and to seek help, but they opted to use self-

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controlling and distancing, citing multiple reasons for their approach. First, the negative perception of CSA and the negative implications of the disclosure inhibited the women's disclosure in adulthood. Second, the families' lack of acknowledgment of mental illness and the stigma behind it hindered the women from seeking social support to cope with their CSA during adulthood. Third, the wish to avoid disclosing a family matter and involve an outsider, especially in cases of familial abuse, was an additional barrier to seeking social support, specifically professional help.

In general, many Arabs believe that mental illness is some sort of possession, insanity, or evil spirit, so depression, anxiety, or symptoms of PTSD are not typically acknowledged (Abu-Ras, 2007; Youssef & Deane, 2006). This lack of acknowledgment either results from denial or poor knowledge of mental illness, which leads to the underutilization of mental health care services. Furthermore, mental illness is considered shameful, stigmatizing, and embarrassing to the survivors and their families. In other words, having a family member who has a mental illness or has sought mental health care can affect the prospects of an entire family's women to getting married (Abu-Ras, 2007; Al-Krenawi & Graham, 2000; Youssef & Deane, 2006). Thus, in order for the women to save the honor and reputation of their natal family name, they may not seek mental health services. In some instances, the women were discouraged from seeking professional help by their family members (Youssef & Deane, 2006), which was also reported by some of the women in the current study. Youssef and Deane (2006) conducted a study among Arabic-speaking communities in Australia to explore mental illness perceptions and preferred forms of treatment among survivors of intimate partner violence. They found that the shame and stigma of disclosing family matters played an integral role in preventing the women from seeking mental health services. Fatalism is another value that may explain the lack of seeking professional help. In other

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words, women who hold this value might attribute their mental illness to fate or bad luck (Haboush & Alyan, 2013).

Although self-controlling and distancing were the most prevalent coping methods, using different methods at a different time may indicate psychological adjustment (Jones, 1997). In the 2018 study by Timraz et al., emotion-focused coping, self-controlling, distancing, and positive reappraisal were used more often during adulthood than problem-focused coping. The women's perception of CSA to be outside their locus of control may induce their adoption of emotion-focused coping rather than problem-focused coping (i.e., seeking social support, confrontive coping, planful problem solving) that is usually used when the event is appraised within one's control (Brand & Alexander, 2003). Overall, the women of the present study were either college students or graduates. This educational status may suggest that despite the silence of the topic and not seeking support, these women were doing well and were capable of the emotional focus that is necessary to attain advanced education

Strengths and Limitations of the Study

The first strength of this study is that it is the first mixed-methods study that explored coping with CSA and long-term psychological outcomes among Arabic female survivors of CSA. The findings have improved our understanding of how CSA characteristics, social reactions to CSA disclosure, and culture influenced the women's coping and long-term psychological outcomes. Second, this study provides an insight into the Arabic culture norms and values perceived by the women to influence their journey of surviving CSA. The qualitative interviews provided a rich narrative of the coping strategies adopted by the women in the aftermath of abuse and in adulthood. Third, this study provided an opportunity for the survivors to share their stories

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and express their feelings in a non-judgmental and confidential environment. Talking about a traumatic experience is considered therapeutic and many women felt relieved after the interview.

CSA is a sensitive topic that is stigmatizing and poorly acknowledged by many people. Thus, it was assumed that many Arabic women would not feel comfortable sharing their CSA experience with an unknown person such as the PI. A variety of data collection methods such as in-person, phone, and email interview were introduced to overcome the recruitment challenges and to allow those who wish to maintain their anonymity to be able to participate in the study. In other words, the study's methods were carefully crafted to be sensitive and receptive to the cultural background of the women.

The study limitations need to be acknowledged. First, the study sample lacks diversity. The women were self-selected in response to the study brochure and university web page advertisement, and they were willing to share their story with the researcher. All the women were either college students or college educated. Thus, the findings of the study may not reflect the CSA experiences of female survivors of Arabic descent in all settings. Proper planning for recruiting Arabic women, especially for a sensitive topic like CSA, is crucial. Different recruiting methods were employed in this study including active and passive methods. Nonetheless, the majority of the women were recruited through an online advertisement that was posted on a weekly basis on the university web page. Involving female community leaders and influencers who are well known in the Arabic community and trusted by the women might help in recruiting a more diverse sample of Arabic female survivors.

As a second limitation, English proficiency was required for participating in the study. Therefore, Arabic female survivors who were not fluent in English did not have the opportunity to be part of the study. As a third limitation, the email interview needed to be completed within 72

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hours, but this duration may have been inadequate for the participants for a couple of reasons. First, not all participants were familiar with the email interview process. More explicitly, some women assumed that they would receive one email that consisted of all the questions instead of multiple emails. Second, all the emails were encrypted as an additional privacy measure. However, this measure was bothersome for the participants because they had to use a password every time they received a new email to see its content. Third, encrypted emails were not supported by some smartphones, and the participants had to have access to a laptop to do the interview, which required more time to do the interview. Future studies that implement online data collection should offer more time to complete the interview. Researchers should provide a clear description of the process before initiating the interview and assess the prospective participant's familiarity with the procedure of online data collection.

Recommendations for Future Research

This is the first mixed-methods research to address Arabic women's experience with CSA. Further research studies with this population are warranted. The retrospective nature of the study did not allow us to identify the dynamics of coping with CSA and how it changes over time. Therefore, longitudinal studies are recommended to collect data on coping changes and persistence. Also, longitudinal studies could examine the intrapersonal, interpersonal, and environmental factors that may impact the coping process.

Future studies should include English and non-English speaking participants from diverse settings. The CSA experience of those who are not fluent in English may be different from the women in our study, especially when it comes to disclosure and seeking support (e.g., professional, legal). In addition, this study was conducted in a metropolitan area that has a large population of

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Arabs/Arab Americans, which may influence the women's acculturation level. Thus, having a sample from a different area where Arabs are a smaller minority might yield different findings.

All the women in this study had been living in the United States for years prior to the study interview. Although these women were more attracted to Arabic culture, the impact of the American culture cannot be ignored. In other words, the experience of Arabic women who live in their country of origin may be different from the experience of those living in the United States. Thus, further research among Arab/Arab Americans is recommended to identify the differences in the social reactions, impact of Arabic culture, coping, and long-term psychological outcomes.

Implications for Practice

This study produced a substantial body of knowledge about surviving CSA in an Arabic context. Such knowledge can be useful for healthcare professionals and researchers who are working with Arabic families and survivors of CSA. On the individual level, healthcare professionals should be aware of the collectivist nature of Arabs and the important role that the family plays in the individual's life. Psychotherapies that are implemented in Western societies have an individualistic perspective that may not be applicable for Arabic survivors of CSA. Therefore, when clinicians work with Arabic women, they should have a framework that integrates the family and other cultural values as part of the intervention for optimal outcomes. The stigma of mental illness and seeking mental health services, especially for women, can lead to the underutilization of such services (Al-Krenawi & Graham, 2000). To overcome this challenge, integrating mental health services as part of regular health care clinics may reduce the stigma, therefore encouraging the women to seek mental health services confidentially without breaching the Arabic culture norms (Al-Krenawi, 1996).

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Lack of knowledge about CSA and perceiving it as a stigmatizing issue discourages many families from proper reporting of CSA to the legal system and from seeking help for the survivors or perpetrators. Thus, increasing family awareness about CSA by offering culturally sensitive psychoeducation is very important and can help to minimize the negative effects of CSA, promote early identification, and initiate proper help for the survivors and perpetrators. The findings of this study can be used to design and guide a social marketing strategy to minimize the stigma of CSA and to promote help-seeking behavior among the Arabic female CSA survivors and their families. A social marketing approach was beneficial in motivating survivors of CSA and their families to overcome the stigma of CSA and seek professional treatment in an ultra-orthodox Jewish community in Israel (Boehm & Itzhaky, 2004). In addition, the findings of the present study can be used to guide the content of the focus of a prevention and intervention program for Arabic survivors of CSA and their families.

Conclusion

CSA is a social issue that affects women worldwide. To date, this is the first mixed-methods study that identified the characteristics of CSA, social reactions to CSA disclosure, cultural perceptions of CSA, coping strategies, and long-term psychological outcomes of women of Arabic descent who reside in the United States. The majority of women in this study experienced contact abuse that was perpetrated by a family member. Twelve survivors of the 15 who disclosed their abuse received mixed reactions to their CSA disclosure but reported the overall reactions as positive. Many Arabic cultural norms and values were identified by the women that influenced their CSA experience. These norms pertained to sexuality, family ties, family reputation, and their perception of CSA and survivors. The women adopted an array of strategies to cope with CSA, and these strategies were greatly influenced by the cultural norms and values held by the women.

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The most common coping strategies employed by the women during adulthood were self-controlling, distancing, and positive reappraisal. The negative psychological outcomes endorsed by the women were low self-esteem, lack of trust, and feeling of insecurity. The overall mean of PTSD symptoms was moderate. The findings of this study will improve the knowledge of healthcare providers who work with Arabic female survivors of CSA and will guide the development of prevention and intervention programs that are culturally appropriate for this population.

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APPENDIX A INSTRUMENTS

Sociodemographic Questionnaire

1- How many years has your family lived in the U.S.?

2- How long have you lived in the U.S.?

3- What is your family country of origin?

4- What are your parent's level of education?

Mother:

Father:

5- How old are you?

- ☐ 18-24 years old
- ☐ 25-34 years old
- ☐ 35-44 years old
- ☐ 45-54 years old
- ☐ 55- 64 years old
- ☐ 65 years or older

6- What is your marital status?

- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Separated
- ☐ Widowed

7- Do you have children?

- ☐ Yes. How many children do you have?______________
- ☐ No

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8- What is the highest level of education you have completed? If you currently attend school, the highest degree earned.

- ☐ Less than high school
- ☐ High school diploma
- ☐ Technical/vocational training
- ☐ Associate degree
- ☐ Bachelor's degree
- ☐ Master's degree
- ☐ Doctoral degree
- ☐ Professional degree (MD, JD, etc)
- ☐ Other

9- Are you currently employed?

- ☐ Yes
- ☐ No

10- Please describe the nature of your employment.

11- Do you have any health issues?

- ☐ Yes
- ☐ No

12- What kind of health issues do you have?

13- Do you take any kind of medication?

- ☐ Yes
- ☐ No

14- If you take medication, is it prescribed or do you able to buy it without a prescription?

- ☐ Need prescription
- ☐ Buy it myself

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15- What medication do you take?

16- Do you have health insurance?

- ☐ Yes
- ☐ No

17- What is your household income per year?

- ☐ Less than $10,000
- ☐ 10,001-20,000
- ☐ 20,001-30,000
- ☐ $30,001- or greater

18- What is your religious preference?

- ☐ Christian
- ☐ Muslim
- ☐ Catholic
- ☐ Jewish
- ☐ Hindu
- ☐ Buddhist
- ☐ Agnostic
- ☐ Atheist
- ☐ Other (*specify*): ______________________

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Qualitative Interview Guide

Qualitative Descriptive Study Interview Guide

NOTE: Please contact the principal investigator Mrs. Timraz at shahrazadtim@hotmail.com if you wish to obtain a copy of the complete interview guide.

I really appreciate your time and effort to come today to share your experience with me. As I mentioned to you, I am conducting this interview to gain more understanding of how you, as a woman of Arabic descent, cope with your CSA and the psychological impact on you. This interview will help me to understand more about your experience and to develop culturally sensitive ways to help women like yourself to live a better life.

Your name will not be noted on any of the forms. Please try not to say any names but if you choose to, I will disguise the names when the interview is transcribed. Only the four faculty members that advise me will know what you say but will never know your name.

If you do not mind, I would like to audio record this interview because I would never be able to remember everything you tell me and I do not want to miss anything. A professional transcriptionist and I will listen to the audio recording. The transcriptionist will not know your name.

We will start the interview with open-ended questions and then followed by five surveys that will take approximately 45 minutes. These surveys ask about your feelings to help me understand how child sexual abuse impacted you. Once you have read the survey questions and are worried that you may have a problem, I will provide a list of professional counselors to everyone so you can contact someone for further evaluation. During the interview, if you need to take a break or stop, please let me know. If there are any questions that you do not want to answer, you are free to skip those and we will move to the next questions. You are free to leave this interview anytime you would like to.

Would you like to ask any questions before we start?

I. Introduction

1. Can you tell me a little about yourself?
2. If you don't mind I would like to know how you heard about this study?

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II. Antecedent Factors

A- Characteristics of Abuse

1. Can you tell me about the time you were abused?

   Probes:

2. How were you abused? What did he/she do to you?

B- Social Reaction to Abuse Disclosure

1. Have you ever disclosed your abuse to anyone? (disclosure)

   Probes: family member, friends, healthcare provider.

C- Culture

1. How do you think being of Arabic descent impacts you as a survivor of childhood sexual abuse?

D- Acculturation

1. Can you tell me how important it is to you to follow or honor Arabic values? What are the reasons?

III. Mediating Processes (Appraisal & Coping)

1. How do you appraise or evaluate your experience of CSA? or How do you feel about your experience of CSA?

   Probes: harmful, challenging, threating

2. As a survivor of CSA, what do you do to deal/cope with the abuse?

   Probes: pray, exercise, do chores, isolate myself, avoidance, denial, smoke.

IV. Psychological Outcomes (Morale & Functioning in the World

1. How often do you think or remember the abuse?
2. What do you do to avoid thinking about it?
3. Can you describe to me your experience when you remember the abuse?

   Probes: reliving the abuse again or reliving the most traumatic part of it

Conclusion

What was it like to talk to me today?

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Acculturation Rating Scale for Arab Americans II-E
(ARSAA–IIE)

Acculturation Rating Scale for Arab Americans II (ARSAA II)

Circle the number that best describes your response to each of the items below

No.	Item	Not at all	Very little or not very often	Moderatel y	Much or very often	Extremely often or almost always
1.	I speak Arabic	1	2	3	4	5
2.	I speak English	1	2	3	4	5
3.	I enjoy speaking Arabic	1	2	3	4	5
4.	I associate with Americans	1	2	3	4	5
5.	I associate with Arabs or Arab Americans	1	2	3	4	5
6.	I enjoy listening to Arabic language music	1	2	3	4	5
7.	I enjoy listening to English-language-music	1	2	3	4	5
8.	I enjoy Arabic TV	1	2	3	4	5
9.	I enjoy English language TV (American TV)	1	2	3	4	5
10.	I enjoy English language movies (American movies)	1	2	3	4	5
11.	I enjoy Arabic language movies (Arabic movies)	1	2	3	4	5
12.	I enjoy reading e.g., books in Arabic	1	2	3	4	5
13.	I enjoy reading e.g., books in English	1	2	3	4	5
14.	I write (e.g., letters, notes) in Arabic	1	2	3	4	5
15.	I write (e.g., letters, notes) in English	1	2	3	4	5
16.	My thinking is done in English language	1	2	3	4	5
17.	My thinking is done in Arabic language	1	2	3	4	5

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No.	Item	Not at all	Very little or not very often	Moderately	Much or very often	Extremely often or almost always
18.	My contact with my home country has been	1	2	3	4	5
19.	My contact with the U.S.A. has been	1	2	3	4	5
20.	My father identifies or identified himself as An Arab	1	2	3	4	5
21.	My mother identifies or identified herself as an Arab	1	2	3	4	5
22.	My friends, while I was growing up, where of Arabic origin	1	2	3	4	5
23.	My friends, while I was growing up, where of American origin	1	2	3	4	5
24.	In my family, we cook Arabic foods	1	2	3	4	5
25.	My friends now are of Anglo origin (Americans)	1	2	3	4	5
26.	My friends now are of Arabic origin (Arabs)	1	2	3	4	5
27.	I like to identify myself as a White American	1	2	3	4	5
28.	I like to identify myself as an Arab American	1	2	3	4	5
29.	I like to identify myself as an Arab	1	2	3	4	5
30.	I like to identify myself as an American	1	2	3	4	5

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Social Reactions Questionnaire
(SRQ)

HOW OTHER PEOPLE RESPONDED...

The following is a list of behaviors that other people responding to a person with this experience often show. Please indicate how often you experienced each of the listed responses from other people by placing the appropriate number in the blank next to each item.

0	1	2	3	4
Never	Rarely	Sometimes	Frequently	Always

1. Told you it was not your fault
2. Pulled away from you
3. Wanted to seek revenge on the perpetrator
4. Told others about your experience without your permission
5. Distracted you with other things
6. Comforted you by telling you it would be all right or by holding you
7. Told you he/she felt sorry for you
8. Helped you get medical care
9. Told you that you were not to blame
10. Treated you differently in some way than before you told him/her that made you uncomfortable
11. Tried to take control of what you did/decisions you made
12. Focused on his/her own needs and neglected yours
13. Told you to go on with your life
14. Held you or told you that you are loved

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15. Reassured you that you are a good person

16. Encouraged you to seek counseling

17. Told you that you were to blame or shameful because of this experience

18. Avoided talking to you or spending time with you

19. Made decisions or did things for you

20. Said he/she feels personally wronged by your experience

21. Told you to stop thinking about it

22. Listened to your feelings

23. Saw your side of things and did not make judgments

24. Helped you get information of any kind about coping with the experience

25. Told you that you could have done more to prevent this experience from occurring

26. Acted as if you were damaged goods or somehow different now

27. Treated you as if you were a child or somehow incompetent

28. Expressed so much anger at the perpetrator that you had to calm him/her down

29. Told you to stop talking about it

30. Showed understanding of your experience

31. Reframed the experience as a clear case of victimization

32. Took you to the police

33. Told you that you were irresponsible or not cautious enough

34. Minimized the importance or seriousness of your experience

35. Said he/she knew how you felt when he/she really did not

36. Has been so upset that he/she needed reassurance from you

37. Tried to discourage you from talking about the experience

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38. Shared his/her own experience with you

39. Was able to really accept your account of your experience

40. Spent time with you

41. Told you that you did not do anything wrong

42. Made a joke or sarcastic comment about this type of experience

43. Made you feel like you didn't know how to take care of yourself

44. Said he/she feels you're tainted by this experience

45. Encouraged you to keep the experience a secret

46. Seemed to understand how you were feeling

47. Believed your account of what happened

48. Provided information and discussed option

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Social Reaction Questionnaire–Childhood Sexual Abuse (SRQ–CSA)

HOW OTHER PEOPLE RESPONDED…

Below is a list of possible ways that other people may have behaved toward you after they found out about the experience. Please indicate how often you experienced each of the listed responses by placing the appropriate number in the blank next to each item. <u>Please remember to indicate only the responses that you received when you were 14 years old or older.</u>

0	1	2	3	4
NEVER	RARELY	SOMETIMES	FREQUENTLY	ALWAYS

____ 1. Reacted to your story with disbelief.

____ 2. Made light of or minimized the offender's actions.

____ 3. Made direct sexual advances toward you.

____ 4. Reacted in a threatening or hostile manner toward you.

____ 5. Denied the abuse occurred.

____ 6. Actively showed disapproval of the offender's abuse, for example, by seeking a separation, forcing him/her to seek treatment, cooperating with the legal system to get him/her prosecuted.

____ 7. Remained passive, refused to take sides.

____ 8. Chose the offender over you/took the offender's side at your expense.

____ 9. Reacted with embarrassment or disgust.

____ 10. Accused you of fantasizing, lying, or making it up.

____ 11. Helped stop the abuse from happening again.

____ 12. Told you that you must have enjoyed it because it went on for so long.

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Ways of Coping Revised
(WCQ-R)

Please read each item below and indicate, by using the following rating scale, to what extent you used it in the situation [to be determined by researchers, for example, "the most stressful situation this past week," "the most stressful situation related to your illness this past week," "the laboratory task we have asked you to perform"].

0	1	2	3
Not Used	**Used Somewhat**	**Used Quit A Bit**	**Used A Great Deal**

1. Just concentrated on what I had to do next – the next step.
2. I tried to analyze the problem in order to understand it better.
3. Turned to work or substitute activity to take my mind off things.
4. I felt that time would make a difference – the only thing to do was to wait.
5. Bargained or compromised to get something positive from the situation.
6. I did something which I didn't think would work, but at least I was doing something.
7. Tried to get the person responsible to change his or her mind.
8. Talked to someone to find out more about the situation.
9. Criticized or lectured myself.
10. Tried not to burn my bridges, but leave things open somewhat.
11. Hoped a miracle would happen.
12. Went along with fate; sometimes I just have bad luck.
13. Went on as if nothing had happened.
14. I tried to keep my feelings to myself.
15. Looked for the silver lining, so to speak; tried to look on the bright side of things.

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16. Slept more than usual.

17. I expressed anger to the person(s) who caused the problem.

18. Accepted sympathy and understanding from someone.

19. I told myself things that helped me to feel better.

20. I was inspired to do something creative.

21. Tried to forget the whole thing.

22. I got professional help.

23. Changed or grew as a person in a good way.

24. I waited to see what would happen before doing anything.

25. I apologized or did something to make up.

26. I made a plan of action and followed it.

27. I accepted the next best thing to what I wanted.

28. I let my feelings out somehow.

29. Realized I brought the problem on myself.

30. I came out of the experience better than when I went in.

31. Talked to someone who could do something concrete about the problem.

32. Got away from it for a while; tried to rest or take a vacation.

33. Tried to make myself feel better by eating, drinking, smoking, using drugs or medication, etc.

34. Took a big chance or did something very risky.

35. I tried not to act too hastily or follow my first hunch.

36. Found new faith.

37. Maintained my pride and kept a stiff upper lip.

38. Rediscovered what is important in life.

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39. Changed something so things would turn out all right.

40. Avoided being with people in general.

41. Didn't let it get to me; refused to think too much about it.

42. I asked a relative or friend I respected for advice.

43. Kept others from knowing how bad things were.

44. Made light of the situation; refused to get too serious about it.

45. Talked to someone about how I was feeling.

46. Stood my ground and fought for what I wanted.

47. Took it out on other people.

48. Drew on my past experiences; I was in a similar situation before.

49. I knew what had to be done, so I doubled my efforts to make things work.

50. Refused to believe that it had happened.

51. I made a promise to myself that things would be different next time.

52. Came up with a couple of different solutions to the problem.

53. Accepted it, since nothing could be done.

54. I tried to keep my feelings from interfering with other things too much.

55. Wished that I could change what had happened or how I felt.

56. I changed something about myself.

57. I daydreamed or imagined a better time or place than the one I was in.

58. Wished that the situation would go away or somehow be over with.

59. Had fantasies or wishes about how things might turn out.

60. I prayed.

61. I prepared myself for the worst.

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62. I went over in my mind what I would say or do.

63. I thought about how a person I admire would handle this situation and used that as a model.

64. I tried to see things from the other person's point of view.

65. I reminded myself how much worse things could be.

66. I jogged or exercised.

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PTSD Diagnostic Scale for DSM-5
(PDS-5)

PTSD Diagnostic Scale for DSM-5

(PDS-5)

Subject ID________ **Date__________**

TRAUMA SCREEN

Have you ever experienced, witnessed, or been repeatedly confronted with any of the following:
(Check all that apply)

☐ Serious, life threatening illness (heart attack, etc.)

☐ Physical Assault (attacked with a weapon, severe injuries from a fight, held at gunpoint, etc.)

☐ Sexual assault (rape, attempted rape, forced sexual act with a weapon, etc.)

☐ Military combat or lived in a war zone

☐ Child abuse (severe beatings, sexual acts with someone 5 years older than you, etc.)

☐ Accident (serious injury or death from a car, at work, a house fire, etc.)

☐ Natural disaster (severe hurricane, flood, earthquake, etc.)

☐ Other trauma (Please describe briefly):

____

____

____

☐ None

*** If NONE, please STOP and return this questionnaire ***

If you marked any of the above items, which single traumatic experience is on your mind and currently bothers you the most:
(Check only one)

☐ Serious, life threatening illness (heart attack, etc.)

☐ Physical Assault (attacked with a weapon, severe injuries from a fight, held at gunpoint, etc.)

☐ Sexual assault (rape, attempted rape, forced sexual act with a weapon, etc.)

☐ Military combat or lived in a war zone

☐ Child abuse (severe beatings, sexual acts with someone 5 years older than you, etc.)

☐ Accident (serious injury or death from a car, at work, a house fire, etc.)

☐ Natural disaster (severe hurricane, flood, earthquake, etc.)

☐ Other trauma (Please describe briefly):

____

____

____

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PTSD Diagnostic Scale for DSM-5

(PDS-5)

Instructions: Below is a list of problems that people sometimes have after experiencing a traumatic event. Write down the most distressing traumatic event that you checked on the last page:

Please read each statement carefully and circle the number that best describes how often that problem has been happening and how much it upset you over THE LAST MONTH. Rate each problem with respect to the traumatic event that you wrote above.

For example, if you've talked to a friend about the trauma one time in the past month, you would respond like this: (because one time in the past month is less than once a week)

Talking to other people about the trauma

0	(1)	2	3	4
Not at all	Once a week or less/a little	2 to 3 times a week/somewhat	4 to 5 times a week/very much	6 or more times a week/severe

1. Unwanted upsetting memories about the trauma

0	1	2	3	4
Not at all	Once a week or less/a little	2 to 3 times a week/somewhat	4 to 5 times a week/very much	6 or more times a week/severe

2. Bad dreams or nightmares related to the trauma

0	1	2	3	4
Not at all	Once a week or less/a little	2 to 3 times a week/somewhat	4 to 5 times a week/very much	6 or more times a week/severe

3. Reliving the traumatic event or feeling as if it were actually happening again

0	1	2	3	4
Not at all	Once a week or less/a little	2 to 3 times a week/somewhat	4 to 5 times a week/very much	6 or more times a week/severe

4. Feeling very EMOTIONALLY upset when reminded of the trauma

0	1	2	3	4
Not at all	Once a week or less/a little	2 to 3 times a week/somewhat	4 to 5 times a week/very much	6 or more times a week/severe

5. Having PHYSICAL reactions when reminded of the trauma (for example, sweating, heart racing)

0	1	2	3	4
Not at all	Once a week or less/a little	2 to 3 times a week/somewhat	4 to 5 times a week/very much	6 or more times a week/severe

6. Trying to avoid thoughts or feelings related to the trauma

0	1	2	3	4
Not at all	Once a week or less/a little	2 to 3 times a week/somewhat	4 to 5 times a week/very much	6 or more times a week/severe

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PTSD Diagnostic Scale for DSM-5

(PDS-5)

7. **Trying to avoid activities, situations, or places that remind you of the trauma or that feel more dangerous since the trauma**

0	1	2	3	4
Not at all	Once a week or less/a little	2 to 3 times a week/somewhat	4 to 5 times a week/very much	6 or more times a week/severe

8. **Not being able to remember important parts of the trauma**

0	1	2	3	4
Not at all	Once a week or less/a little	2 to 3 times a week/somewhat	4 to 5 times a week/very much	6 or more times a week/severe

9. **Seeing yourself, others, or the world in a more negative way (for example "I can't trust people," "I'm a weak person")**

0	1	2	3	4
Not at all	Once a week or less/a little	2 to 3 times a week/somewhat	4 to 5 times a week/very much	6 or more times a week/severe

10. **Blaming yourself or others (besides the person who hurt you) for what happened**

0	1	2	3	4
Not at all	Once a week or less/a little	2 to 3 times a week/somewhat	4 to 5 times a week/very much	6 or more times a week/severe

11. **Having intense negative feelings like fear, horror, anger, guilt or shame**

0	1	2	3	4
Not at all	Once a week or less/a little	2 to 3 times a week/somewhat	4 to 5 times a week/very much	6 or more times a week/severe

12. **Losing interest or not participating in activities you used to do**

0	1	2	3	4
Not at all	Once a week or less/a little	2 to 3 times a week/somewhat	4 to 5 times a week/very much	6 or more times a week/severe

13. **Feeling distant or cut off from others**

0	1	2	3	4
Not at all	Once a week or less/a little	2 to 3 times a week/somewhat	4 to 5 times a week/very much	6 or more times a week/severe

14. **Having difficulty experiencing positive feelings**

0	1	2	3	4
Not at all	Once a week or less/a little	2 to 3 times a week/somewhat	4 to 5 times a week/very much	6 or more times a week/severe

15. **Acting more irritable or aggressive with others**

0	1	2	3	4
Not at all	Once a week or less/a little	2 to 3 times a week/somewhat	4 to 5 times a week/very much	6 or more times a week/severe

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PTSD Diagnostic Scale for DSM-5

(PDS-5)

16. Taking more risks or doing things that might cause you or others harm (for example, driving recklessly, taking drugs, having unprotected sex)

0	1	2	3	4
Not at all	Once a week or less/a little	2 to 3 times a week/somewhat	4 to 5 times a week/very much	6 or more times a week/severe

17. Being overly alert or on-guard (for example, checking to see who is around you, being uncomfortable with your back to a door)

0	1	2	3	4
Not at all	Once a week or less/a little	2 to 3 times a week/somewhat	4 to 5 times a week/very much	6 or more times a week/severe

18. Being jumpy or more easily startled (for example when someone walks up behind you)

0	1	2	3	4
Not at all	Once a week or less/a little	2 to 3 times a week/somewhat	4 to 5 times a week/very much	6 or more times a week/severe

19. Having trouble concentrating

0	1	2	3	4
Not at all	Once a week or less/a little	2 to 3 times a week/somewhat	4 to 5 times a week/very much	6 or more times a week/severe

20. Having trouble falling or staying asleep

0	1	2	3	4
Not at all	Once a week or less/a little	2 to 3 times a week/somewhat	4 to 5 times a week/very much	6 or more times a week/severe

DISTRESS AND INTERFERENCE

21. How much have these difficulties been bothering you?

0	1	2	3	4
Not at all	Once a week or less/a little	2 to 3 times a week/somewhat	4 to 5 times a week/very much	6 or more times a week/severe

22. How much have these difficulties been interfering with your everyday life (for example relationships, work, or other important activities)?

0	1	2	3	4
Not at all	Once a week or less/a little	2 to 3 times a week/somewhat	4 to 5 times a week/very much	6 or more times a week/severe

SYMPTOM ONSET AND DURATION

23. How long after the trauma did these difficulties begin? [circle one]
    a. Less than 6 months
    b. More than 6 months

24. How long have you had these trauma-related difficulties? [circle one]
    a. Less than 1 month
    b. More than 1 month

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Beck Depression Inventory-II
(BDI-II)

BDI-II

Date:

Name: ______ Marital Status: ______ Age: ______ Sex: ______

Occupation: ______ Education: ______

Instructions: This questionnaire consists of 21 groups of statements. Please read each group of statements carefully, and then pick out the **one statement** in each group that best describes the way you have been feeling during the **past two weeks, including today**. Circle the number beside the statement you have picked. If several statements in the group seem to apply equally well, circle the highest number for that group. Be sure that you do not choose more than one statement for any group, including Item 16 (Changes in Sleeping Pattern) or Item 18 (Changes in Appetite).

1. Sadness

0 I do not feel sad.
1 I feel sad much of the time.
2 I am sad all the time.
3 I am so sad or unhappy that I can't stand it.

2. Pessimism

0 I am not discouraged about my future.
1 I feel more discouraged about my future than I used to be.
2 I do not expect things to work out for me.
3 I feel my future is hopeless and will only get worse.

3. Past Failure

0 I do not feel like a failure.
1 I have failed more than I should have.
2 As I look back, I see a lot of failures.
3 I feel I am a total failure as a person.

4. Loss of Pleasure

0 I get as much pleasure as I ever did from the things I enjoy.
1 I don't enjoy things as much as I used to.
2 I get very little pleasure from the things I used to enjoy.
3 I can't get any pleasure from the things I used to enjoy.

5. Guilty Feelings

0 I don't feel particularly guilty.
1 I feel guilty over many things I have done or should have done.
2 I feel quite guilty most of the time.
3 I feel guilty all of the time.

6. Punishment Feelings

0 I don't feel I am being punished.
1 I feel I may be punished.
2 I expect to be punished.
3 I feel I am being punished.

7. Self-Dislike

0 I feel the same about myself as ever.
1 I have lost confidence in myself.
2 I am disappointed in myself.
3 I dislike myself.

8. Self-Criticalness

0 I don't criticize or blame myself more than usual.
1 I am more critical of myself than I used to be.
2 I criticize myself for all of my faults.
3 I blame myself for everything bad that happens.

9. Suicidal Thoughts or Wishes

0 I don't have any thoughts of killing myself.
1 I have thoughts of killing myself, but I would not carry them out.
2 I would like to kill myself.
3 I would kill myself if I had the chance.

10. Crying

0 I don't cry anymore than I used to.
1 I cry more than I used to.
2 I cry over every little thing.
3 I feel like crying, but I can't.

SAMPLE

Subtotal Page 1

Continued on Back

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APPENDIX B

Institutional Review Board (IRB) Approval

WAYNE STATE UNIVERSITY

IRB Administration Office
87 East Canfield, Second Floor
Detroit, Michigan 48201
Phone: (313) 577-1628
FAX: (313) 993-7122
http://irb.wayne.edu

NOTICE OF EXPEDITED APPROVAL

To: Shahrazad Timraz
College of Nursing

From: Dr. Deborah Ellis or designee ______________________
Chairperson, Behavioral Institutional Review Board (B3)

Date: May 11, 2017

RE: IRB #: 034517B3E

Protocol Title: Coping with Child Sexual Abuse and Its Psychological Outcomes Among Female Surviviors of Arabic Descent: A Mixed-Method Study

Funding Source: Sponsor: Sigma Theta Tau International, Incorporated

Protocol #: 1703000407

Expiration Date: May 10, 2020

Risk Level / Category: Research not involving greater than minimal risk

The above-referenced protocol and items listed below (if applicable) were **APPROVED** following *Expedited Review* Category (#7)* by the Chairperson/designee *for* the Wayne State University Institutional Review Board (B3) for the period of 05/11/2017 through 05/10/2020. This approval does not replace any departmental or other approvals that may be required.

- Revised Protocol Summary Form (revision received in the IRB office 05/09/17)
- Research Protocol (received in the IRB office 03/12/17)
- Medical records are not being accessed therefore HIPAA does not apply
- A waiver of written documentation of consent for the Research Information Sheet has been granted according to 45CFR 46 117(c) and justification provided by the Principal Investigator in the Protocol Summary Form. This waiver satisfies: 1) risk is no more than minimal, data are survey responses with minimal risk content, 2) That the research involved no procedures for which written consent is normally required outside the research context, consent would not be required for these procedures outside the research context. 3) The consent process is appropriate, 4) An information sheet disclosing the required and appropriate additional elements of consent disclosure will be provided to participants.
- A waiver of written documentation of consent for Oral consent has been granted according to 45CFR 46 117(c) and justification provided by the Principal Investigator in the Protocol Summary Form. This waiver satisfies: 1) risk is no more than minimal, data are survey responses with minimal risk content, 2) That the research involved no procedures for which written consent is normally required outside the research context, consent would not be required for these procedures outside the research context. 3) The consent process is appropriate, 4) An information sheet disclosing the required and appropriate additional elements of consent disclosure is inappropriate.
- Research Information Sheet - also for Oral Consent (revision dated 05/11/2017)
- Study Advertisements (2)
- Study Brochure
- Resources List
- Qualitative Descriptive Study Interview Quide (Appendix B)
- Data Collection Tools (6) : i) Sociodemographic Questionnaire (Appendix A), ii) Acculturation Rating Scale for Arab Americans II -ARSAA II (Appendix C), iii) Social Reactions Questionnaire – SRQ (Appendix D), iv) Ways of Coping (Appendix E), v) PTSD Diagnostic Scale for DSM-5 (Appendix F) and vi) Beck Depression Inventory – II (Appendix G)

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- Please note: This submission was reviewed under the IRB Administration Office Flexible Review and Oversight Policy, therefore the expiration date is May 10, 2020.

- Federal regulations require that all research be reviewed at least annually. You *may* receive a *"Continuation Renewal Reminder"* approximately two months prior to the expiration date; however, it is the Principal Investigator's responsibility to obtain review and continued approval ***before*** the expiration date. Data collected during a period of lapsed approval is unapproved research and can never be reported or published as research data.
- All changes or amendments to the above-referenced protocol require review and approval by the IRB **BEFORE** implementation.
- Adverse Reactions/Unexpected Events (AR/UE) must be submitted on the appropriate form within the timeframe specified in the IRB Administration Office Policy (http://www.irb.wayne.edu//policies-human-research.php).

NOTE:

1. Upon notification of an impending regulatory site visit, hold notification, and/or external audit the IRB Administration Office must be contacted immediately.
2. Forms should be downloaded from the IRB website at **each** use.

*Based on the Expedited Review List, revised November 1998

Notify the IRB of any changes to the funding status of the above-referenced protocol.

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ARABIC WOMEN'S EXPERIENCE OF CHILDHOOD SEXUAL ABUSE: A MIXED-METHOD STUDY

by

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Major: Nursing

Degree: Doctor of Philosophy

Background and purpose: Childhood sexual abuse (CSA) is an existing social problem that affects children worldwide, leading to poor psychological outcomes in adulthood. Childhood adversities including CSA account for 44.6% of childhood and 26%–32% of adult-onset psychiatric disorders. Furthermore, CSA is the second leading cause of posttraumatic stress disorder (PTSD) and influences an array of other outcomes such as depression, anxiety, hostility, and low self-esteem. Worldwide, approximately 8%–13% of girls have experienced sexual abuse. According to the few studies conducted in Arabic countries, CSA ranges from 7%–27%. Coping with CSA is a well-studied factor in regard to its impact on females' experience of CSA and long-term psychological outcomes. Nonetheless, there is a paucity of research on coping with CSA among female survivors of Arabic descent. There are multiple factors that influence coping with CSA, such as the characteristics of CSA, culture, and social reactions. The purpose of this study was to explore CSA characteristics, Arabic culture values and beliefs, social reaction to abuse disclosure, coping, and psychological outcomes among female CSA survivors of Arabic descent.

Theoretical framework: This study was guided by the Folkman and Lazarus stress and coping model. The model consists of the antecedent factors, mediating process, and short- and long-term effects. The antecedent factors for this study were CSA characteristics, Arabic culture,

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and social reactions to CSA disclosure. The mediating process was coping with CSA. To fulfill the purpose of the study, the long-term effect at the psychological domain was selected.

Methods: Utilizing a convergent mixed-method design, 19 Arabic female survivors of CSA were enrolled in the study through health and counseling centers, universities, and social media. Women were included in the study if they were 18 years and older, were of Arabic descent, had a history of CSA before age 17, and were fluent in English. Qualitative data were collected first by individual semi-structured face-to-face, phone, and email interviews that lasted 1-2 hours. The interview guide was developed by the researcher and included questions about CSA characteristics, Arabic culture and acculturation, social reactions to CSA disclosure, coping, and long-term psychological outcomes. To collect quantitative data of social reaction to CSA, acculturation, coping, depressive symptoms, and PTSD, the women completed validated surveys online. A password-protected email account was created to send the surveys to the women and receive the completed questionnaires. The qualitative data was analyzed by content analysis. The credibility of the study was achieved by peer review and triangulation. Descriptive statistics and correlation were used for quantitative data. The qualitative and quantitative results were merged in a matrix for convergent mixed-method analysis.

Results: The majority of the women in this study had experienced contact familial CSA without penetration. The women identified sexuality, family ties, family honors, perception of CSA and survivors of CSA as some of the Arabic values and beliefs that influenced them as Arabic survivors of CSA. Family, hospitality, and respect were some of the Arabic values that were honored by the women. The women were more attracted to the Arabic culture than the American culture as reflected in the high mean score for acculturation. The survivors employed multiple strategies to cope with their CSA during adulthood. However, quantitative data indicated that self-

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controlling, distancing, and positive reappraisal were the most frequent coping strategies employed during adulthood. CSA recall and triggers, sleep issues, and interpersonal issues such as low self-esteem, lack of trust, feeling of insecurity, and sexual issues were the long-term psychological outcomes reported by the survivors. Quantitatively, the sample had mild depressive symptoms and moderate PTSD.

Conclusion: CSA is an existing problem among Arabic females and leads to negative outcomes. Arabic female survivors employed a wide range of coping strategies during adulthood. The findings of this study expand the current state of science on how Arabic female survivors of CSA cope with their experience and the long-term psychological outcomes influenced by the CSA characteristics, culture, acculturation, and social reactions to CSA. The findings of this study can be used to design culturally sensitive programs that aim to prevent CSA and treat survivors of Arabic descent.

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Bachelor of Science in Nursing from the Faculty of Medicine and Applied Medical Sciences at King Abdul–Aziz University, Jeddah, Saudi Arabia 2001-2007.

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Publications

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