Out of Africa: Coping Strategies of African Immigrant Women Survivors of Intimate Partner Violence

LAURA TING

School of Social Work, University of Maryland, Baltimore County, Baltimore, Maryland, USA

We explored the coping behaviors of 15 immigrant African survivors of intimate partner violence (IPV) in the United States. Similarities and differences in coping strategies between African and other immigrant women were noted. Results from the qualitative analysis are that African immigrant survivors utilized multiple coping strategies including beliefs in spirituality and divine retribution, a future orientation, and a sense of self-efficacy. Acceptance/endurance of abuse, which they believe was “normal” in male/female relationships; minimization of the abuse; and avoidant behaviors and thoughts also were used. Informal and formal support/help seeking, and knowledge of available services empowered women. Implications for policy, practice, and future research are discussed.

Violence against women continues to be a problem worldwide; specifically, the problem of gender violence perpetrated by intimate partners against women is a critical global problem and affects all societies. While researchers have examined and documented the negative and long-term effects of IPV on women, our goal was to explore the coping behaviors utilized by immigrant women survivors of IPV. In particular, using a qualitative approach, we conducted in-depth interviews of immigrant women from Africa, an underserved group, to understand and describe the strategies they utilized to cope with IPV after immigration to a new country. Our rationale for the

Received 20 April 2009; accepted 17 September 2009.

The author thanks Megan Anders, BA, and Sheri Laigle, MSW, for their help, and the women who participated in the study.

Address correspondence to Laura Ting, PhD, 1000 Hilltop Circle, Academic IV, B364, Baltimore, MD 21250, USA. E-mail: LTing@umbc.edu
study was that African immigrants are a growing population, not just in the United States, but throughout the world, yet there is limited information on how African women live with and cope with the abuse and violence they experience from intimate partners. We believe that what we learned from the women in this study will have relevance to clinicians, advocates, and policymakers in different countries throughout the world. In order to help women survivors and to offer culturally sensitive, appropriate services and outreach, it is important for practitioners and agency personnel to first understand the ways women have coped on their own and within their own belief systems.

According to researchers at the World Health Organization (WHO) who have conducted multisite studies with various international samples, the proportion of women abused during their lifetime by an intimate partner ranged from 15% to 71% (García-Moreno, Jansen, Watts, Ellsberg, & Heise, 2005). Overall, one in five women reported being abused, but the majority did not seek formal help due to shame, fear of retaliation, or lack of knowledge about services. In many countries, services were also unavailable.

In addition to physical injuries sustained, women exposed to IPV are left with the increased risk of developing long-term negative mental health problems such as post-traumatic stress disorder (PTSD), depression, and anxiety (Arias & Pape, 1999; Calvete, Corral, & Estévez, 2008; Krause, Kaltman, Goodman, & Dutton, 2008). Along with the isolation often imposed on victims of abuse, such factors, if untreated, have been associated with risk of suicide attempts (Sansone, Chu, & Wiederman, 2007; Thompson, Short, Kaslow, & Wycoff, 2002). Suicide has been used as a way to escape from the abuse, as noted in several cultures (Lee, 1997; Patel & Gaw, 1996; Strachan, Johansen, Nair, & Nargundkar, 1990; Yasan, Denis, Tamam, Ozmen, & Ozkan, 2008). Most women worldwide, however, have tried to cope by attempting to leave their partners or by seeking informal help (Garcia-Moreno et al., 2005).

It is not always clear how women have coped when they have left their country of origin, despite the available research on help-seeking behaviors of immigrant women and the prevalence of abuse among immigrant communities in the United States. While Tjaden and Thoennes (1998) estimated that one in four American women have experienced abuse in her lifetime, immigrant women in the United States have reported higher rates of abuse. Some researchers found up to 60% of immigrant women having been abused by an intimate partner in the United States (Brownridge & Halli, 2002; Field & Caetano, 2003; Hassouneh-Philips, 2001; Kim & Sung, 2000; Loun & Vega, 2001; Raj & Silverman, 2003; Tran & Des Jardins, 2000; Yick, 2000; Yoshihama, 2002; Yoshioka & Dang, 2000), and also they consistently found that immigrant victims were less likely to access services due to cultural and language barriers, which make them at high risk of reabuse. As migration occurs, it is important for health professionals in host countries to acknowledge
the existence of and risks of IPV within immigrant communities. Service providers throughout the world, especially in the health care arena, are often the first point of contact for these women and are in the unique position of assessing for abuse and providing referral and intervention. It is important, therefore, to have an understanding of immigrant survivors' experiences of abuse and their coping behaviors in order to intervene effectively.

We focused, in this study, on the underserved group of African immigrant women and their experiences of abuse in the United States. Partly because of their limited numbers, but also due to their similarity in race to African American women, the tendency has been to include them with African American women within research samples and for service provision. It would be inaccurate to assume their experiences were the same as African American women, however, particularly in light of having undergone the process of immigration. It is also not clear either whether their experiences would be similar to those of other immigrant women. Thus, our focus was on immigrant African women survivors of IPV, and we wanted to qualitatively understand the coping strategies and mechanism they used while being abused.

Due to political and economic instability in their native countries, many Africans have emigrated to North America and Europe in the past decades for political asylum and employment opportunities. In Europe, especially Mediterranean countries close to Africa, there has been an influx of African immigrants; other countries, like Germany and France, have an estimated one-third of their foreign born population from Africa (Choe, 2007). The racial composition and labor force of Europe has changed with African immigration. In the United States, according to the 2000 census, immigrants from Africa have more than doubled between 1990 and 2000 to over 1 million people (Grieco, 2004). While representing only 3% of the foreign born in the United States, African immigrants are a small but growing minority. The continual expected growth of the African immigrant population both in the United States and Europe makes it imperative to look separately at African immigrants as an individual group and one potentially with experiences different from other immigrant groups.

Researchers with survivors of IPV have found that women’s coping strategies have an impact upon their mental health. In particular, the use of emotional focused, avoidant or disengaged coping strategies, such as the use of denial, behavioral distractions, cognitive distortions, and wishful thinking, have been correlated with more PTSD symptomology (Arias & Pape, 1999; Krause et al., 2008), anxiety, and depression (Calvete et al., 2008). On the other hand, the use of active or solution-focused coping in survivors also have been found to be associated with more depression and PTSD in some survivors (Kocut & Goodman, 2003) as well as associated with less depression among other IPV samples (Goodkind, Gillum, Bybee, & Sullivan, 2003). Hamby and Gray-Little (2007) argued that such contrary findings were
not surprising for several reasons. Not only were there differences amongst the sample of survivors in terms of length and severity of abuse, but the assumption that active, solution-focused strategies were positive and effective coping methods, while avoidant, disengaged strategies were negative and ineffective coping methods within an abusive situation was too simplistic. To apply the active/adaptive and passive/maladaptive duality framework to explain how women survive and cope with IPV underestimated the complexities of women’s situations, their support systems, and availability of resources (Hamby & Gray-Little, 2007).

Researchers examining coping in immigrant women of other backgrounds and nationalities indicated that IPV survivors utilized various coping mechanisms and help-seeking behaviors. Brabeck and Guzmán (2008) reported that Mexican immigrant women sought out formal and informal help, and they had different personal coping tactics such as avoidance, defense, and escape strategies; social/familial and religious/psychological strategies also were used. Yoshihama (2002) found that place of birth, immigration status, and perceived effectiveness interacted with coping strategies and psychological distress in IPV survivors of Japanese descent in the United States, thus highlighting the complex relationship between passive and active strategies and psychological outcomes. Other Asian immigrants have utilized praying, formal and informal help seeking, accepting fate/karma, minimizing, positive reframing of abuse, and hoping for future change as ways of coping (Bhuyan, Mell, Senturia, Sullivan, & Shui-Thornton, 2005; Das Gupta & Warrier, 1996; Erez & Bach, 2003; Lee, Pomeroy, & Bohman, 2007; Midlarsky, Venkataramani-Kothari, & Plante, 2006; Takano, 2006).

No research, however, was located on coping and African immigrant survivors. There is existing research on African survivors with a focus on South African women. The research included reports on the rates and incidents of abuse, cultural acceptance of gender violence, and impact of IPV on HIV/AIDS transmission within South Africa (Abrahams, Jewkes, Laubscher, & Hoffman, 2006; Boonzaier & La Rey, 2003; Dunkle et al., 2004; Fox et al., 2007; Jewkes, Levin, & Penn-Kebana, 2002; Managa, Pengpid, & Peltzer, 2007; Onyejekwe, 2004). Due to the lack of information available on immigrant African women, our goals of this study, therefore, were to explore the coping strategies utilized by African survivors of IPV upon immigration to the United States. The specific research questions follow:

1. What are the coping strategies of African immigrant women survivors of IPV?
2. Are there any differences and similarities in their coping strategies after immigration?
3. Are their coping strategies similar or different from other immigrant survivors of IPV?
Coping Strategies of African American Women

METHOD

Sample

Fifteen immigrant women from sub-Saharan countries voluntarily participated in the study. More than 75% of women were from West Africa however, women also immigrated from central, east, and South Africa. They came from both rural and urban areas, with their times of emigration to the United States ranging from 1 to 17 years ago. The mean age of respondents was 39.81 ($SD = 6.82$, ranging from 28 through 52 years); all women were married but separated from their husbands at the time of the interview. There was a huge variation in length of marriages, from less than 6 months to 33 years. While women reported they were able to choose their husbands, love usually was not cited as the reason for their marriage. The majority of women were married in Africa to African husbands. Two women (13%) married American Black men they had met in the United States after immigration. The husbands were, on average, older, more educated, and employed, with legal immigration status. Specific sociodemographics of the sample are presented in Table 1.

Sample Recruitment and Procedure

After receiving approval from the university’s Institutional Review Board, researchers recruited a purposive sample from three victim empowerment

<table>
<thead>
<tr>
<th>TABLE 1 Respondents’ and Partners’ Demographics</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>N = 15</strong></td>
</tr>
<tr>
<td>Years emigrated</td>
</tr>
<tr>
<td>Number of children</td>
</tr>
<tr>
<td>Age at time of study</td>
</tr>
<tr>
<td>Age at marriage</td>
</tr>
<tr>
<td>Length of marriage</td>
</tr>
<tr>
<td>Length of courtship</td>
</tr>
<tr>
<td>&lt;6 months</td>
</tr>
<tr>
<td>6 months &lt;1 year</td>
</tr>
<tr>
<td>&gt;1 year</td>
</tr>
<tr>
<td>Level of education</td>
</tr>
<tr>
<td>&lt;High school</td>
</tr>
<tr>
<td>High school graduate</td>
</tr>
<tr>
<td>Some college</td>
</tr>
<tr>
<td>College graduate</td>
</tr>
<tr>
<td>Graduate school</td>
</tr>
<tr>
<td>Current employment status</td>
</tr>
<tr>
<td>Unemployed</td>
</tr>
<tr>
<td>Employed</td>
</tr>
<tr>
<td>Religion</td>
</tr>
<tr>
<td>Christian</td>
</tr>
<tr>
<td>Muslim</td>
</tr>
</tbody>
</table>
groups and one African women’s support group in a northeast suburban agency serving victims of abuse. Women also referred their friends and acquaintances not formally associated with the agency. The findings reflected data from the 15 participants who meet the criteria of being a first-generation African immigrant and abused by an intimate partner. Respondents abused by other family member, such as a sister-in-law, nephew, or uncle, were not included in the analysis.

After the potential risks, compensation and voluntary nature of the study were explained, respondents signed the informed consent and completed a one-time, in-depth interview and were compensated $30. The interviews were conducted at a safe place determined by the women, generally at either the domestic violence agency or at the women’s homes, depending upon their preference. The interviews took between 1.5 to 3 hours, were audiotaped with the women’s consent, and were later transcribed verbatim for analysis. The interviews were in a semistructured format with follow-up probes being utilized. Questions were open ended, such as, “Please tell me how you got through each day.” and “How did you cope? What was helpful to you?” The interviewers took notes during and after the interview as part of an audit trail to maintain and ensure trustworthiness and dependability (Guba, 1981). Several respondents sought out and spoke with the interviewer voluntarily after the interview, and provided additional bits of information when they saw the researcher while they were waiting for their support group to commence, indicating they had forgotten to mention certain details during the initial meeting. No one, however, was formally interviewed a second time.

This study is a qualitative description of women’s experiences. We described the coping strategies of women using their own voices (Creswell, 2007). We chose this approach because our research was exploratory in nature, attempting to understand women’s lives and coping behaviors, and because there is limited knowledge available on immigrant African women’s coping experiences. Using a qualitative approach with open-ended questions allowed us to gather in-depth, rich, descriptive information that would not have been available using quantitative research and data collection methodologies. The verbal narratives of the women provided a reflection of their individual, personal “lived” experiences of coping with abuse, and they revealed the content and meaning of the behaviors that were unique to them. Data were analyzed concurrent to the interviews and continued until the point of saturation was perceived to have been reached, when no new information was forthcoming (Padgett, 2008; Sherman & Reid, 1994). Line-by-line coding and the constant comparison method were used to explore emerging themes by two researchers separately. As interviews occurred, new information was constantly compared with previously coded themes, and new relationships and typologies were uncovered to be either included or refined. Final categories were identified and named to reflect the existing
data. Any differences in coding were discussed until consensus was reached (Glaser & Strauss, 1967).

RESULTS

Coping Strategies of African Immigrant Women Survivors of IPV

For the first research question, certain themes emerged from the women’s narratives that highlighted the various coping strategies utilized by African immigrant women.

_Hoping for change and thinking relationship will get better_. Initially, many women coped through wishful thinking that the abusive behaviors will stop on their own, or hoping their husbands will change:

I had hope he would change since in my family, my father had changed. We went to live with my grandparents when my father was abusing my mother. They talked to my father, and he changed. He stopped, so I had hope my husband would too. Some men do. I believed it was possible.

_Looking to the future: Having a future orientation_. Women coped and endured for the future good of their children. One woman’s narrative very succinctly highlighted this sacrifice: “I was comforted by the fact that my children all turned out to be independent, upstanding. I see their success and I felt I did the right thing for them by staying, for all the opportunities they are getting here, that they would not get in Africa.”

Women also described how focusing on the future allowed them to endure the current abusive behaviors: “I told myself that I was staying for the green card [legal immigration status]. When the papers come through, then I can leave with my children. I can get working papers, support myself and the kids then.” Other women’s narratives supported this theme: “I need him only for now, but when the children are older, and I can work, I will not need his money; I will not need him.”

_Seeing God’s help and comfort in prayers, having faith_. The majority of women felt their faith in God helped them cope. There were some who took comfort in their personal relationship with God: “I prayed; I felt comfort in praying. At night I read the Bible where it said, ‘that I will be with you, as you travel, when you are suffering, I am with you.’ So that was comforting me, that God was with me.” Others reported seeking more formal help with clergy: “I told my pastor; I asked him for help, for him to talk to my husband. When my husband refused to go to church, or talk to the pastor, he [the pastor] prayed for me and my situation.” Other women went to informal prayer groups:
Yeah, that is what is holding most women together now. We have these groups. We learn the Bible; we pray; we try to comfort each other and not be the judge... We only put it in prayers for God to help... It is a big thing; their prayers help me through. I was always, even now, with all my children, going to church.

Believing in God’s will and divine justice. Not only was religion and faith a comfort to African women in the current study, the belief in God’s Will and divine retribution allowed women to cope with the abuse. This was highlighted in the following narrative:

Yes, I had to believe in God. “Oh God, you are might and you are great. You are the God who cannot fail to know everything. You hear my prayers; your eyes are sharp and see everywhere. You know where I am, how I am suffering.” I believe that God will take care for me, that God has a reason for having me suffer, and I believe that God is just, that God will punish my husband for what he did to me. Someday I will get justice and he [her husband] will get his punishment.

Doing nothing: Stoicism, fatalism, and acceptance of fate. In addition to accepting God’s will, women in this study also voiced the acceptance of their fate as women in a male-dominated patriarchal culture. One narrative eloquently described this acceptance and sense of stoicism:

Men have penises, and in Africa, that makes them Gods. We women are less than the dirt under their feet. We are treated like their slaves. They think they have the power to control us and it is better not to fight them. My mother said, “The sooner you learn this, the easier it will be for you.” I was taught this, and I accepted this for a long time.

Many women reported that they felt they were not able to do anything, and the best thing to do was to not fight back: “I just let him have his way; it [his anger] will pass. I did nothing, since if I do something, he beats me more.” This submissive behavior was a coping strategy that allowed women to escape from further violence and abuse. Survivors initially tried to appease and please their husbands to avoid abuse:

I tried to cook his favorite African dishes for him. I kept the children quiet when he wanted to sleep, but it was no use, so I just stopped and let him do whatever he wants. It makes no difference [what I did], not at all.

Using behavioral distraction. Many women in this study described the use of behavioral distractions, such as focusing on their children and focusing on being grateful for the maternal child relationship. Women’s narratives
revealed a special bond between themselves and their children, which helped them cope: “My son, he is very protective of me; he tells me when he grows up, he will take care of me.” Another woman related the following:

My daughter, she saw how he treated me. She was afraid of him, but she will come and cry sometimes with me and say, “Mommy, I love you,” and “Don’t cry. I hate to see when Daddy’s hitting you.” She come and wipe my tears.

Other women in this current study reported the use of work and school as additional distractions: “I try to study; I will take my children to the library and we will study together. They have homework and I have to study for my nursing licensing exams too.” Work was a distraction for many women who were able to find employment, a place to escape and earn some money, as well as have a social network, even if colleagues did not know about the abuse. One woman compared herself with the clients she worked with and stated, “I work with adults with disabilities. I tell myself I am not suffering as much as they are, in wheelchairs: they can’t walk.” Others work in adult day care: “I am busy all day, changing diapers, helping them. There’s no time to think.”

Cognitive reframing, avoiding, denying, and minimizing the abuse. Women survivors in this study also coped by active denial; some avoided thinking about their abusive experiences. Others cognitively reframed their husband’s abusive behaviors as love. One specific narrative highlights this coping strategy:

I used to think that my husband, he’s so controlling that I thought it was showing me he loved me. Sort of like we say to our children: “We’re doing this and making you do this for your own good.” I thought to myself, “This is a man who is concerned for me.”

Respondents indicated that, “I tried not to think of it. When he is not at home, I didn’t have to think of it. I was happy when he was at work, or out with his friends. Maybe he is with his other girlfriends.” Most respondents minimized the severity of the abuse:

In my country, it is okay for men to discipline their wives. I told myself this was not abuse, this was “normal discipline.” Other wives I know said the same thing, “oh yes, my husband hits me too; that’s normal,” so that is how we believed, and how we all survived.

Believing in oneself, a sense of self-efficacy. African women survivors also described believing in themselves and their ability to survive the abusive relationship. Women’s narratives reflect this sense of self-efficacy: “I tell
myself that I will be strong, that I am not going to let him break me.” Another woman added this perspective:

Women from my tribe, we are strong—we are survivors. We accept pain; women are the ones who bear children. I just tell myself, “Yeah, I’ve lived [today], and tomorrow I will live too.”

Women in the current study noted, “In my country, we have a saying that women persevere, and go on.” Another survivor said, “I will not let him know how much I am suffering. I do not want to let him have that power. I have faith that I will survive whatever he does. Yes, he is bigger and stronger than me, but he can’t hurt me here (pointing to her heart).”

Receiving affirmation and emotional support from family. While some women’s narratives indicated that their families were barriers toward their help seeking, several women spoke about their sense of relief and affirmation when they reported the abuse and their families believed them. Despite the families not being able to do anything about the abusive situation since they were so far away, women reported that the verbal and emotional support from the family helped them feel less isolated and able to cope: “My sisters, they say, ‘If it gets too much, don’t stay there; just leave,’ although other people were saying they should not tell me that.” Others report that their families provided suggestions: “They say I should call his family together [in the U.S.], to talk to his father and brothers.” Some even reported that “My brother, he telephoned here to talk to my husband, but my husband did not listen to him or come to the phone.” Another woman appealed to her husband’s family. “His mother [in Africa], I made the phone call to her, and she tried to talk to him for me.”

Talking to others informally. For some respondents, it was very helpful to tell others what was happening: “I cried with my coworkers; I told women at work. I couldn’t hide what was going on. It was too much to keep to myself.” While some stated it was difficult to admit to others the abuse, other women’s narratives indicated otherwise:

No, it was not hard to tell people. I tell people so that my heart can be open and lighter. I don’t keep some thing in my heart; I was telling everyone. I told everything. I went to other women for advice. They gave me ideas of what to do, in case, if something happened and where to go.

Seeking services and formal sources of support. Formal help seeking also was described by women: Going to [support] group was good. They are [African] women like me there, being though the same things. We are together. I learn many things I didn’t know about that helped me, like the “cycle of abuse” and it is not my fault. Talking to my counselor also helped:

I walked in the court building; I didn’t know anything or who to talk to. I just walked in and said, “I’m suffering; my husband is mistreating
me. Is there any place here that can help me?” Then she told me, “Go
to second floor; that is where people can help.” And they helped me.
When you cry, they answer your cry. They open their arms to welcome
you and listen to your problems.

**Being empowered: Knowing help and resources were available.** Even
when women were not ready to make any decisions about leaving their
relationship, they voiced the ability to cope and “go on” when they knew
help was available. The knowledge that external resources were available
gave them a sense of safety and allowed them to “get through” day by day. “I
knew I could call 911 [the emergency number] and the police will come; my
husband, he knew I knew it too, and that stopped him from being very bad.”
This knowledge provided a sense of empowerment. One woman reported:

I talked to a neighbor. She’s the one who told me that you can call police;
the police can help you and my husband would be arrested. He’s not
supposed to abuse you, it’s a crime. And she arranged with the people
from her church to help me. One day two people came to my door,
knock on the door. When I opened, they just give me telephone number
and said, “This is our number, call us any time; we can take you to a
safe place and get you a lawyer.” And I was keeping that number in my
pocket.

**Differences in Coping Between the United States and Africa**

For the second research question regarding whether African women sur-
vivors of IPV coped differently in the United States than in Africa, women
in this current study noted utilizing many similar coping and help-seeking
behaviors while in their country of origin, such as seeking informal and fam-
ily support, using prayer, having faith in God and in their ability to survive,
accepting fate, and minimizing abuse. In addition, wishful thinking, hop-
ing for change, and behavioral distractions also were utilized. One notable
difference was that while most women did not utilize formal services in
Africa when being abused, many reported formally seeking help in America.
Women noted with surprise the effectiveness of being in group or personal
counseling, which were not available to them in Africa, and how it helped
them cope: “In Africa, you can go to the police, and they will laugh at you
and send you home. They tell you your husband is right to discipline you.
You are a bad wife to try to bring him shame [by going to the police].”
Women clearly indicated the following:

There is nowhere [in Africa] for a woman to go. You cannot even go to
friends’ house. They may feel sorry for you, but they cannot do anything
for you. Their husbands will not allow it, and they don’t want trouble
with their husbands.
Others’ voices concurred: “There is no programs, no counselors for women, no shelters. Maybe now, maybe in some big cities, there’s something. But when I was in Africa, I never heard of anything for women; here, I can get help.” Abuse was also so commonplace in their communities, it was not identified as abuse: “We call it ‘husbands-teaching-his-wife-to-be-a-good-wife.’” The denial was from a lack of knowledge of what constituted abuse, and the minimization was in comparison to what others experienced: “My husband, he was not so bad; other women, their husbands, were bad, very bad.”

Upon immigrating to the United States, women survivors reported what helped was the knowledge that services were available, even if they were not ready to utilize the services: “I learned wife abuse is a crime here, and I can go for help, and no one will tell me to go home, or laugh at me.” The knowledge of being able to formally seek help empowered them. The knowledge of their rights as women empowered them. The sense of empowerment allowed the survivors in this study to put up or cope with the abuse, until the time was right for them to utilize the services. Even if they chose not to leave, it provided a safety net for them and a bargaining tool: “I knew he wouldn’t really hurt me since he knew I could call the police and he would have to leave the house.” For some survivors, unlike in Africa, they felt they had some power over their abusive husbands in the United States and a way to control the abuse, to keep it from becoming extreme.

Differences in Coping in Comparison With Other Immigrant Survivors

Many similarities between African women’s coping behaviors and the behaviors of other immigrant survivors were noted through the narratives of African women in this study. The initial attempts to minimize the abuse and placate and appease their husbands were common behaviors utilized by immigrant women who were first generation or military brides (Erez & Bach, 2003; Yoshihama, 2002). Among certain African survivors, having a future orientation was similar to Asian immigrants who focused on living for the future and future gains. Accepting fate, “karma,” or gender role inequalities also has been common in Asian immigrant survivors (Bhuyan et al., 2005; Bui, 2003; Das Gupta & Warrior, 1996), as was the seeking of informal support from families and friends (Bhuyan et al., 2005; Takano, 2006; Yoshioka, Gilbert, El-Bassel, & Baig-Amin, 2003). Other immigrant groups from Europe or Latin America, however, felt shame and did not want to have family or friends know of the abuse; instead, they preferred to seek formal help from police, service agencies, and professionals, far from the gossip within a close-knit immigrant community (Konczak, 2007; Yoshioka et al., 2003). Like other immigrants, African women survivors indicated they were learning that formal services existed in their adoptive countries, and that gender inequality was not readily accepted.
African women in the current study reported faith in God and spirituality as an important coping strategy. The use of faith and prayer was also common in Latino immigrant survivors (Brabek & Guzmán, 2008) and with nonimmigrant African American survivors in the United States as well (El-Koury et al., 2004; Taft, Bryant-Davis, Woodward, Tillman, & Torres, 2009). Overall, there were more similarities between African immigrant women and other immigrant survivors than differences in terms of coping strategies.

DISCUSSION

Strength and Limitations

Before discussing the findings of the current study, some of the limitations need to be noted. The current findings are all self-report data, and the possibility of social desirability bias may exist. The ability to generalize the current findings to the larger population of African immigrant survivors in the United States and to all African women internationally is also limited by the current small sample of self-selected women. It is important to note that heterogeneous cultures exist within Africa and that African customs are not monolithic, and immigrants from Africa should not be stereotyped. There are several strengths to this study, however. Rich, holistic insights can be gained from listening to the abused women’s own voices and narrations, which were reflective of the unbiased “lived experiences” of the respondents. Padgett (2008) indicates that using detailed in-depth personal narratives of respondents makes the qualitative data more trustworthy and credible. In addition, the women in this study ranged in age, education, and geographic locations from Africa, which also provided diversity to the voices. Finally, this study is also the first known research conducted on the qualitative experiences of African immigrant women in the United States and their coping strategies with IPV, an important topic that has received limited attention in the past.

Implications

From the women’s narratives, it was clear that African immigrant women, similar to many other immigrant women, lack the awareness of IPV as a crime until they immigrated. Despite their overwhelming cultural acceptance of male to female gender violence, the lack of women’s rights in African society, and the lack of services and resources available for survivors of abuse, African immigrant women have managed to cope in myriad ways. Male entitlement and domination were everyday occurrences within the lives of these women, and their survival both in Africa and in the United States depended upon their resiliency and ability to cope with the abusive behaviors in whatever manner possible.
One important difference is that once African women immigrated and realized wife abuse was a crime, and that services were available to them, they incorporated and utilized that knowledge. One implication arising from this finding is the need to provide all African immigrant women with information about services and their rights as victims of criminal behaviors. This would be important in the United States, the site of the current study, as well as in other countries where African women have immigrated. Even if women do not immediately access such services, the knowledge they gain provided them with a sense of empowerment and was used to check the abusive behaviors of their husbands. It became an important coping strategy. It is imperative, therefore, for all service providers, worldwide, to continue efforts to reach and educate the “hidden” population of immigrant women. Suggestions for outreach to immigrant women include posting flyers at places commonly frequented by immigrants, such as language schools, ethnic supermarkets, food pantries, hair salons, and medical facilities. Medical personnel must routinely assess for abuse and provide information and referrals. African language or local community newspapers can be utilized to reach women. Despite the fact that many immigrants come from English-speaking countries, English may still not be their preferred tongue; therefore, having informational public service announcements in various dialects can reach more women and are viewed as more reliable and trustworthy. Women in the current study reported having some access to African music/radio stations, blogs, or Internet websites providing news of their home countries. Thus, to convince local, national, and international organizations of the need to provide public health announcements would be a first step toward reaching women.

Churches and clergy are also important in the campaign to end male violence. African women noted the importance of faith, spirituality, and prayer in their lives. Informal help seeking within the religious community occurred with varying levels of success. A recommendation would be to help educate the local clergy, as well as national and international religious organizations, about the prevalence of abuse and ways to provide help. Unfortunately, some prior researchers have indicated that common responses of clergy were focused on keeping marriages intact regardless of abuse (Taft et al., 2009), so it would be critical to have clergy collaborate in outreach efforts to women. Interfaith coalitions and community partnerships between governmental and private nonprofit organizations would be important and allow for better service provision as well. In addition, some African immigrants have been resettled or relocated through international aid organizations. These private or public organizations (including nongovernmental organizations [NGOs]) would be in the position to provide information, medical and psychological assessments, and referrals, having been trusted and accepted by the refugees.
Schoolteachers and counselors should continue their efforts for students in preventive education on dating and family violence in hopes that the message will reach children who are either themselves in abusive relationships or witnessing family violence. Health education curriculum should include resources, but also information on rights of individuals, including immigrants, to live an abuse-free life. School-sponsored community forums may be accessible and trusted by immigrant parents valuing education. With over three million foreign-born children school aged (U.S. Census, 2001), and many more children as U.S.-born second-generation citizens with parents of first-generation immigrant status, schools can be invaluable as sources of information. School officials also can identify and refer to services those students with learning and behavioral issues associated with family violence, such as underachievement, substance use, chronic absenteeism, or being bullied or overly aggressive (Holt, Buckley, & Whelan, 2008; Lang & Stover, 2008). It follows that professionals working with children also should be trained to assess on a routine basis for underlying family violence.

Another implication is the need for coordinated services and training for first responders such as police and medical personnel, as well as child welfare workers, mental health professionals, and legal advocates. Due to shame, stigma, and fear of deportation, many immigrants tend not to access formal services until the situation is critical (Ting & Panchanadeswaran, 2009). Professionals need to realize that when abuse is disclosed, not only will this be a crisis situation, but the incident will probably be a culmination of long-term abuse, with a survivor having reached the end of her endurance or felt herself to be in imminent danger. Clinicians, police, emergency room personnel, and crisis intervention intake workers not only need routinely to assess for family violence, but also need to educate and assess women on their risks of lethality, as well as risk for suicide, and immediately activate safety planning to local shelters or services. While this particular group of African immigrant women did not actively mention suicide as a coping strategy, many women in this study indicated experiencing at times symptoms of depression, feelings of isolation, lack of social support, low sense of self-efficacy, and hopelessness. These are all factors that have been associated with increased risk of suicide attempts among victims of abuse (Sansone et al., 2007; Thompson et al., 2002). Suicide has been associated with family violence, and has been a response to victimization in several immigrant cultures, both as an escape mechanism and as a way of retaliation by bringing shame to the abuser and his family (Lee, 1997; Patel & Gaw, 1996; Strachan et al., 1990; Yasan et al., 2008). Thus, suicide hotline workers also need to be trained to assess for IPV and have available additional resources on immigrants’ rights in cases of partner violence, in order to educate immigrant women on their ability to leave an abusive situation while maintaining legal immigration status in the new country.
In terms of clinical interventions, women from this study highlighted the helpfulness of individual and group counseling that was culturally competent. Many respondents indicated their initial lack of understanding of the therapeutic process in self-help and mutual aid groups, how “talking to someone” could help them feel better. Women reported this was a new concept to them, as many believed mental health services were for only “crazy people,” and they feared stigma. Clinicians need to be aware of the skepticism that may occur when women are being referred to counseling and need to explain the process of mutual aid and self-empowerment. Many non-European immigrants somaticize complaints, reporting physical health symptoms rather than mental health concerns, and clinicians need to be aware of the language they utilize in assessments and treatment with immigrant survivors. Culture competency involves knowing what questions to ask and how to ask them. In cultures where gender inequality is not the norm, more internal focused, reflective strategies that are less confrontational may be more adaptive and acceptable to help immigrant women cope, as well as be seen as effective (Yoshihama, 2002).

For immigrant African women, and in many other cultures where maintaining a marriage and family are important, the treatment goals need to be prioritized differently. Interventions may focus toward educating women on ways to be safe if they choose to return to their family situation. The collective, family-oriented perspective may be valued by African immigrant clients instead of Westernized viewpoints focusing on individual needs and self-actualization; clinicians, therefore, need to be aware of their own cultural and personal biases when working with immigrant survivors with different value systems.

In this study, while many of the forms of coping utilized could have been categorized into the traditional coping strategies (i.e., approach/active/positive versus avoidant/passive/disengaged strategies) conceptualized by researchers (Carver, 1997; Lazarus & Folkman, 1984), it was important to assess the women in the context of their experiences and situations. Hamby and Gray-Little (2007) recommended that what works to help women cope is individually determined. What is effective should not be prescriptive, “one size fits all.” Each immigrant woman has to utilize coping strategies for her own survival and best outcomes. Internationally, to meet the growing demands of African immigrants as this population increases, however, the need for culturally competent interventions and research becomes more and more pressing.

As yet, we have, in this study, only explored one aspect of African immigrant women’s experience with IPV using a limited sample from the United States. Using a qualitative approach, we did not measure outcomes or conduct follow-ups. Therefore, it is recommended that future researchers should assess long-term effects of violence and quantitatively measure coping, health, and mental health outcomes such as PTSD, depression, and
anxiety. It also would be important to identify factors that were protective and increased resiliency over time in this population of immigrant survivors.

As our individual societies become more international, and we become true citizens of the world, it is important to understand the process by which immigrant survivors of IPV cope and when they seek formal help. It is necessary to have the information and skills to serve all segments of the population, as IPV is a pervasive problem. Immigration can increase the risk of IPV and exacerbate the abuse. Intimate partner violence (IPV) is associated with and has implications for immigrant women’s physical, mental, sexual, and reproductive health; therefore, it is important that, globally, we combat it together.

REFERENCES


Coping Strategies of African American Women


