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Exploring Help-Seeking Behavior among Minority Women Survivors of Intimate Partner Violence (IPV) in the Mid-South of the United States

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EXPLORING HELP-SEEKING BEHAVIOR AMONG MINORITY WOMEN SURVIVORS OF INTIMATE PARTNER VIOLENCE (IPV) IN THE MID-SOUTH OF THE UNITED STATES

by

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Dedications

To my grandmother, Agnes Blakely, father, Robert Schmidt, and mother, Linda Schmidt,

with love and admiration

To my wife, Samantha, daughter, Alden, and sons Lennox, Alexander, and Julien,

with love and commitment

To David and Ricki Le Vine,

with love and appreciation

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Abstract

One in four US women have experienced intimate partner violence (IPV): lifetime prevalence of physical IPV 31.5% and psychological aggression 47.1% among survivors. African American and Hispanic women's lifetime IPV is 43.7% and 37.1%, respectively—higher than White women's (34.6%). IPV poses significant risks to physical, psychological, and emotional health. Women affected by IPV, especially minority survivors, face barriers in seeking help from informal and formal supporters. Barriers and facilitators to formal help-seeking for minority survivors are not well understood. This study explored barriers and facilitators to formal support help-seeking among African American and Hispanic IPV women survivors. Qualitative study using grounded theory methodology was conducted with 29 survivors (15 African American, 14 Hispanic). Key barriers to formal help-seeking were lack of knowledge about support resources, avoidance of judgment, experiencing abuse as the norm, and lack of interaction with police. African American participants delayed formal help-seeking because they lacked information about support resources, did not want to be judged weak, experienced norms emphasizing romantic relationships, and avoided contact with police due to fear of abusers' reprisals. Hispanic participants delayed formal help-seeking because they lacked information about support resources and victims' rights, did not want to be ridiculed, experienced norms emphasizing marriage and motherhood, and received little information from police. Key facilitators to formal help-seeking included five novel findings: taking steps to acquire information about support resources, changing one's thinking about support resources, resisting abusers' manipulation tactics, covering basic needs, and feeling empowered. African American participants used help-lines and library resources, changed their doubts about support resources as they experienced their benefits, resisted abusers' pleas to drop charges, employed personal and many formal resources to meet needs, and found purpose in helping others. Hispanic

participants used radio and newspapers, changed their misperceptions about support resources as they encountered more supportive helpers and services than expected, and employed personal and few formal resources to meet needs. Findings indicate formal support interventions that build upon survivors' strengths may be useful in promoting survivors' earlier initiation of help-seeking as well as their retention in support services and programs.

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Chapter 1: Introduction and Background

Introduction

Intimate Partner Violence (IPV) involves physical, sexual, and/or psychological aggression perpetrated by one partner against the other with whom an intimate relationship is currently or once was shared (Breiding, M. J., Basile, Smith, Black, & Mahendra, 2015). Among women IPV survivors in the United States, lifetime prevalence of IPV physical violence is 31.5% (95% CI: 29.9-33.2), psychological aggression is 47.1% (95% CI: 45.3-48.8), stalking is 9.2% (95% CI: 8.2-10.3), rape is 8.8 (95% CI: 7.8-9.8), and other sexual violence (e.g., coercion and unwanted contact) is 15.8 (95% CI: 14.6-17.1) (Breiding et al., 2014). Over 13% of women and nearly 4% of men in the United States have been injured as a result of physical, sexual, and stalking IPV in their lifetime (Breiding et al., 2014). In Tennessee, where IPV statistics for 2013-2015 do not include Hispanic women, 31% of reported IPV victims were African American women and 40% were White women (Tennessee Bureau of Investigation CJIS Support Center, 2017). Over 82% of domestic violence reports in Tennessee during 2013-2015 involved aggravated or simple assault (Tennessee Bureau of Investigation CJIS Support Center, 2017). Physical IPV victimization is associated with injury, poorer physical health, and chronic disease (Coker, Smith, Thompson, McKeown, & Bethea, 2002).

In addition to the physical assault suffered by IPV victims, IPV can lead to mental trauma, depression, and heavy drinking (World Health Organization, 2016). Furthermore, physical abuse is typically accompanied by emotional or psychological abuse, impacting victims' mental health (Michele C. Black, 2011; Coker, Smith, et al., 2002; Heise & Garcia-Moreno, 2002; T. A. Roberts, Klein, & Fisher, 2003; Tjaden & Thoennes, 2000; Warshaw, Brashler, & Gil, 2009). Survivors suffer from PTSD (Beijer, Scheffel Birath, DeMartinis, & af Klinteberg,

2015; Michele C. Black, 2011; T. P. Sullivan & Holt, 2008), major depressive disorder (Michele C. Black, 2011; de Dios, Anderson, Caviness, & Stein, 2014), anxiety and hostility (Michele C. Black, 2011), and suicidality (Michele C. Black, 2011; Coker, Smith, et al., 2002; T. A. Roberts et al., 2003). Physical, sexual, or psychological IPV can also lead to damage to the cardiovascular, reproductive, gastrointestinal, genitourinary, and brain and nervous systems (Michele C. Black, 2011).

Help-Seeking for IPV

Help-seeking for IPV—to leave one's abuser and engage in trauma recovery—involves survivors' use of social support. Social support was initially conceived as a type of information that indicated to a person she was cared for and indeed part of a mutually supportive network (Cobb, 1976). Social support has since developed into a complex array of related concepts (see El-Bassel, Gilbert, Rajah, Foleno, & Frye, 2001; Heaney & Israel, 2008; Thoits, 2011; Trotter & Allen, 2009). Social support sources are of two forms: informal and formal (see Goodman, Dutton, Weinfurt, & Cook, 2003; Gottlieb & Bergen, 2010; Krause, Kaltman, Goodman, & Dutton, 2008; Liang, Goodman, Tummala-Narra, & Weintraub, 2005; Rose, Campbell, & Kub, 2000; Sylaska & Edwards, 2014). Examples of informal sources, termed informal supporters, typically used by IPV survivors include friends and family (see Alaggia, Regehr, & Jenney, 2012; Bauer, Rodriguez, Quiroga, & Flores-Ortiz, 2000; Goodman et al., 2003; Lucea et al., 2013; Petersen, Moracco, Goldstein, & Clark, 2005a; Rodriguez, Sheldon, Bauer, & Perez-Stable, 2001; Sylaska & Edwards, 2014). Examples of formal sources, termed formal supporters, typically used by IPV survivors include medical professionals, mental health counselors, domestic violence shelters or programs, police, and the courts (see Fraser, McNutt, Clark, Williams-Muhammed, & Lee, 2002; Goodman et al., 2003; Morrison, Luchok, Richter, & Parra-

Medina, 2006; Rose et al., 2000; Sylaska & Edwards, 2014). Informal supporters, formal supporters, and most often a combination of informal and formal supporters (see, for example, Bent-Goodley, 2007; El-Bassel et al., 2001; Evans & Feder, 2014; Rizo & Macy, 2011) help connect IPV survivors with formal sources of support, or formal support resources. Informal supporters are important to formal support help-seeking, because they often act as a bridge to formal supporters. Formal supporters are important, because they play crucial roles in survivors' efforts to escape their abusers, recover from trauma, and prevent future IPV. Fanslow and Robinson (2010) observed that just 6% of the IPV survivors they sampled disclosed exclusively to formal supporters; survivors' pathways to formal support resources predominantly ran through informal supporters.

IPV survivors have rated both informal and formal support more useful than trying to handle abuse alone (Brabeck & Guzmán, 2008; Goodman et al., 2003). However, informal support, offered through friends and family, can quickly become exhausted (Meyer, 2011). Survivors who delay accessing formal supporters and their resources may experience extended periods with no supporters of either type. Accessing formal supporters is especially problematic for minority women, because African American and Hispanic IPV victims are reluctant to turn to formal sources of social support, including medical and mental health resources (see Stockman, Hayashi, & Campbell, 2015) with some indication that formal support utilization is lowest among Hispanic women compared to White and African American women (Lipsky, Caetano, Field, & Larkin, 2006). Their reticence regarding formal support is crucial for intervention, since formal support has been shown to protect survivors from further physical injury (Liang et al., 2005). Women receiving formal support services through a shelter in one study had twice the odds of avoiding further harm from IPV during their two years post-intervention (C. M. Sullivan

& Bybee, 1999). Many IPV survivors need the resources of formal support (e.g. counseling and recovery treatment, orders of protection, and legal assistance) to leave their perpetrators (Brown, 1997; Liang et al., 2005).

The literature indicates that African American women typically turn to formal supporters only when their perpetrator has become severely violent (Bent-Goodley, 2007; M. R. Yoshioka, DiNoia, & Ullah, 2001). The vast majority of IPV studies focus on White women (Klevens, 2007) whereas prevalence of lifetime IPV for African American and Hispanic women is reported to be 43.7% and 37.1%, respectively—higher than that for White women (34.6%) (M. C. Black et al., 2011). African American women also are disproportionately affected by physical sequelae of IPV (e.g., stress, CVD, and HIV/AIDS) (see Lucea et al., 2013). Compared to White couples in a nationally-representative random digital dialing survey, African American couples were 2.36 times more likely to experience severe IPV (Hampton & Gelles, 1994). Additionally, African American women disproportionately fall in the lower socio-economic strata—another risk factor associated with IPV (M. D. Mitchell et al., 2006). The brass ring of IPV help-seeking research to-date is formal support, specifically understanding how to improve survivors' access to and use of formal support resources, inclusive of informal supporters' roles in helping survivors reach that point. Moreover, survivors' abuse cessation, trauma recovery, and ongoing IPV prevention needs are extremely complex, requiring a system of formal supporters comprised of police, lawyers, caseworkers, counselors and therapists, and many other government, non-profit, and faith-based helpers.

Barriers to Help-Seeking from Formal Support

Prior studies have identified IPV help-seeking barriers specific to minority women, including avoidance of formal support due to higher rates of prosecution and loss of child

custody (Bent-Goodley, 2007), negative interactions with medical professionals (Paranjape, Tucker, Mckenzie-Mack, Thompson, & Kaslow, 2007), and low self-efficacy (Marianne R. Yoshioka, Gilbert, El-Bassel, & Baig-Amin, 2003). Specific barriers to help-seeking faced by African American women include heightened concerns over alerting formal support, particularly police. Some victims cite the long history of discrimination towards African Americans as their reason for not reporting abuse (Kearney, 2001; Marianne R. Yoshioka et al., 2003)—particularly fear of unequal treatment of African American male perpetrators by the justice system (Gondolf, Fisher, & Mc Ferron, 1988). Consequently, African American IPV survivors may be less likely to seek help from formal support than White women. Specific barriers to help-seeking faced by Hispanic women include language barriers and cultural acceptance of male dominance and violence (Rizo & Macy, 2011). Fears of deportation, police, injury, victimization of children, isolation, and loss of financial support predominate (Rizo & Macy, 2011). Additionally, religious beliefs, discrimination, lack of culturally appropriate services, and lack of knowledge regarding legal rights constitute barriers to resource utilization (see the systematic review by Rizo & Macy, 2011).

Facilitators to Help-Seeking from Formal Support

With respect to facilitators, one consistent motivator regardless of race is mothers' concerns for their children's safety. Qualitative studies show mothers attribute their resource utilization to their concern for their children's safety (Rizo & Macy, 2011). Additionally, severity of violence is associated with African American women's help-seeking from formal supporters (Lucea et al., 2013; M. D. Mitchell et al., 2006), as is injury (see Sylaska & Edwards, 2014). Informal social support, specifically in the form of emotional support, is also associated with women's help-seeking from formal supporters (Kocot & Goodman, 2003). Factors

protective against IPV remain unverified (Sylaska & Edwards, 2014). For one thing, qualities that make a relationship safe versus dangerous have not been investigated (Sato-DiLorenzo & Sharps, 2007).

Gaps in the Literature on Formal Support for IPV Help-Seeking

First, help-seeking and disclosure studies have largely focused on barriers to help-seeking (see Rizo & Macy, 2011). Consequently, more is known about women's difficulties accessing formal support resources than facilitators that may help them overcome barriers to formal support resources and potentially life-saving support. Second, most IPV help-seeking studies of minority women focus on a single racial or ethnic group and rarely are African American women compared to Hispanic women (Raj & Silverman, 2002). Very few studies, in fact, have examined the IPV experiences of immigrant or Hispanic women and their experiences of abuse recurrence (Raj & Silverman, 2002). The lack of knowledge regarding the experiences and help-seeking needs of Hispanic IPV survivors is a critical concern due to their growing population in the United States (Shuman, 2014). Third, existing literature on IPV help-seeking lacks a cohesive understanding of survivors' experiences (Ammar, Orloff, Dutton, & Aguilar-Hass, 2005; Rizo & Macy, 2011), and limited qualitative research exists on IPV survivors' help-seeking (Liang et al., 2005). With respect to IPV help-seeking studies focusing on Hispanic women, Rizo and Macy (2011) found only seven published qualitative studies. In their literature review on IPV survivors' use of informal supporters, Sylaska and Edwards's (2014) report "little is known about the specifics of the situation, process, and nature of IPV victims' disclosure" (p. 13).

Where Hispanic women are included in the IPV literature, studies provide inconsistent findings regarding survivors' help-seeking behaviors, with some studies concluding Hispanic women are less likely to seek help and others concluding Hispanic women are more likely to

seek help than their non-Hispanic counterparts (see Rizo & Macy, 2011). Studies have also concluded that Hispanic women are more likely to seek help from police than their non-Hispanic counterparts, only to be completely contradicted by other studies (Rizo & Macy, 2011). Hispanic sample characteristics have been used inconsistently, with some studies, for example, including immigration status, length of time in the US, and English language proficiency and others not including these factors (Rizo & Macy, 2011). With respect to African American women, barriers and facilitators to formal support help-seeking are extremely under-researched. Limited evidence suggests African American women avoid formal support help-seeking due to higher rates of prosecution for IPV and loss of child custody among African Americans compared to other ethnic/racial groups, which in turn may increase African American women's risk for IPV revictimization compared to other groups (Bent-Goodley, 2007). Additionally, African American female survivors' fear of unequal treatment of their African American male perpetrators by the justice system may discourage them from calling the police or pursuing orders of protection (see Gondolf et al., 1988).

Given what we do know about the potentially protective effects of formal help-seeking and utilization of formal support resources on women's health and safety (see Liang et al., 2005; see also Sylaska & Edwards, 2014) and the disproportionate IPV burden on African American and Hispanic women, it is critical we learn more about these survivors' experiences of formal support help-seeking. To aid intervention, "minority" groups need to be studied in relation to one-another to better understand the similarities and differences in their formal help-seeking barriers and facilitators. For instance, my review of the IPV help-seeking literature pertinent to this study's aims yielded 43 publications. Of those, only 7% (n = 3) included help-seeking factors and/or experiences affecting African American women and Hispanic women but did not

form comparisons. Four of the five community agencies partnering in this study primarily serve African American and Hispanic women IPV survivors. Little evidence exists, therefore, to inform these practitioners how to tailor their programs and services to each minority group.

Purpose of the Study

The purpose of this study is to explore barriers and facilitators to formal support help-seeking for intimate partner violence (IPV) among minority women survivors in the Mid-South of the United States and, while doing so, fill key, recognized gaps in the literature. The specific aims of this study are:

Specific Aim 1: To explore similarities and differences in barriers to formal support help-seeking between African American and Hispanic IPV women survivors.

Specific Aim 2: To explore similarities and differences in facilitators to formal support help-seeking between African American and Hispanic IPV women survivors.

Conceptual Framework Guiding the Study

I used the Information-Motivation-Behavioral Skills (IMB) model (J. D. Fisher & Fisher, 1992; W.A. Fisher & Fisher, 1999) and its constructs and sub-constructs to inform the development of interview questions and to provide a level of theoretical sensitivity to the study's grounded theory analysis. The IMB model emphasizes three practical areas for intervention: knowledge and beliefs about health behaviors, motivations to engage in health behaviors, and behavioral skills required to perform health behaviors. The IMB model was developed to investigate social and behavioral determinants of health behaviors, develop interventions based on evidence regarding determinants, and evaluate the effectiveness of interventions (William A. Fisher, Fisher, & Harman, 2003).

My study primarily focuses on the first aspect of this model: to understand social and behavioral determinants of formal support help-seeking for IPV (the health behavior) by exploring barriers and facilitators of help-seeking. I therefore employ information, motivation, and behavioral skills, and their sub-constructs, in data collection and analysis. Information and motivation are independent constructs, which may each affect health behavior directly or via behavioral skills (the mediating factor). Additionally, information and motivation may influence each other (Rongkavilit et al., 2010). For example, accurate information regarding the protective effects of a health behavior may sustain motivation to adhere to that behavior (Rongkavilit et al., 2010). Information, motivation, and behavioral skills affect behavior performance, which in turn impact health outcomes (Rongkavilit et al., 2010).

Study Population and Design

The study population consisted of women IPV survivors from the Memphis, Tennessee metropolitan area. Survivors were eligible to participate in the study if they were female, 18 years of age and older, experienced one or more forms of intimate partner violence (IPV) (physical, sexual, and/or psychological), current client of one of five non-profit or local government counseling or support agencies in the Memphis, Tennessee metropolitan area, engaged in individual and/or group counseling, abused by a male intimate partner, fluent English or Spanish speaker, and African American, Black, Hispanic, or Latina, inclusive of African, Caribbean, Spanish, Portuguese, or indigenous Central or South American ancestry. Participants could be mothers, women without children, married, or unmarried. These five study sites constituted the majority of the region's non-profit and government agencies serving survivors and families coping with IPV. Agency programs relevant to this study included individual counseling, separate but concurrent group programs for mothers and their children, a group

program for women without children, a temporary residential shelter with caseworkers serving as counselors, and a year-long residency program with faith leaders serving as counselors. Exclusion criteria for this study included if women were in a same-sex relationship, under the age of 18, unexposed to IPV, not participating in counseling services, not fluent in either English or Spanish, and did not identify themselves as African American, Black, Hispanic, Latina, or other identities inclusive of African, Caribbean, Spanish, Portuguese, or indigenous Central or South American ancestry. Women who clinicians screened as not capable of participating in group therapy and individual counseling (e.g., due to debilitating health, physical, mental, and cognitive or emotional limitations) and women who returned to their abuser or engaged in a new abusive relationship were also excluded. Women who met inclusion criteria were approached by their clinicians and informed about the study with the request to consent to participate. Clinicians conducted recruiting, because their rapport with clients mitigated pressure to participate. This qualitative study employed semi-structured interviews with 14 African American and 15 Hispanic IPV women survivors. As the principal investigator, I conducted all interviews, although I did train two Spanish-speaking individuals who helped with simultaneous translation during interviews with Hispanic women.

Significance of the Study

To promote formal support help-seeking to escape abuse, recover from trauma, and prevent future IPV, we need to know what IPV survivors found to be effective help-seeking facilitators and why. To promote earlier initiation of help-seeking as well as maintained help-seeking, we need to be aware what IPV survivors found to be barriers and why. And to understand the challenges throughout the help-seeking process, we need to understand participants' experiences with those they turn to for help and those they avoid. This study's use

of qualitative methods helps explore and identify a large set of barriers and facilitators, and my use of the IMB model helps explore why those barriers and facilitators affected participants the way they did.

Furthermore, this study examines the help-seeking experiences of survivors belonging to racial/ethnic groups disproportionately affected by IPV and who form the study region's dominant IPV services client base. The study sites selected constitute the region's IPV "safety net" organizations, providing a comprehensive view of formal support services accessed. The study takes a further comprehensive view of survivors' experiences, from types and duration of IPV suffered to trauma recovery. This study also augments our understanding of IPV help-seeking barriers and facilitators with particular sensitivity to the experiential similarities and differences between African American and Hispanic survivors, which may inform help-seeking promotion efforts (e.g., promoting knowledge about IPV and availability of services or designing social marketing interventions) and program and services tailoring (e.g., promoting enrollment and retention in counseling by adapting group therapy programs to reflect culturally-relevant themes and implications).

This study addresses several limitations of the literature: (1) Despite the CDC's epidemiological surveillance data indicating IPV disproportionately affects minority women, the IPV literature provides minimal focus on minority women (Bradley et al., 2005; Tjaden & Thoennes, 2000). This study focuses on African American and Hispanic women IPV survivors. (2) Very limited literature exists regarding the intrapersonal, interpersonal, or situational variables affecting IPV survivors' formal support decisions and experiences (Sylaska and Edwards's, 2014). This study explores survivors' personal characteristics, social support, and past and present circumstances that appear to present barriers and facilitators to formal support

help-seeking. (3) Limited research on social and cultural factors affecting IPV help-seeking exists (Cummings et al., 2012; Spivak et al., 2014; Stockman et al., 2015). This study's use of the IMB model facilitates exploration of social motivation, a sub-construct of motivation, which explicitly considers the influence of social and cultural factors on behavioral motivation. (4) Others have noted the lack of qualitative research in this area and/or problems drawing consistent conclusions from existing qualitative studies (Broadhurst, 2003; Liang et al., 2005; Rizo & Macy, 2011; Taft et al., 2009). Much of that problem may owe to the difficult challenge of defining help-seeking (Rizo & Macy, 2011), which has obvious implications for quantitative measurement as well. This study provides both a broad and deep view of help-seeking, contributing to current efforts to operationalize this complex construct. Critically, the lack of qualitative research in this area has the unwanted and ironic effect of silencing women who are just beginning to regain their voices. Consequently, Taft et al.'s (2009) study of IPV among African Americans calls for research that "gives voice" (p. 57) to African American men and women in order to better understand how to intervene. The results of this study foreground participants' voices to the extent possible for this medium. (5) There is a lack of behavioral models to guide investigation and understanding of factors influencing IPV survivor's help-seeking behaviors (see Sylaska & Edwards, 2014). To my knowledge, this study is the first to use the IMB model in an IPV-related study.

Chapter 2: Literature Review

This chapter focuses on the current state of knowledge on IPV help-seeking, identifying specific gaps in the literature. I narrowed my literature review on barriers and facilitators to help-seeking for formal support and searched for studies that included investigation of African American and Hispanic women IPV survivors' help-seeking experiences or factors affecting their help-seeking. I begin by introducing the literature review's methodology and move on to further explaining IPV help-seeking, distinguishing it from the closely related concept of IPV disclosure. I then review the existing literature following the IMB framework while critically explicating its relevance to help-seeking among IPV minority women survivors.

I investigated the IPV literature to identify existing knowledge and knowledge gaps regarding IPV help-seeking. Based on the health disparities identified in Chapter 1 and my study's aims and theoretical orientation, I narrowed my search with the following terms: intimate partner violence, domestic violence, male to female, help-seeking, formal and informal support, women, minority, Black, African American, Hispanic, and Latina. Iterative searching and reviewing were used to identify as many sources as possible during the period September 2017 to March 2018. The specific aims of the review were to survey types of help-seeking employed (i.e., formal and informal), common factors (barriers and facilitators to help-seeking) examined across the literature, characteristics of study samples (i.e., race/ethnicity), research settings (e.g., agency, community, urban, and rural), and study designs, guiding theories, and survivors' help-seeking needs (i.e., information).

PubMed, PubMed Central, and Google Scholar were used for initial searching. Chapter and article citations from the resulting literature were used to capture resources missed during the database searches. This method of concurrent searching and reviewing was used to identify as

many sources as possible. I included journal articles (studies, literature reviews, systematic reviews, and meta-analyses), books (inclusive of anthologies), book chapters, and unpublished dissertations focused on intimate partner violence help-seeking. Studies focused solely on abuse disclosure were excluded, as were studies focused solely on survivors' experiences with the courts. Forty-three papers (33 studies and 10 literature reviews) were found to be relevant for this literature review.

IPV and Related Constructs

Liang et al. (2005) define IPV help-seeking as a process that includes "defining the problem, deciding to seek help, and selecting a source of support" (p. 82). Liang et al. (2005) therefore provide a three-stage model for IPV help-seeking: (1) recognition of a problem and definition of IPV as the problem, (2) decision to find help, and (3) choice of support provider. Help-seeking also has been defined as disclosing IPV victimization in order to obtain help (Mays, Caldwell, & Jackson, 1996; Morrison et al., 2006; Taylor, Hardison, & Chatters, 1996). Liang et al.'s definition may be less prone to confusion with definitions of disclosure. For instance, IPV disclosure (see Sylaska & Edwards, 2014) is known to occur with and without intent to escape abuse. Disclosure includes forced disclosure, or cases in which others alert formal supporters, such as the police, without the consent of the IPV survivor (Jackson, Cram, & Seymour, 2000; Molidor & Tolman, 1998; Sylaska & Edwards, 2014). Differences in definitions of help-seeking notwithstanding, sources cited agree help-seeking is primarily about survivors' intentional engagement in disclosing abuse and seeking help to escape and recover from abuse.

Studies on disclosure, a critical aspect of accessing help, typically fall into three categories: (1) association between social support and/or coping and disclosure to informal and/or formal supporters (see Iverson et al., 2013; Levendosky et al., 2004), (2) association

between abuse frequency and/or severity and decisions to disclose or reactions received to the decision to disclose (see Lipsky, Caetano, & Roy-Byrne, 2009; Lucea et al., 2013; T. P. Sullivan, Schroeder, Dudley, & Dixon, 2010), and (3) association between disclosure and health outcomes (inclusive of supporters' reactions to survivors' abuse disclosures) (Coker, Smith, et al., 2002; Paranjape et al., 2007). Studies focusing on help-seeking include disclosure and the aforementioned associations but also examine survivors' experiences beyond disclosure. For example, a help-seeking study may investigate how disclosure to informal supporters influences subsequent disclosure to and help-seeking from formal supporters (see Rose et al., 2000).

However, the distinctions between help-seeking and disclosure are nuanced, creating a literature that often uses the two terms interchangeably. Consequently, my review of the IPV help-seeking literature also includes studies and reviews that on their face appear to deal strictly with disclosure events—either as exposure or outcome. I was careful to parse the difference. Studies and reviews focusing solely on disclosure events were excluded. Studies and reviews using the term disclosure, but nonetheless investigated help-seeking as a process, were included.

Conceptual Framework guiding the Study: The IMB Model

This study employs the Information-Motivation-Behavioral Skills (IMB) Model: a model of health behavior I used to first explore and later theoretically code IPV survivors' help-seeking behaviors (see Figure 1) (J. D. Fisher & Fisher, 1992; W.A. Fisher & Fisher, 1999). Originally designed to study HIV risk and prevention behaviors, the IMB model was designed for use across three stages of research: investigation of social and behavioral determinants, development of interventions based on the results, and evaluations of the interventions (William A. Fisher et al., 2003). The first stage, adapted for use in this study, focuses on the constructs of information, motivation, and behavioral skills as determinants of health behavior. Information and motivation

are independent constructs, which may each affect health promotion behavior directly or via behavioral skills (the mediating factor situated between information/motivation and health behavior). Additionally, information and motivation may influence each other. For example, accurate information regarding the protective effects of a health behavior may sustain motivation to adhere to that behavior (see Rongkavilit et al., 2010). Information, motivation, and behavioral skills affect behavior performance, which in turn impacts health outcomes (William A. Fisher et al., 2003).

The ***information construct*** represents knowledge about and attitudes towards a given health behavior (William A. Fisher et al., 2003). The information construct is a combination of three information concepts: (1) People use relevant knowledge and specific facts to inform health behavior decisions. (2) People use simple rules (or "heuristics," in Fisher's terminology) to guide health behavior decisions. (3) And people reason from information at hand to develop conceptions of and beliefs about a given health behavior (or implicit theories, in Fisher's terminology), which influence whether and under what circumstances they enact the health behavior (J. D. Fisher & Fisher, 1992; William A. Fisher et al., 2003). Information is directly associated with motivation and behavioral skills and directly and indirectly associated with behavior performance (William A. Fisher et al., 2003).

IMB's ***motivation construct*** is borrowed directly from the Theory of Reasoned Action/Theory of Planned Behavior (TRA/TPB) (Ajzen, 2011). The motivation construct represents one's motivation to complete a health behavior. Motivation is bifurcated into two sub-constructs: "personal motivation" and "social motivation." Personal motivations are influenced by one's attitudes and beliefs regarding an outcome and one's evaluation of that outcome, i.e., one's perceived risks and benefits of enacting a health behavior (William A. Fisher et al., 2003).

Social motivations are influenced by one's perceptions of relevant others' support for a given health behavior and one's motivation to comply with that support, i.e., the advice, opinions, or beliefs of relevant others (William A. Fisher et al., 2003). Social motivations may be influenced through interpersonal relationships or via societal, cultural, or community norms, mores, and stigmas (see William A. Fisher et al., 2003). Like information, motivation is directly associated with behavioral skills and directly and indirectly associated with behavior performance (William A. Fisher et al., 2003).

The ***behavioral skills*** construct represents one's perceived ability to enact a given health behavior as well as one's perceived ability to *plan* to enact a given health behavior. Behavioral skills, therefore, represents one's perceived self-efficacy to undertake, or plan to undertake, a given health behavior (see William A. Fisher et al., 2003). In addition to one's perceived self-efficacy, behavioral skills includes one's objective skills to perform a health behavior (William A. Fisher et al., 2003). Behavioral skills is similar to TPB's construct of "perceived behavioral control" (Ajzen, 2011), which consists of beliefs regarding facilitators and/or barriers to behavioral performance ("control beliefs") and the "perceived power" of these facilitators and/or barriers to influence one's behavior (Ajzen, 2011). In the IMB model (Figure 1), the behavioral skills construct is situated on the pathway between information and health behavior performance and the parallel pathway between motivation and health behavior performance. While information and motivation may directly impact behavior performance under certain circumstances, as posited by the IMB model, their individual effects on behavior performance are typically mediated by behavioral skills (William A. Fisher et al., 2003).

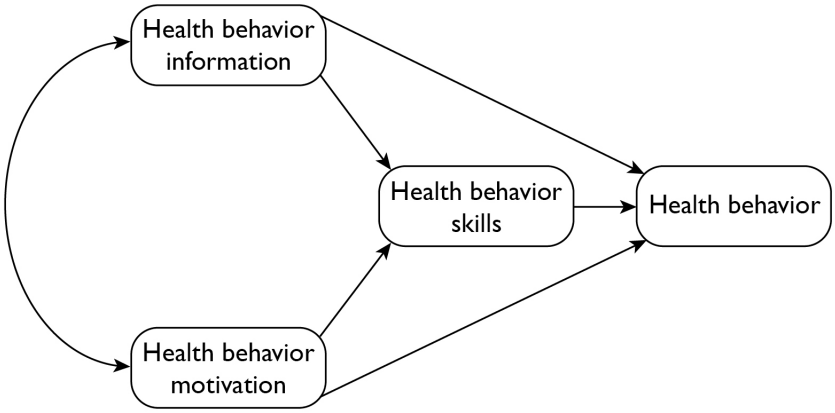

Figure 1. Information-Motivation-Behavioral Skills Model
Fisher, J. D., & Fisher, W. A. (1992). Changing AIDS risk behavior. *Psychological Bulletin*, *111*, 455–474.

Application of IMB Model to IPV Help-Seeking

Since no dominant theory exists to understand factors influencing IPV survivor's help-seeking behaviors (Sylaska & Edwards, 2014), the IMB model could be an excellent choice as an organizing framework for this study. The IMB model can help address knowledge gaps regarding survivors' supportive or inhibitive relevant knowledge, heuristics, and implicit theories (information), personal and social influences on help-seeking (motivations), and perceived self-efficacy (behavioral skills) affecting their IPV help-seeking behavior. Further knowledge regarding survivors' formal help-seeking behaviors (i.e., seeking help from police, courts, and domestic violence agencies versus friends and family) is particularly needed. African American and Hispanic IPV survivors are especially reluctant to turn to formal sources of social support, including medical and mental health resources (see Stockman et al., 2015), placing them at risk for revictimization. The current literature indicates that African American women typically turn to formal support only when their perpetrator has become severely violent (Bent-Goodley, 2007; M. R. Yoshioka et al., 2001). Their reticence regarding formal support is a crucial point for intervention, because formal support has been shown to protect survivors from further physical

injury (Liang et al., 2005). Women receiving formal support services through a shelter in a study had twice the odds of avoiding further harm from IPV during their two years post intervention (C. M. Sullivan & Bybee, 1999). The majority of IPV survivors need the resources of formal supporters (e.g. counseling and recovery treatment, orders of protection, and legal assistance) to leave their perpetrators (Brown, 1997; Liang et al., 2005). In fact, survivors have rated both informal and formal support more useful than trying to handle abuse alone (Brabeck & Guzmán, 2008; Goodman et al., 2003).

IPV Help-Seeking Literature and Literature Gaps Pertinent to IMB's Information Construct

Few studies have examined what survivors know and think about IPV and how their knowledge and cognitions influence their help-seeking. With respect to relevant information and specific facts, IPV survivors are often unaware that resources such as police intervention, restraining orders, domestic violence counseling programs, and primary and emergency care are available to them (Bauer et al., 2000; Brabeck & Guzmán, 2008; Crandall, Senturia, Sullivan, & Shiu-Thornton, 2005; Few, 2005; Krishnan, Hilbert, & VanLeeuwen, 2001; Lucea et al., 2013; Raj & Silverman, 2002; Rizo & Macy, 2011; Sabina, Cuevas, & Schally, 2012; Shuman, 2014). And IPV surviving immigrant women were unaware of laws protecting them (Adams & Campbell, 2012; Bauer et al., 2000; Crandall et al., 2005; Raj & Silverman, 2002). Only a few studies (Brown, 1997; Petersen et al., 2005a; Randell, Bledsoe, Shroff, & Pierce, 2012) offered empirical evidence of information as a help-seeking facilitator. In one study, for example, support groups provided information that helped women end their abuse (Brown, 1997). The use of simple rules as decision aids (or heuristics), e.g., rules of thumb like "marriage is forever" and "keep quiet if you want to keep your kids out of DCS" (quotes mine), has been demonstrated in

only a few studies involving minority women (see, for example, Brabeck & Guzmán, 2008; Raj & Silverman, 2002; Shuman, 2014). Very few studies have explored survivors' reasoning (implicit theories). With respect to implicit theories, Kearney (2001) observed survivors' rationalizations for not seeking help, including claims that endurance of abuse is requisite to maintaining love. Barnett (2001) observed rationalization was one process, along with denial and minimization, enabling survivors to blame someone or something besides their abuser for the violence they suffered. The help-seeking literature relevant to information lacks comparisons between groups with different demographic characteristics, including immigration status.

IPV Help-Seeking Literature and Literature Gaps Pertinent to IMB's Motivation Construct

Personal help-seeking motivations identified in the literature include experiencing increased abuse severity and frequency (Ammar et al., 2005; Petersen, Moracco, Goldstein, & Clark, 2005b; Randell et al., 2012; Shuman, 2014; Sylaska & Edwards, 2014), wanting to prevent further abuse (Evans & Feder, 2014), fearing harm from and fearing causing harm to the abuser (Randell et al., 2012), and possessing spirituality (Brabeck & Guzmán, 2008; Randell et al., 2012). Concern for children (Akers & Kaukinen, 2009; Rizo & Macy, 2011) was the most commonly identified personal motivator for seeking help, but it was also a multifaceted motivation defying easy operationalization: Some IPV surviving mothers were concerned about their children witnessing violence (Ammar et al., 2005). Others were concerned their children might become involved in the violence (Davis, Taylor, & Furniss, 2001), or they wanted to protect their children from the violence (Evans & Feder, 2014). Some were concerned their children might become violent (Petersen et al., 2005a), while others were concerned about the toll on their children from witnessing IPV (Randell et al., 2012).

Social motivations identified in the literature involve the roles of and survivors' reactions to their formal and informal supporters, including formal support from medical professionals and police (Randell et al., 2012) and informal supporters' positive appraisals of help-seeking (Ammar et al., 2005; Brabeck & Guzmán, 2008). The influence of formal and informal social supporters is well documented in the IPV help-seeking literature (see, for example, Hadeed & El-Bassel, 2006; Meyer, 2011; Overstreet & Quinn, 2013; Paranjape et al., 2007; Rose et al., 2000; Sabina et al., 2012; Sayem, Begum, & Moneesha, 2015) as is the influence of community norms and attitudes (see, for example, Adams & Campbell, 2012; Barnett, 2001; Bauer et al., 2000; Crandall et al., 2005; Davis et al., 2001; Evans & Feder, 2014; Gondolf et al., 1988). However, few studies examine the distinctions between motivations to disclose abuse and motivations to seek help (Bent-Goodley, 2007; Montalvo-Liendo, 2009; Murdaugh, Hunt, Sowell, & Santana, 2004; Naved, Azim, Bhuiya, & Persson, 2006). Consequently, the roles of motivation across the help-seeking spectrum, from disclosure to recovery, remain understudied and therefore insufficient to inform comprehensive approaches to intervention.

The IPV help-seeking literature predominantly demonstrates that motivation, particularly concern for children and severity and/or frequency of abuse experienced, serves as a facilitator to help-seeking. However, the good intentions of others may adversely impact survivors' motivation to seek help, e.g., policies resulting in both parties being arrested (Alaggia et al., 2012) or unwanted (forced) disclosure by a friend, co-worker or family member suspecting abuse (Sylaska & Edwards, 2014). Other barriers include PTSD and depression, common across African American, Hispanic, and White respondents in one study, which compromised their motivation to plan and seek help (Lipsky et al., 2006).

IPV Help-Seeking Literature and Literature Gaps Pertinent to IMB's Behavioral Skills Construct

Prior studies have identified IPV help-seeking barriers specific to minority women, including avoidance of formal supporters due to higher rates of prosecution and loss of child custody (Bent-Goodley, 2007), negative interactions with medical professionals (Paranjape et al., 2007), and low self-efficacy (Marianne R. Yoshioka et al., 2003). Specific barriers to help-seeking faced by African American women abused by African American male perpetrators include heightened concerns over alerting formal supporters, particularly police. Some victims cite the long history of discrimination towards African Americans as their reason for not reporting abusers (Kearney, 2001; Marianne R. Yoshioka et al., 2003)—particularly fear of unequal treatment of African American male perpetrators by the justice system (Gondolf et al., 1988). Consequently, African American IPV survivors may be less likely to seek help from formal supporters than White women. The relevance of this disparity is affirmed for this study's location by Henning & Klesges' (2002) study in Shelby County, Tennessee comparing resource utilization between White and African American survivors of physical IPV. African American women were less likely to use formal support services than White women: logistic regression analysis indicated White women are nearly two times more likely than African American women to utilize counseling/supportive resources (OR, 1.87; 95% CI, 1.31, 2.70).

The literature identifies many factors that may impede survivors' abilities to seek help. Acquisition of formal support may be compromised by language barriers (Adams & Campbell, 2012; Bent-Goodley, 2007; Bloom et al., 2009; Lipsky et al., 2006) and lack of medical and social service providers (Bent-Goodley, 2007; Krishnan et al., 2001). Abilities to make plans to seek help may be compromised by the psychological toll of abuse (Alaggia et al., 2012; Barnett,

2001; Hien & Ruglass, 2009; Lipsky et al., 2006) as well as the effects of isolation (Brabeck & Guzmán, 2008; Few, 2005; Krishnan et al., 2001), financial dependence on the abuser (Barnett, 2001; Bent-Goodley, 2007; Brabeck & Guzmán, 2008; Hien & Ruglass, 2009; Liang et al., 2005; Petersen et al., 2005b), lack of trust in formal supporters (Bent-Goodley, 2007; Bloom et al., 2009), and victim blaming and shaming (Brabeck & Guzmán, 2008; Evans & Feder, 2014). Only three papers meeting inclusion criteria included facilitators to behavioral skills: seeking help to gain the ability to talk about abuse (Alaggia et al., 2012), selecting the right people and the right means to seek help (Davis et al., 2001), and providing emotional support to boost survivors' confidence in their own abilities to seek help and/or remain free of abuse (Rose et al., 2000) constituted the only behavioral skills facilitators I found in the 43 publications reviewed. The literature primarily focuses on factors impeding IPV survivors' behavioral skills and lacks findings demonstrating facilitators to their development or use. Attention also lies with resources needed and accessed (see Letourneau, Duffy, & Duffett-Leger, 2012) but not with behavioral skills needed to access those resources. And while survivors' perceived availability to access help-seeking resources is examined (Lucea et al., 2013; Meyer, 2011), survivors' perceived ability to use those resources is lacking considerably. Likewise, the literature does not cover survivors' perceived abilities to complete help-seeking behaviors with or without the aid of social supporters or their perceived ability to acquire social supporters in the first place.

While much ground relevant to IMB constructs has been covered, only 16 of the 43 publications focused on African American (n = 7) and Hispanic (n = 9) women. Only two of those 16 studies consisted of near-equal samples of African American and Hispanic formal help-seeking women but did not perform comparisons (see El-Bassel et al., 2001; Gilbert, El-Bassel, Chang, Wu, & Roy, 2012). My study's focus on formal help-seeking similarities and differences

between African American and Hispanic survivors is relevant to their formal support providers, given that African American and Hispanic IPV survivors constitute the two main racial/ethnic groups seeking formal support from non-profit and government agencies in the study's geographic region. Given the literature's limited findings, it should not be presumed the two groups of survivors share identical experiences of help-seeking barriers and facilitators. For example, cultural differences as well as immigration status pose unique challenges for Hispanic women survivors of IPV but remain understudied (Bauer et al., 2000).

Further Explication of the Role of Social Support in IPV Help-Seeking

Social support sources, as described in the IPV literature, are of two forms: informal and formal (see Goodman et al., 2003; Gottlieb & Bergen, 2010; Krause et al., 2008; Liang et al., 2005; Rose et al., 2000; Sylaska & Edwards, 2014). Examples of informal sources typically include friends and family (see Goodman et al., 2003; Sylaska & Edwards, 2014). Examples of formal sources include clergy, medical professionals, mental health counselors, domestic violence shelters or programs, police, and the courts (Goodman et al., 2003). Key functions of social support are emotional support, informational support (which includes appraisal support), tangible support, and structural support. Emotional support consists of love, sympathy, and encouragement (Berkman, 2000; Levendosky et al., 2004; Schwarzer & Knoll, 2007; Thoits, 2011). Informal supporters are the typical sources of emotional support (Berkman, 2000). Informational support consists of advice, feedback (appraisal support), and information regarding available resources (Berkman, 2000; Schwarzer & Knoll, 2007; Thoits, 2011). Advice and guidance have also been termed practical support (Sylaska & Edwards, 2014). Informal and formal supporters are sources of informational support. Tangible support consists of practical aid, often for basic needs, i.e., food, housing, childcare, and financial assistance by informal and

formal supporters (Berkman, 2000; Schwarzer & Knoll, 2007; Thoits, 2011). Structural support consists of social network qualities, i.e., number of supporters (Levendosky et al., 2004), the pattern of social ties (Gottlieb & Bergen, 2010), social integration (Hlebec, Mrzel, & Kogovšek, 2009), and network density and interactions (Nurullah, 2012). Structural support therefore incorporates formal and informal supporters. Social support is measured as provided support, received support, or perceived support (see Gottlieb & Bergen, 2010; Nurullah, 2012; Schwarzer & Knoll, 2007; Uchino, Bowen, Carlisle, & Birmingham, 2012). Informal and formal supporters can be sources of provided, received, and perceived support. Provided support is the provision of support, but as assessed by the provider, not the receiver (Nurullah, 2012; Schwarzer & Knoll, 2007). Received support is the support one is aware of receiving and is assessed by the receiver, not the provider (Nurullah, 2012). Perceived support is a person's belief in the availability of support should she ever need to receive it (Gottlieb & Bergen, 2010; Hlebec et al., 2009; Schwarzer & Knoll, 2007). Perceived support is the most widely studied of the three due to its extensive association with health outcomes (Uchino et al., 2012).

IPV survivors who delay formal resource utilization may experience extended periods with little to no social support, because emotional and tangible support, offered through friends and family, may quickly become exhausted (Meyer, 2011). This can be particularly dangerous, as utilization of informal support may be a precursor to utilization of formal support. In fact, Fanslow and Robinson (2010) observed that just 6% of the IPV survivors they sampled disclosed exclusively to formal supporters. Studies have not, however, identified factors that may motivate survivors, specific to or regardless of race, to seek formal support sooner rather than later.

Hyman, Forte, Du Mont, Romans, and Cohen's (2009) cross-sectional study of disclosure to formal supporters by Canadian women observed minority women were significantly less

likely (p <. 03) than White women to use any social service. This difference, observed in their bivariate analysis, disappeared when the authors controlled for a range of variables that constitute the experiential differences between these groups. In other words, their logistic regression analysis confirmed that minority status, per se, does not account for the difference in resource utilization but rather the variance is owed to the differences in risk factors faced by minority women compared to those faced by White women, such as marital status, income, immigration status, and IPV severity.

African American and Hispanic IPV victims are reluctant to turn to formal sources of social support, including medical and mental health resources (see Stockman et al., 2015) with some indication that formal support utilization is lowest among Hispanic women compared to White and African American women (Lipsky et al., 2006). Consequently, minority women may wait until the violence becomes severe before turning to formal supporters. For this reason, it is presumed, physical injury is often associated with disclosure to formal supporters (Bent-Goodley, 2007; Sylaska & Edwards, 2014).

The direct relationship between social support and the functioning, safety, and health of IPV victims has been given serious attention in the IPV literature. Emotional support from informal supporters may help women overcome isolation, enhancing their likelihood of employing formal supporters in their efforts to overcome their abuse (Rose et al., 2000). Women with higher social support may experience less depression (Ridings et al., 2016). Social support, particularly appraisal support and tangible support, may make it more feasible for women to leave abusive relationships (Waldrop & Resick, 2004). Familial informal supporters may help protect women from experiencing IPV as well as protect those who have experienced IPV from more frequent abuse than those without such familial support (Wright, 2015). The links between

IPV and depression and anxiety may be mediated by social support for low SES African American women (M. D. Mitchell et al., 2006). Formal supporters may enhance the safety of IPV victims via dedicated advocacy (Liang et al., 2005). Both formal and informal sources of social support may protect women from ongoing abuse (Liang et al., 2005). Conversely, formal supporters may be failing IPV victims by not providing enough support for them to leave their abusive relationships (Barnett, 2001). Furthermore, a cross-sectional study of 1,152 IPV surviving women found significant protective associations between higher levels of social support and physical health, mental health, anxiety, depression, PTSD, and suicide attempts (Coker, Davis, et al., 2002).

Relationships between Social Support and Coping in IPV Help-Seeking

Social support also serves as a major coping resource (Lazarus & Folkman, 1984). As such, discussions of social support are not complete without attention to the role social support plays in coping with stressors introduced by injury, illness, or trauma. The Cognitive Theory of Stress and Coping (a.k.a. Transactional Stress Theory, a.k.a. Transactional Model of Stress and Coping) (Lazarus & Cohen, 1977; Lazarus & Folkman, 1984) provides a framework for understanding the relationship between stress and coping and how coping impacts individuals' decision-making and behaviors. Stress is relational: it is the outcome of the relationship between person and environment (Folkman, 1984). Coping involves the use of ever-changing strategies to manage stress (Folkman, Lazarus, Dunkel-Schetter, DeLongis, & Gruen, 1986). Stress is a person-environment defined relationship that the victim appraises as exceeding her personal resources (Folkman, 1984). Coping, then, is the process through which an individual employs strategies to manage intrapersonal, interpersonal, or other social-ecological demands that she appraises to be taxing or otherwise exceed her own resources (see Folkman et al., 1986). Coping

is determined by one's appraisal of a threat. If the appraiser believes she can change the threatening situation, she will engage in problem-focused coping. If she believes she cannot change conditions for the better, she will engage in emotion-focused coping (Lazarus, 1993, 2006). Potential benefits, not just risks, may be appraised.

Coping is assigned two main functions: regulating distress and addressing the problem causing the distress (Folkman, 1984). Whether victims choose to regulate their stress or address the problems causing stress depends on their coping style. Those with emotion-focused coping styles will employ stress regulation strategies, while those with problem-focused coping styles will employ problem-solving strategies. Emotion-focused coping strategies include altering one's cognitions of the problem to make it seem less threatening. A person who devalues what she would gain if she surmounted the problem, or compares her circumstances to others worse off, or who makes attempts to live with a situation she feels unable to alter is employing emotion-focused coping strategies (Folkman, 1984). Avoidance also constitutes emotion-focused coping, specifically avoiding the thought of the problem (Lazarus, 1993). Problem-focused coping addresses the posed threat with intent to prevent or overcome it. A person who develops an action plan and is dedicated to putting that plan in motion is employing problem-focused coping strategies (Folkman & Moskowitz, 2004).

Coping styles vary in terms and descriptions across the coping literature and in studies of IPV. Victims employing a problem-focused coping style use informal and formal supporters to attain support functions, such as tangible and informational support, to escape their abuse. Victims employing an emotion-focused coping style rely mainly on informal sources for emotional support (Liang et al., 2005) to cope with their ongoing abuse. Other studies (Iverson et al., 2013; Tobin, Holroyd, Reynolds, & Wigal, 1989) draw on the related coping styles of

engagement/disengagement coping. Engagement coping, similar to problem-focused coping, involves the use of cognitive strategies and social support to prevent or overcome IPV victimization. Disengagement coping, similar to emotion-focused coping, involves avoidance. Unlike emotion-focused coping, those employing disengagement coping strategies may withdraw from social support (Tobin et al., 1989).

IPV studies (Krause et al., 2008; Waldrop & Resick, 2004) draw on yet another related coping dichotomy: approach/avoidant coping. Approach coping, like problem-focused coping, involves problem solving and the use of social support (Holahan & Moos, 1987). Avoidant coping, similar to disengagement coping but also described as a form of emotion-focused coping (Krause et al., 2008), involves denial, avoidance, and wishful thinking (Holahan & Moos, 1987). Similarly, distancing (Folkman et al., 1986; Folkman & Moskowitz, 2004) is a strategy survivors may employ to avoid coping with their distress.

One's choice of coping strategies may be aided by social support, particularly appraisal support, per Rose et al.'s (2000) interpretation of Thoits (1986) work on psychological well-being. This coping assistance, as Thoits termed it, takes place directly through supporters' provision of advice, feedback, and direct intervention (tangible support functions best when received by a victim with a problem-focused coping style) and indirectly through compassion and understanding (emotional support best received by a victim with an emotion-focused coping style) (Thoits, 2011). Supporters may also help victims engage in reappraisal (Lazarus, 1993), reorienting victims' cognitions and behaviors towards problem-focused strategies. Furthermore, individuals believing assistance is available from friends and family if needed (perceived support) more frequently adopt a problem-focused coping style (Hinton & Earnest, 2010). In

their review of the literature, Waldrop & Resick (2004) found women survivors of IPV regard social support as a vital coping resource.

The relationship between coping and social support may be bidirectional. In their overview of longitudinal studies on victims of distress (not inclusive of IPV), Schwarzer & Knoll (2007) documented a substantial literature (see, for example, Klauer & Winkeler, 2002; Manne, Winkel, Ostroff, Grana, & Fox, 2005; Schulz & Schwarzer, 2004; Silver, Wortman, & Crofton, 1990) supporting the hypothesis that social support and coping influence each other. As the reviewers explain, appraisal relies partly on perceived social support. This point may be pertinent to secondary appraisal in IPV, in which victims appraise their resources to manage or overcome abuse.

Background on Other Behavioral Theories Used in the IPV Help-Seeking Literature

Several models and theories were assessed for their applicability to the aims of this study. Rather than attempt to prove no other model or theory can address my problem statement, I instead corroborated my choice of the IMB model by citing gaps in the literature I believe the model may address. Additionally, I considered the applicability of theories used in the IPV literature to address the gaps in the literature I identified. Following is a brief summary of other models and theories applied in the IPV help-seeking literature.

Sylaska and Edwards' (2014) conducted a review of 41 articles on IPV disclosure and help-seeking. According to their review, the Transtheoretical Model (TTM) (see Prochaska, DiClemente, & Norcross, 1992) emerged as one of three main theories extant in the literature. The ecological model and survivor theory constitute the two other emergent frameworks identified in their review. Studies employing TTM emphasize the process of disclosure and the difficult stages victims experience as they determine their approaches to escaping or living with

abuse. Indeed, victims' recognition of IPV as a problem—as aberrant and damaging behavior—is a legitimate concern, as evidenced in several studies examining the relationship between victims' perceptions of normative relationship behavior and their endurance of abuse (see Fanslow & Robinson, 2010; Lucea et al., 2013; Morrison et al., 2006).

Liang et al.'s (2005) three-stage model for IPV help-seeking—(1) recognition of a problem and definition of IPV as the problem, (2) decision to find help, and (3) choice of support provider—is strikingly similar to TTM's stages of change. For victims who believe abuse is a normal part of intimate relationships, a barrier between precontemplation (not included in Liang et al.'s model) and contemplation obviously exists (see Evans & Feder, 2014). The use of TTM helps identify this barrier and thereby inform intervention. TTM's focus on intrapersonal factors, such as the individual's cognitions regarding social and interpersonal norms, however, may be at odds with the interpersonal and social-ecological construction of norms. This contradiction in Liang et al.'s model is mitigated by Ullman's (2010) addition of social reactions to victims' disclosure. Ullman's model also built on Liang's framework to include additional intrapersonal level factors affecting IPV disclosure outcomes, notably substance abuse (Sylaska & Edwards, 2014). Another critical limitation of TTM is its linear structure. Goodman, Dutton, Weinfurt, and Cook (2003) cite the lack of empirical evidence to support the applicability of TTM's linear sequence in IPV. They find fault with the assumption that victims move from private to public help-seeking as they progress from facing to overcoming their abuse.

The social-ecological model's (McLeroy, Bibeau, Steckler, & Glanz, 1988) applicability to IPV is apparent. From an ecological perspective, factors across multiple levels conspire to affect the IPV disclosure process (Alaggia et al., 2012). Intrapersonal characteristics (e.g., coping skills), interpersonal factors (e.g. social support), organizational-level resources (e.g., domestic

violence services), and social factors (e.g., policies encouraging or discouraging abuse disclosure) may be combined to form a holistic picture of IPV help-seeking. This comprehensive view accommodates the study of IPV perpetration and victimization at multiple levels, including the co-occurrence of substance abuse (Gilbert et al., 2012). From a feminist perspective, the ecological model recognizes women as agents negotiating paths and assembling resources to cope with IPV (Riger, Raja, & Camacho, 2002). Moreover, interventions recognizing women as active agents who determine the meanings of their own lives may help counter male dominance (see El-Bassel et al., 2001; Kearney, 2001) and isolation (see Hinton & Earnest, 2010; Kocot & Goodman, 2003; Rose et al., 2000; Waldrop & Resick, 2004).

Gondolf and Fisher's (1988) survivor theory, the third of the three dominant theories in Sylaska and Edward's (2014) review of the IPV disclosure and help-seeking literature, casts women not as victims but as empowered survivors seeking help, disclosing abuse, and preventing further IPV perpetration. Informed by feminist theory, survivor theory enjoys significant empirical support (Sylaska & Edwards, 2014). For example, Gondolf and Fisher's (1988) survey of 6,612 IPV survivors residing in shelters and Bowker's (1984) survey of 136 IPV survivors residing in the community (meaning not in shelters) both found that the greater the severity of abuse, the more likely women were to undertake efforts to prevent their further abuse.

My literature review identified other theories used in the IPV literature. Social Cognitive Theory's (SCT) (Bandura, 1986) focus on self-efficacy foregrounds the importance and potential of victims' agency. SCT can be used to incorporate multiple ecological levels of determinants while emphasizing the roles of social support and coping in IPV victims' experiences. Benight and Bandura (2004) reviewed the literature on perceived self-efficacy in posttraumatic recovery. One cross-sectional study they cited (Lerner & Kennedy, 2000) observed how the relationship

between abusers' actions and survivors' intentions to leave and remain separated from their abusers was moderated by self-efficacy. The greater survivors' self-efficacy, the greater the likelihood survivors would remain separated from their abusers. In a non-randomized, quasi-experimental trial (C. C. Benight & Midboe, 2002), IPV victims receiving cognitive behavioral therapy to improve coping efficacy experienced reduced PTSD, whereas the standard treatment group experienced no PTSD abatement. Furthermore, Benight and Bandura (2004) draw a line from the beneficial effects of social support (e.g., reductions in stress, depression, and poor physical health) to enhanced self-efficacy. Benight and Bandura (2004) maintain that modeling of successful coping strategies by survivors' social supporters cause survivors to witness and then experience the benefits of constructive, adaptive coping and in turn experience enhanced self-efficacy. While SCT is inclusive of social support, the breadth of social support concepts are not fully encompassed by SCT.

Rationale for Using the IMB Model

The IMB model incorporates social support and key constructs from health behavior theories, i.e., SCT's self-efficacy, TRA/TPB's attitudes and subjective norms (recast as personal motivations and social motivations, respectively), and TRA/TPB's control beliefs and perceived power (reconfigured as objective abilities and perceived abilities). Like SCT, IMB may be used to incorporate multiple ecological levels of determinants. For example, information exists at multiple levels, inclusive of information disseminated through communities and organizations as well as information influenced by policies and policy changes.

The need to include distal barriers and facilitators in studies of IPV help-seeking is evident in gaps previously identified in the literature. Limited research exists on social and cultural factors affecting IPV help-seeking (Cummings, Gonzalez-Guarda, & Sandoval, 2013;

Spivak et al., 2014; Stockman et al., 2015). In their study of IPV's disproportionate health impacts on minority populations, Stockman et al., (2015) identified the lack of research on social and cultural factors associated with IPV prevention, intervention, and help-seeking behaviors. The authors call for researchers to investigate the roles of "social, cultural, structural, and political barriers," such as immigration, acculturation, historical racism, perceived discrimination, and medical mistrust, in IPV survivors' formal help-seeking. Cultural and social norms also have been identified as potential and under-investigated barriers to IPV help-seeking (Stockman et al., 2015). Gonzalez-Guarda and Sandoval (2013) found an absence of research on societal-level factors affecting Hispanic women's IPV risk, and the CDC concluded that community- and societal-level risk factors remain largely unknown for IPV survivors regardless of race (Spivak et al., 2014). This may not be surprising, given that violence studies as a whole tend to focus either on intrapersonal- or community-level factors at the expense of truly multi-level, social-ecological research (Lauritsen & Schaum, 2004). Societal level factors such as IPV services funding; public awareness; racial stereotyping; immigration policies; and racial disparities in arrest, incarceration, and loss of child custody rates may impact minority women's motivations to seek help and the barriers they perceive to seeking help. Shuman (2014) suggests religion and community norms might influence Hispanic women's help-seeking behaviors.

Perceived community norms and attitudes may contribute to some survivors' perceptions of abuse as normal (Barnett, 2001). Studies reviewed by Lucea et al. (2013) document survivors' perceptions of violence as normal and not a serious problem. In contrast, survivors who do recognize IPV as a serious problem are more likely to seek providers of informal and formal social support (Liang et al., 2005). Likewise policy-level factors, such as new deportation policies, may impact survivors' personal motivations and perceived abilities to seek help. Many

factors influencing IPV help-seeking are distal, structural barriers—survivors' fears of deportation (for themselves or their abuser) (Sugg, 2015) and child removal (Evans & Feder, 2014; Sugg, 2015), civil servant and medical professional indifference (Evans & Feder, 2014; Kearney, 2001), mistrust of the justice system (Marianne R. Yoshioka et al., 2003), food and housing insecurity (Sugg, 2015), lack of insurance (Lucea et al., 2013), and economic isolation and social class (Liang et al., 2005)—while others are sociocultural—religious beliefs (Kearney, 2001; Sugg, 2015) and community permissiveness of IPV (Lucea et al., 2013). Corroboration for IMB's use is evident throughout the literature. While I may be the first to use the IMB model in IPV help-seeking, attention to information, motivation, and behavioral skills is hardly novel—as demonstrated in the preceding review of the literature. The literature's attention to information, motivation, and behavioral skills (albeit not typically termed as such), highlights consensus among researchers as to relevant help-seeking factors and gaps requiring attention. What is not typical is putting these three highly common foci together in one study. I have only found four other studies that incorporated elements of all three constructs (see Alaggia et al., 2012; Barnett, 2001; Davis et al., 2001; Evans & Feder, 2014).

Choice of Qualitative Study Design

The 33 studies meeting my review's inclusion criteria (10 of the 43 were reviews) were near equal parts qualitative (n = 15) and quantitative (n = 14); the remaining four studies were mixed methods. While this tells us something about how the ground has been covered, further examination brings into question how well qualitative research to-date has investigated help-seeking for IPV. A large body of qualitative research exists on love in abusive relationships (see Kearney, 2001) but not on women's decisions to leave abusive relationships when they possess limited resources (Ridings et al., 2016). Another body of qualitative research exists on coping

(see Waldrop & Resick, 2004), but limited qualitative research exists on IPV survivors' help-seeking (Broadhurst, 2003; Liang et al., 2005; Rizo & Macy, 2011; Taft et al., 2009). Consequently, qualitative studies of help-seeking and, relatedly, resource utilization, lack a cohesive understanding of survivors' experiences (Ammar et al., 2005). Not surprisingly, this has led to a body of literature—particularly in the area of formal support help-seeking—with inconsistent methods and results. Even the conceptualization of help-seeking and disclosure as parts of a single process (see Sylaska & Edwards, 2014) may, upon further exploration, turn out to be a misconception.

Furthermore, the research purpose and aims are qualitative in nature, because women's voices need to be heard and understood (see Krefting, 1991) to inform future research and intervention designs. I explored the process of help-seeking from the survivors' perspectives (see Cohen & Crabtree, 2008) and their experiences with information, motivation, and behavioral skills to reveal differences in help-seeking facilitators and barriers between racial/ethnic groups. These aims are consistent with interpretivism (see Cohen & Crabtree, 2008; see Patton, 2002; see Rolfe, 2006) and my use of grounded theory methodology. Most significantly, I solicited thick description (see Starks & Brown Trinidad, 2007; see Tracy, 2010) of experiences during help-seeking. Thick description, or rich data (Charmaz, 2014), can help identify relevant factors that otherwise may go unnoticed. The relevance of uncovering relevant factors cannot be understated in the area of IPV help-seeking given the complexity of the phenomenon.

Lastly, qualitative methods are important to ascertaining the specifics of social and cultural influences. Uncovering this level of specificity requires immersive methods of research, data to differentiate the needs of survivors from different backgrounds who, even if living in the same societal context, may be differentially affected by policies and biases within that very same

society. Failing to capture the barriers and facilitators faced by different groups, particularly minority groups already underserved and disproportionately affected by IPV, risks failed recovery and prevention efforts (Bent-Goodley, 2007).

In order to inform intervention with further exploration of survivors' help-seeking needs, future studies of IPV help-seeking should focus on barriers and facilitators but dedicate more attention to facilitators; compare subgroups of minority women survivors on barriers and facilitators observed; and consider the how proximal, intermediate, and distal factors contribute to survivors' informational, motivational, and behavioral skills barriers and facilitators to IPV help-seeking.

Chapter 3: Methods

Purpose of the Study

The purpose of this study is to explore barriers and facilitators to help-seeking for formal support among IPV minority women survivors in the Mid-South of the United States. Since the purpose of this study is exploratory in nature, I used qualitative method to investigate the study's specific aims. I explored the process of help-seeking from the survivors' perspectives (see Cohen & Crabtree, 2008) and their experiences with information, motivation, and behavioral skills to reveal help-seeking facilitators and barriers. Most significantly, women's voices need to be heard and understood (see Krefting, 1991) to inform future research and to develop intervention designs. My intent was to collect thick description (see Starks & Brown Trinidad, 2007; see Tracy, 2010) of these women's experiences in the context of help-seeking. Thick description, or rich data (Charmaz, 2014), can help identify relevant variables, including potential confounders, mediators, and moderators—that otherwise may go unnoticed.

Rationale for Use of Grounded Theory

Several other qualitative approaches could have been used to reveal important information about IPV help-seeking. A phenomenological approach would have helped me delve into the essence (see "Phenomenology Online," n.d.) of help-seeking, revealing women's cognitions and emotions regarding their experiences and the meanings they assign to them. Ethnography and narrative inquiry could have provided thick descriptions of help-seeking experiences, contexts, and meanings (see Padgett, 2012). Grounded theory and phenomenology (as practiced in the social and behavioral sciences versus European philosophy) both create detailed explications of experiences, often accompanied by visual diagrams. A grounded theory and its visualization depict parts forming a whole—the empirically derived model.

Phenomenology, on the other hand, uses motifs and themes (e.g., Thomas et al., 2013) to create a series of detailed portraits culminating in a depiction of a phenomenon's "essence," rather than a theory, per se. My purpose, however, was to understand women's experiences of IPV help-seeking from formal supporters using the IMB constructs of information, motivation, and behavioral skills. My study, therefore, began with sensitizing concepts (Charmaz, 2014) derived from an extant model, an approach for which grounded theory was not initially designed but evolved to incorporate (Kelle, 2007). Consistent with grounded theory, my approach required the development of formal-theoretical categories, grounded in data but informed by theoretical sensitivity (IMB), to achieve a detailed and yet cohesive analysis and presentation of barriers and facilitators to formal support help-seeking.

Study Population and Participant Selection

The study population consisted of women 18 years of age and older who experienced one or more forms of intimate partner violence (IPV) and who were receiving one formal support (i.e., counseling, housing assistance, and legal aid) from Memphis, Tennessee non-profit and government agencies. These agencies included Kindred Place (formerly the Exchange Club Family Center), the Shelby County Crime Victims Center, the Family Safety Center, the YWCA, and Moriah House. Given the study's focus on minority women and the makeup of program participants, recruitment was limited to African American and Hispanic women with and without children, married and unmarried.

Inclusion criteria: The inclusion criteria for this study was female, 18 years of age and older, experienced one or more forms of intimate partner violence (IPV) (physical, sexual, and/or psychological), current client of one of five non-profit or local government counseling or support agencies in the Memphis, Tennessee metropolitan area, engaged in individual and/or group

counseling, abused by a male intimate partner, fluent English or Spanish speaker, and African American, Black, Hispanic, or Latina, inclusive of African, Caribbean, Spanish, Portuguese, or indigenous Central or South American ancestry. Participants may be mothers, women without children, married, or unmarried.

Exclusion criteria: The exclusion criteria included male, female in a same-sex relationship, female under the age of 18, non-exposed to IPV, non-participant in counseling services, fluent in neither English nor Spanish, and possessing neither African American nor Hispanic identity/race/ancestry. Women who clinicians screened as not capable of participating in group therapy and individual counseling (e.g., due to debilitating health, physical, mental, and cognitive or emotional limitations) were excluded, as were women who returned to their abuser or engaged in a new abusive relationship.

Sample Recruitment: Participants were recruited purposively over a nine-month period as clients meeting inclusion criteria progressed through counseling and support services at the recruiting facilities. I used discussions with survivors' clinicians to identify participants who met inclusion criteria but were not in crisis. This allowed me to access members of a protected population using purposeful sampling only. Clinicians were requested to serve as recruiters due to their rapport with clients. This rapport, I believe, helped prevent women from feeling pressured to participate in the study. Furthermore, the clinicians were in frequent contact with clients. Should a client no longer have met inclusion criteria due, for example, to a new crisis, the clinicians would be the first to know. Their familiarity with each client's present circumstances meant the clinicians would have the most current knowledge of each prospective participant's eligibility for the study when executing the recruiting protocol.

Two methods were used to recruit participants: face-to-face recruiting and phone recruiting. The procedure for face-to-face recruiting was as follows. Each prospective participant was approached individually, inside the agency's main building or satellite location, before or after a counseling session or receiving a support service. They each received a recruitment flyer and were read a recruiting script by the recruiter. During the script reading, the recruiters emphasized that the study was voluntary. The recruiting clinician then introduced those interested in the study to me. I then scheduled the participant for an interview. If the prospective participant had a child or children age five or older attending the children's program and needed childcare during the interview, I, with the mother's consent, scheduled childcare by a former service agency clinical intern. Recruiting flyers and scripts were produced in English and Spanish. Bilingual (Spanish and English) clinicians recruited women who primarily spoke Spanish. Monolingual (English only) clinicians recruited women who primarily spoke English. Bilingual clinicians also served as translators when I scheduled interviews and childcare with Spanish-speaking clients.

The procedure for phone recruiting was as follows. A clinician placed the call to the potential participants for this study using a number the client had provided on her intake form. The phone number was one the client identified as safe to call. If the client did not answer, the caller left a voice message stating only "This is (caller's name) at (caller's phone number)." Per the agency's use of preceding safety protocols, the IPV survivor would recognize the name but the abuser, if one was present, would not know who it was. Also, per previous safety planning with the client, the client would know to find a safe place and time to call back. If the client answered, the caller stated, "This is (caller's name). Is it safe to talk?" If the client said no, the caller ended the call. If the client said yes, the caller stated the purpose of the call and continued

with the recruiting script. If, after completing the phone recruiting script, the survivor did not agree to participate, the caller thanked her for her time and ended the call. If, after completing the phone recruiting script, the survivor agreed to participate, the caller scheduled the interview using an interview scheduling record. A separate script was used for phone recruiting due to the need for additional safety precautions. While safety from an abuser was self-evident during face-to-face recruiting on the facilities' premises, the safety of women on the other end of a phone line could not be assumed. I worked with agency clinicians to combine the content of the face-to-face recruiting script with the pre-existing safety protocols used by agency staff when phoning clients.

The phone script writing process involved careful consideration of various call scenarios. The resultant script included instructions for the recruiters and text to read aloud to prospective participants. The instructions guided the recruiter to the appropriate text to read if the call goes to voicemail, if a male answers, if a male refuses to hand the phone to the intended recipient, if a female answers, to confirm the intended client is speaking, to confirm if it is safe to talk and what to say if it is or is not, to confirm the client is no longer with the abuser and what to say of she is or is not, and to ascertain appointment time, language preference, childcare needs, and interviewer preference. Interviewer preference was added to inquire whether the potential participant was comfortable with the idea of a White male interviewer or if she preferred a female interviewer instead.

Open times for interviews were selected to meet specific safety and client care criteria. One provider, for example, serves offenders as well as survivors, providing anger management, relationship, and parenting courses to men charged with domestic abuse. Offender and victim services take place in the same building, albeit on different floors and at different hours. Since

the interviews were to take place in this same building, we allotted interview time periods that were outside one hour of the beginning and one hour of the ending of offender program meeting times. Additionally, we allotted interview time periods that coincided with clinical staff hours. While the interview guide was not intended to facilitate recall of abuse experiences, we nonetheless wanted to ensure the availability of clinical support should any participant exhibit signs of distress.

Recruiting methods (face-to-face and phone) and the selection of open times for interviews (interview scheduling record) were used to facilitate comparisons between African American survivors and Hispanic women IPV survivors by providing access to all eligible participants and balancing the sample on race/ethnicity. Specifically, I learned that the opportunity to recruit eligible participants would be compromised by the fact that some clients needed to leave immediately after their counseling sessions (the face-to-face recruiting window), because they worked night shifts. Consequently, this subset of eligible women who work night shifts would be excluded from the study, introducing bias, e.g., due to sampling frame. Using the phone, clinicians could recruit women they would not have time to recruit in person.

The extensive open time slots, availability of three interviewers, the use of several recruiters, and the nine-month period allotted to data collection were all intended to facilitate the recruitment of the targeted number of participants from each of the minority groups. To maintain the quality of relevant data, I wanted to recruit participants with hindsight but who were not so distant from their initial attempts to access formal help that recall bias would compromise their responses. I attempted, therefore, to recruit women when they reached four to six weeks of counseling. While I could not control what participants from different agencies learned in counseling, I believed recruiting during the first several weeks of counseling would help control

for differences in treatment exposure. This strategy provided enough time for women to become acclimated to their agency of choice and receive other, basic services but not so much time as to adversely impact their recall. Furthermore, I chose to recruit participants who received counseling prior to our interview to avoid recruiting IPV survivors in immediate crisis.

The literature survey identified 15 qualitative studies meeting our basic inclusion criteria of male-to-female IPV and formal and/or informal help-seeking by IPV survivors. Sample sizes ranged from nine to 75 with a median *N* of 29.5. We attempted to recruit 30 participants: 15 African American and 15 Hispanic. Our recruiting protocol stipulated that this number was subject to change, based on data required to cover all aspects of our study aims and reach theoretical saturation on all themes identified (Morse, 1991). I was able to recruit14 African American and 15 Hispanic IPV women participants for this study.

Sample Size Rationale

Sample size in grounded theory is typically determined by saturation (Charmaz, 2014; B. G. Glaser, 1978; Morse, 1991), or the point at which no new properties or themes emerge from the data to alter, augment, or otherwise qualify the theoretical categories that emerged through prior data coding. I observed significant repetition in participant accounts between the 10th and 12th interviews. I used the remaining two interviews with African American participants and the remaining three interviews with Hispanic participants to clarify emergent themes. Saturation is difficult to demonstrate and thus defend. It is also very tempting to site rules of thumb for sample size in qualitative research just as it easy to become overwhelmed by the number of differing opinions among experts regarding these rules of thumb. To manage the temptation and confusion, I employed a method that appears to incorporate the most relevant factors influencing qualitative study sample sizes. This rather new method is called information power (Malterud,

Siersma, & Guassora, 2015). Information power is determined by study aims, sample specificity, use of established theory, quality of dialogue, and analysis strategy (Malterud et al., 2015), which, when all assessed, provides a rough guide to sample size in qualitative research. For instance, my study aims limited the number of eligible participants to those who remained enrolled in formal support programs and services (e.g., 29 in 2018 for the region's largest non-profit IPV counseling provider). The reasoning goes that the fewer people eligible, the more they have in common; and the less variation among participants, the fewer number of participants available and required. Sample specificity created further commonalities among my participants, which drove down the number of participants required: I was looking at two specific groups. Within and between groups, participants were the same on gender and very similar on SES and types of IPV experienced, which consequently limited the likelihood participants would share wildly varying accounts. Additionally, I used an established model (IMB). The use of theories and models focuses the analysis down to specific constructs of interest. The more focused the analysis, the less searching, and therefore, the faster one can see emergent patterns and repetition of those patterns. Of course, the quality of the data collected is paramount. The quality of dialogue—the extent to which participants shared substantive information—owed partly to the rapport we established but likely more to participants' strong motivations to help other women by sharing their experiences. The richer each participants' content, the fewer participants needed to fill in the blanks. Finally, my analysis strategy involved comparisons, which necessarily required a larger sample. According to the criteria of information power, my study should not have required more than six to 10 participants per group. However, the information power method provides little guidance on exact sample size, which is why I also continued to use saturation as a guide to determine when I had reached a sufficient number of participants.

Procedures for Obtaining Informed Consent

The interviewer gave each participant the informed consent document prior to commencing the interview. Those who primarily spoke English received the English version, and those who primarily spoke Spanish received the Spanish version of the informed consent document. To protect participants' safety, they were given a separate copy of the informed consent document to take home that omitted all mention of the service agency and domestic violence. "Community center" replaced the agency's name and "health behavior" replaced "domestic violence." The participants were nonetheless read the original informed consent document—the version they signed (or declined to sign).

To avoid embarrassment or confusion due to literacy problems, the interviewer read aloud the informed consent document to the participant from one copy while the participant followed along with another copy. The interviewer read one section at a time and asked the participant if she had any questions. If so, the interviewer answered her questions before moving on to the next section. When the interviewer finished reading the entire document, he or she again asked the participant if she had any questions. In addition to answering any questions, the interviewer explained to the participant that she was free to pause or end the interview at any time. Additionally, the interviewer informed the participant that she could request that the audio recording of her interview be deleted at any time during the interview. If the participant did not consent, the interviewer thanked her and gave the $25 Kroger gift card and a receipt to sign documenting that she received the gift card. If the participant agreed to participate, she signed the interviewer's copy of the informed consent document. The interviewer then retrieved the participant's copy of the original informed consent document and gave her the blinded copy to

sign and take home. The interviewer then handed the participant the $25 Kroger gift card and a receipt to sign documenting that she received the gift card. The interviewer proceeded with the interview.

Twenty nine IPV-surviving women participated in semi-structured interviews conducted at one government agency location—a victims services center—and four non-profit agency locations, including a shelter, a year-long program and residency facility, a victims support services agency, and a victims and family counseling agency. Data obtained from one participant, who did not experience IPV, were excluded. Two African American survivors declined to participate while another four agreed but did not appear for their interviews. One Hispanic survivor declined to participate while another two did not appear for their interviews. Interpretation of data obtained from participant interviews was further informed by discussions with the participants' counselors and the PI's direct observations through assisting family counselors and attending weekly counseling debriefing sessions. Direct observations, used for source triangulation, were conducted once per week over 24 months. Attendance at weekly clinical debriefing sessions and frequent discussions with the participants' therapists provided further source triangulation.

Procedures to Maintain Data Security

Interview data were transferred from a digital audio recorder to a secure university server. For each interview, the audio recording was shared with a transcriber via a secure link. The transcriber returned the transcript via email, which the PI backed up to a secure university server. The transcript will remain on the server for a period not to exceed seven years. The transcriber was instructed to delete any backups or locally stored files of both the original audio recording and written transcription once all recordings were transcribed. Each transcript was imported into

NVivo version 11.2.1 (QSR International) for data analysis on the PI's laptop and backed up on a secure university server. The NVivo coding file and imported transcripts will remain on the PI's password protected university laptop for a period not to exceed three years and on the sever for a period not to exceed seven years, by which point the files will be permanently deleted.

Data Collection

The primary data collection method used for this study was a semi-structured interview lasting an average of 66 minutes (*SD* = 16). Shortly before each scheduled interview, the PI set up the audio recorders, gift card, gift card receipt, informed consent documents (researcher copy and participant copy), and interview guide in a private room inside the service agency. The PI met the participant and the translator (if needed) in the lobby and directed them both to the interview room. When participants required childcare, a former clinical intern accompanied the PI to the lobby to meet the participant and her child or children. The childcare provider informed the participant which playroom she and the child(ren) would be using and then escorted the child(ren) to the playroom while the interviewer escorted the participant to the interview room.

After administering informed consent and delivering the gift card, the interviewer began facilitating the interview using a semi-structured interview guide (please see Appendix B). The guide contained a brief demographic information section [age, marital status, number of children, education, race/ethnicity, living with (e.g., spouse, parents, friend), number of people in the home, number of weeks receiving services, and personal income], and 28 questions covering the IMB constructs of information, motivation, and behavioral skills.

Our interview guide was adapted from Smith's (2011) IMB-based semi-structured interview guide for HIV care utilization. Smith's guide asks questions regarding HIV treatment knowledge, treatment behavior, and treatment behavioral skills and structural barriers. Our

study's guide included questions regarding domestic violence formal support resource knowledge, formal support resource utilization motivation, and resource utilization behaviors and skills. In addition to the topic area differences, the structure of our guide deviates from Smith's in two ways. Smith used the situated IMB model (sIMB) (Amico, 2011). The sIMB model introduces structural barriers—a broad construct "situating" the other three constructs within "socio-cultural-environmental contexts," community and cultural norms, and access to trusted providers (Smith, Fisher, Cunningham, & Amico, 2012). Our study narrows the situating construct to community norms, focusing on community attitudes towards domestic violence and community attitudes towards formal help-seeking for domestic violence.

Instrument development and testing information regarding Smith's guide was neither found in the instrument's documentation (Smith, 2011), nor in the published study (Smith et al., 2012) for which it was designed. While validity testing typical of survey instruments is not applicable here, maintaining reliability, or dependability in the use of qualitative studies, usually involves pilot testing with subject matter experts as well as testers who share relevant study characteristics with the intended participants. This lack of assurance did not, however, deter us from using Smith's guide as a starting point in the development of our semi-structured interview guide. First, the participant groups and research contexts were substantively different: HIV+ men and women in the Bronx, NY, using clinical care services versus IPV surviving minority women in Memphis, TN, using agency-provided counseling. Even if we knew Smith's interview guide had been rigorously pilot tested and revised, we could not presume transferability to our participants and context. Second, prior to our study, the IMB model had not been used in IPV research. Employing Smith's guide as a starting point helped ensure we created a guide that utilized IMB constructs in the manner they were intended while extending their use to a new

study domain. Given that Smith collaborated with the IMB model's primary developers, Fisher and Amico, on the study (Smith, 2011) for which he developed his interview guide, we safely deemed his guide an expert-reviewed source. Third, our study questions posed both group and temporal comparisons, whereas Smith's study focused largely on the applicability of the IMB model to studies of HIV care utilization. Therefore, the difference in research aims necessitated significant changes in the content and structure of Smith's guide, which rendered the transferability of Smith's instrument moot and by extension any testing of his instrument to ensure dependability.

We added two more sections to the interview guide: demographics and interviewer assessment. The demographics section included the aforementioned items age, marital status, number of children, education, race/ethnicity, living with (e.g., spouse, parents, friend), number of people in the home, number of weeks receiving services, and personal income. While the presence of children became a particular item of concern during recruiting, as explained above, all of the demographic variables served to monitor our effort to purposively sample two groups similar in most demographic respects except for race/ethnicity. We also included this demographic information to help further contextualize participants' experiences and promote dependability and transferability. Lastly, we added interviewer instructions and question prompts to several of the items to better ensure we collected as much of the desired data as possible. The instructions and prompts also served to promote consistent interview facilitation across the three interviewers.

The interview guide was pilot tested with two of the PI's student peers: an African American female with a doctorate in public health and a Latina with a master's degree in public health. The pilot testers, while by no means expected to represent the local communities of

African American and Hispanic IPV survivors, possessed insights regarding the study population the White male PI lacked. The two pilot testers and I rehearsed an interview using the semi-structured interview guide. The Latina pilot tester identified a communication problem with the temporal ordering of the questions. To maintain the three-part IMB structure established in Smith's interview guide, I placed questions regarding time 1 and time 2 together in each construct's section. The Latina pilot tester explained that temporal switching is complicated in Spanish and is further compromised by the manner in which Hispanic/Latinx people relate stories. Consequently, it would be very difficult to interpret from the interview transcript whether the participant was sharing experiences that took place before help-seeking or during help-seeking. The guide was revised so that questions about information, motivation, and behavioral skills prior to formal help-seeking initiation were asked first and then repeated for the time period involving formal help-seeking.

The protected status of our participant pool dissuaded us from inviting IPV survivors to participate in pilot testing. Given the burdens they were already facing, we felt we could not ethically justify using their time for anything short of data collection. English and Spanish versions of the interview guide were, however, shared with clinicians who also were selected to serve as participant recruiters. The clinicians offered feedback on the recruiting materials and informed consent document, but they did not offer input on the interview guide. This was most likely due to the clinicians' demanding work schedules.

Interviewers with prior experience in qualitative research and interview facilitation were trained during a one-hour session. The session began by orienting the interviewers to the study context. The PI provided the interviewers with an orientation manual. The PI based the orientation manual on his experience as a victims services volunteer. The orientation focused on

safety, protocols for arriving and departing, and instructions for escorting out participants. The training continued with the informed consent and interview protocols described above. A section of the orientation manual was reserved for specifying signs of participant distress and what to do in case a participant were to exhibit one or more of these signs. Interviewers were instructed to watch for signs of agitation, defensiveness, and sadness. Mild sadness was a risk declared in the IRB-approved protocol. I directed the interviewers to pause an interview if the participant exhibited moderate or greater agitation, defensiveness, or sadness. Potential scenarios and appropriate responses were reviewed, including when to contact an on-duty clinician for intervention. As stated above, interviews were scheduled to coincide with clinician availability. No participant rejected an interview with the male PI nor stated a preference for a female interviewer. Consequently, I conducted all interviews. English interviews were conducted one-on-one, and Spanish interviews were conducted with the aid of a certified medical translator.

Data Organization and Analysis

I used Charmaz's (2014) constructivist reconceptualization of Glaser's (1978, 1992, 1998, 2005) positivist approach to grounded theory methodology. I proceeded from initial coding using "initial" codes to "focused coding" to form the study's "substantive theory" of IPV help-seeking. Initial coding was conducted inductively, line-by-line. The study instrument used to acquire the data was, however, based on research aims derived from sensitizing concepts (Blumer, 1954). Those sensitizing concepts were drawn from the IMB model. While strict interpreters of grounded theory methodology insist researchers approach their topic as a *tabula rasa*, sensitizing concepts from one's field are indeed used to inform research questions in qualitative research using grounded theory methodology (Bowen, 2006; Charmaz, 2014). My data collection instrument, the semi-structured interview guide, was designed to gather data

needed to address the specific aims of the study. Consequently, my initial coding reflects the earlier use of sensitizing concepts. The sensitizing concepts were quite broad and did not preclude the emergence of new or unexpected codes. Therefore, I was able to maintain an inductive approach to data analysis.

The most salient initial codes were chosen as focused codes. Determinations of salience were based on the conceptual significance and frequency of the initial codes (Charmaz, 2014, p. 113). To identify conceptual significance, I employed the constant comparative method (Barney G. Glaser & Strauss, 1967), which involves comparing data to data, codes to data, and categories to codes to identify similarities, differences, and patterns in the data (Bowen, 2006). Memos (Charmaz, 2014, p. 140; B. G. Glaser, 1998) were used to record our constant comparative observations, tentative explanations, and coding decisions made during initial and focused coding. I used the focused codes to sort and synthesize (Charmaz, 2014, p. 138) the initial codes. Focused coding resulted in substantive categorical codes (Charmaz, 2014, p. 150), which provided a theoretical level of abstraction still grounded in the data (Ng & Hase, 2008).

I then examined relationships between the substantive codes (Charmaz, 2014, p. 150) using theoretical sensitivity—or the use of extant concepts—to guide our examination of the relationships between the substantive codes, as advocated by Glaser (1978) and Charmaz (2014). I did not, however, employ Glaser's coding families or Charmaz's symbolic interactionism. Our process was once again guided by concepts derived from the IMB model (information, motivation, and behavioral skills). The use of concepts from extant theories in grounded theory coding has gained convincing support (see, for example, Bowen, 2006; Goldkuhl & Cronholm, 2010; Kelle, 2007). The requirements are to not force the data to fit the concepts (Charmaz,

2014; Kelle, 2007) or to choose concepts that are so laden with theoretical knowledge as to preclude their use in inductive analyses (Kelle, 2007).

Consistent with conventional grounded theory, I continued to apply the constant comparative method to assess the fit between my theoretical codes and the data—or the extent to which my categories and their properties accounted for variation within the data. Theoretical sensitivity, guided by my choice of extant theory, helped me identify weaknesses and gaps in my theoretical coding during constant comparison. Theoretical saturation was reached when no new data emerged from subsequent transcripts, or participant responses simply became repetitive of earlier responses (Bowen, 2006; Charmaz, 2014).

While I did attempt to extend the IMB model into a new area of study—IPV—I did not use operationalizations of IMB constructs (i.e., information, motivation, and behavioral skills) to establish a priori codes. Nor did I begin with predictions regarding IMB variables or relationships between these variables. Rather, I allowed patterns in participant responses (explicit and implicit) to generate the codes and determine the relationships between codes and between codes and categories/themes. I did, of course, hope to learn how information, motivation, and behavioral skills (facilitated or inhibited) IPV survivors' help-seeking experiences.

To avoid forcing the data to conform to my a priori focus on facilitators and barriers, additional codes were added, where applicable during this process of initial coding. These additional codes were actively sought so as not to preclude new insights or stifle inductive analysis. I used memos throughout initial and focused code to create code notes and theory notes (Strauss & Corbin, 1990). Code notes documented my thinking on emergent topics and recorded differences I noticed in emergent topics between participant groups. These memos constituted my decision tree. Theory notes documented my ideas and decisions regarding between group

comparisons. During focused coding, I revised, eliminated, and merged codes under new headings as I developed themes from patterns in the data, with particular attention to latent meanings (see Charmaz, 2006, 2014; Padgett, 2012). I used discussions with participants' counselors to augment my efforts to seek out and consider disconfirming cases that challenged my interpretations.

Researcher's Involvement

Beginning in May of 2017, and for several months prior to initiating this research, I served as a volunteer staff member at Kindred Place (formerly the Exchange Club Family Center)—the site providing the greatest number of participants. I assisted with the Children's Domestic Violence (CDV) program once per week, participating in the CDV group session with the children as the clinician and clinical interns administered the program curriculum. I also interacted with the children during an open play period following their group session while the clinicians spoke with the children's mothers. The mothers became acquainted with me as one of the people working with their children. I also engaged children in art activities during new client intake each week. Consequently, I was one of the first people new clients saw. Additionally, I participated in weekly debriefing sessions with clinical staff, mainly listening as staff shared pertinent information regarding how each client family's circumstances and challenges affected their abuse recovery.

Ensuring Rigor

Guba's (1981) trustworthiness criteria for qualitative research parallel the criteria for scientific rigor found in quantitative research. Lincoln and Guba (1985) further refined Guba's trustworthiness criteria: credibility, transferability, dependability, and confirmability. My use of these criteria for promoting validity and reliability in qualitative research extend logically from

my study's grounding in constructivism (see Gergen, 1999). I explain my use of each criterion, as follows.

Credibility (Krefting, 1991; Lincoln & Guba, 1985) is akin to internal validity. Credibility, however, is assessed by how fully the researcher represents the multiple realities shared by study participants (see Cohen & Crabtree, 2008). In other words, assessments of credibility ask whether the results are trustworthy interpretations of the observations. Several techniques may be used to promote credibility (see Hsieh & Shannon, 2005; Krefting, 1991). I used prolonged engagement, mitigation of social desirability bias, bracketing, journaling, and memoing to promote credibility. *Prolonged engagement* (Lincoln & Guba, 1985) took place over a 21-month period: May 2017 through February 2019. *Mitigation of social desirability bias* (see Kirk & Miller, 1986) was accomplished by ensuring potential participants that the study was voluntary, using recruiters with established rapport, providing participants the incentive prior to commencing the interview, stating—orally and in writing—our assurances of confidentiality (including the option to stop the interview and delete the audio recordings), detailing the privacy and confidentiality protocols, reiterating my role as a researcher operating independently of any service agencies from which they may be seeking assistance, and offering each participant the choice to be interviewed by me (a White male), an African American woman, or a Latina woman.

Bracketing (Giorgi, 1985)—or the effort to uncover, acknowledge, and set aside one's biases—is commonly associated with phenomenology (Giorgi, 1985; Padgett, 2012; "Phenomenology Online," n.d.). Qualitative methods are not, however, mutually exclusive. I decided to include bracketing, given the gender and racial/ethnic differences between the participants and myself. My approach follows. Rather than begin with my adult biases, I first

engaged in recalling childhood experiences. This use of recollection, termed reflexivity (see Aamodt, 1982; Agar, 1986; Krefting, 1991; Ruby, 1980), closed the distance between the participants' current life circumstances and my own. These recollections were recorded in a private journal. The bracketing process proceeded with reflections on race, ethnicity, and gender to assess potential biases accumulated outside of the aforementioned experiences. These reflections were added to my private journal, where they were repeatedly reviewed throughout the data gathering and analysis stages as a consistent "bias check." Additionally, prolonged engagement served as a form of continuing education regarding the lives and challenges of women and families affected by IPV. Working directly with affected children and attending clinical debriefing sessions each week for two years familiarized me with the life circumstances and challenges faced by IPV survivors. The clinicians' suspension of judgment served as a useful exemplar of bracketing, which I adopted.

A *field journal* (Krefting, 1991; Lincoln & Guba, 1985) was maintained to promote the "auditability" of the study, a further means to promote credibility. The field journal for this study actually consists of multiple records documenting logistics, methodological decisions, and data collection experiences. Scheduling and logistics were documented using an interview scheduling record. A log of decisions regarding methods and their justifications can be found in this study's IRB documentation. I promptly recorded an assessment for each participant interview. The interviewer assessment instrument is included with the semi-structured interview guide in Appendix B.

Memos (Cutcliffe, 2003; Starks & Brown Trinidad, 2007) were used extensively throughout all stages of coding to capture both nascent and refined observations pertinent to theory development. Memos were also used to develop a decision tree, which documented

identification of emergent codes (initial coding), categories (focused coding), and themes (theoretical coding). Memos recorded the my use of and adherence to the constant comparative method, capturing insights and connections in real time as the inductive analysis process moved from the literal and specific to the abstract and general.

Peer examination (Krefting, 1991; Lincoln & Guba, 1985) involved periodic meetings, or debriefing sessions, between the participants' counselors and myself. Debriefing sessions investigated confirming and disconfirming cases and reviewed new insights and problems. Feedback from these debriefing sessions were recorded in memos and used to revise the coding scheme and/or coded selections.

Quality assurance (see, for example, El-Bassel et al., 2001) of transcripts was conducted as follows: Professional transcriptionists provided English transcripts of the English and Spanish audio recordings. I checked English-to-English transcripts against the original audio and corrected errors and omissions directly on the transcript using Microsoft Word. Corrected English-to-English transcripts were imported into NVivo for coding. A bilingual medical translator with certification from the University of Memphis School of Public Health checked Spanish-to-English transcripts against the original audio. The medical translator noted errors, omissions, and inconsistencies using track changes in Microsoft Word. The translator explained any inconsistencies in meaning to me and provided cultural context where participants employed idiomatic expressions. I accepted the track changes and imported the final transcripts into NVivo for coding.

Member checking (Cohen & Crabtree, 2008; Krefting, 1991; Lincoln & Guba, 1985), had it been practicable, would have aided the credibility of my interpretations of participant responses. The lack of member checking is a limitation to this study's credibility. I was unable to

employ member checking largely due to logistical reasons. Follow-up with this population is difficult due to frequent changes of address and phone number. Additionally, follow-up would have required the same safety protocols and extensive human resource and time allocations described in the phone recruiting protocol. These factors made it likely that I would only be able to reach a few participants for follow-up. Given that member checking involves the review of many participant responses combined into an overall "picture," I did not believe I could reach enough participants for follow-up to effect meaningful member checking (see Morse, Barrett, Mayan, Olson, & Spiers, 2002; see Sandelowski, 1986). With only a few member checks to go on, I would lack sufficient feedback to know whether participants truly did or did not recognize themselves in the overall picture formed by my syntheses of the data.

Transferability (Krefting, 1991; Lincoln & Guba, 1985) is akin to external validity. Transferability, however, is assessed by the applicability of the study's findings to contexts similar to the study context. Highly descriptive information regarding the study context is essential to determining this "goodness of fit." The context for this study is the network of non-profit and governmental service agencies in Memphis, Tennessee. Additionally, the results chapter includes demographic information about the participants, duration of received formal support, type of support received, length of abuse, last experience of abuse, types of abuse experienced, and other related variables.

Dependability (Krefting, 1991; Lincoln & Guba, 1985) is akin to reliability and is as equally concerned with repeatability as its quantitative parallel. Dependability can be assessed by how plausibly the same results would occur again with the same participants or within the same or similar context. I employed detailed descriptions of methods and protocols (documented in this chapter) (see Kielhofner, 1982), an audit trail (see Sandelowski, 1986; see Streubert &

Carpenter, 1995), peer review of the research plan, and tools and protocols to promote consistency. With respect to peer review, agency clinicians informed the research plan during months of discussions, focusing largely on feasibility, safety, and IPV survivor needs. Four PhDs from the social and behavioral sciences reviewed the research plan during a dissertation proposal defense. The committee chair reviewed the research plan again before the protocol was submitted to the University of Memphis IRB. The IRB reviewed and then approved the protocol. Consistency (Guba, 1981) was promoted with documentation of explicit inclusion and exclusion criteria; a step-by-step recruiting protocol, including scripts and a flyer; a semi-structured interview guide with prompts; recruiter and interviewer training; a data handling plan; and a data analysis plan. This rigorous detail will permit the transference of the study to other, similar sites, where the reproducibility of the results can be tested.

Confirmability (Krefting, 1991; Lincoln & Guba, 1985) is akin to neutrality. Confirmability, however, emphasizes the neutrality of the data, not the neutrality of the researcher. The neutrality of the researcher was previously addressed by the credibility criterion, specifically bracketing. The neutrality of the data was promoted through adherence to rigorous protocols, which, in turn, promoted adherence to rigorous methods. Several aforementioned materials and protocols are used to promote confirmability. Peer debriefing (for reviews of subsequent coding); interview scheduling record, interviewer assessments, and memos (for maintaining process notes); the study proposal (for documenting the problem statement, purpose, aims, and significance); and the interview guide (for data collection) promote confirmability by providing an external auditor (Guba, 1981) with the information required to judge the neutrality of the data and, by extension, the plausibility of reaching the same conclusions with that same data.

Guidelines for Presenting Qualitative Research

The format and content of this dissertation provide evidence to support adherence to two widely accepted sets of guidelines for rigor in conducting and reporting qualitative research: the Relevance-Appropriateness-Transparency (RATS) guidelines (Clark, 2003) and the Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist (Tong, Sainsbury, & Craig, 2007). RATS focuses on the relevance of the research question(s), the appropriateness of qualitative methods to the study aims, the transparency of study methods (sampling, recruiting, data collection, role of the researcher, and ethics), and the soundness of the study's interpretive approach as evidenced in the data analysis and discussion. With the exception of results and discussion, which I turn to next, the preceding chapters provide content to address all of the RATS criteria. COREQ's emphases are similar to RATS, but strictly codified in the form of a 32-item checklist. The checklist is broken down into three domains: (1) research team and reflexivity, (2) study design, and (3) analysis and findings. For reasons previously stated, two COREQ items pertaining to member checking could not be met. Aside from these few caveats, the preceding and subsequent chapters and appendices provide details and evidence to satisfy the COREQ checklist. I chose both RATS and COREQ in order to ensure rigor as well as sufficient content to address various publishers' preferences.

Chapter 4: Results

Introduction to the Results

This chapter is organized into three sections. Section A covers sample characteristics; Section B focuses on themes pertinent to Aim 1: To explore similarities and differences in barriers to formal support help-seeking between African American and Hispanic IPV women survivors; and Section C focuses on themes pertinent to Aim 2: To explore similarities and differences in facilitators to formal support help-seeking between African American and Hispanic IPV women survivors.

Section A: Sample Characteristics

Twenty-nine IPV surviving women were interviewed. Fourteen participants were African American, and 15 participants were Hispanic. African American participants were predominantly from the Memphis, Tennessee MSRA and Mississippi and spoke English. Hispanic participants were immigrants to the US from Mexico, El Salvador, and Guatemala and spoke Spanish. Participants' mean age was 38.9 years (*SD* = 7.4), had an average 3.1 children (*SD* = 1.7), and 3.6 individuals (*SD* = 1.5) in the household. Just over half (51.7%) the participants earned less than $15K per year (Table 1). Twenty-six participants (90%) were single, separated, or divorced. At the time of the interview, half of the African American participants were living in a shelter, while no Hispanic participants were living in a shelter. In fact, no Hispanic IPV survivors were living in the region's two main shelters during the study's nine-month recruiting period.

Participant groups were similar on length of abuse and trauma, and experience of psychological and emotional abuse as well as physical abuse. Small differences in recentness of abuse and IPV perpetration by a substance-abusing partner were observed. Reports of sexual abuse were markedly different between groups, with two African American participants versus

12 Hispanic participants disclosing sexual abuse. Details of abuses suffered were outside the scope of this study. Generally speaking, physical abuse disclosed by participants included punching, choking, hair pulling, slapping, grabbing, and pushing. Sexual abuse primarily involved rape, emotionally or threateningly coerced and physically forced. Psychological and emotional abuse were coded as inclusive of threats (including threats to kill or take away children), isolation, false imprisonment, constant monitoring, "gaslighting," verbal denigration, lying and deceit, physical and virtual stalking, financial abuse, severe emotional neglect, and sex outside of the marriage or partnership ("cheating"). Participants' abuse sequelae mainly consisted of anxiety, depression, and PTSD. One African American participant and one Hispanic participant reported hospitalization due to injury and stress, respectively. Participants also reported problems sleeping. Hunger was comorbid with IPV for one African American participant and one Hispanic participant.

The majority of participants in both groups discussed experiences with their only or most recent abuser. The majority of African American (n = 11) and Hispanic (n = 13) participants were abused by substance abusers. Participants reported the majority of their substance-abusing perpetrators used a combination of alcohol and illegal drugs. More Hispanic participants (n = 5) than African American participants (n = 2) discussed IPV experiences involving more than one perpetrator. No participant disclosed IPV by more than two perpetrators. The majority (67%) of Hispanic participants experienced IPV in their countries of origin and the US; two survivors did not report location and three survivors experienced IPV in the US only.

African American and Hispanic participants were involved in counseling for nearly equal lengths of time, on average: 2.7 months (SD = 1.5). Participant groups were also similar on forms of counseling used. Participants received counseling from licensed therapists, social

workers, and caseworkers. Differences did exist between groups in counselors' qualifications. All Hispanic participants accessed licensed therapists while just 36% of African American participants accessed licensed therapists.

Table 1: Characteristics of the study sample ($N = 29$)

	Total Sample ($N = 29$) No. (%)	African American ($n = 14$) No. (%)	Hispanic ($n = 15$) No. (%)
Age, mean (SD)	38.9 (7.4)	37.9 (8.6)	39.8 (6.2)
Children, mean (SD)	3.1 (1.7)	2.8 (1.9)	3.3 (1.5)
Living situation			
In shelter or residential program	7 (24.1)	7 (50)	--
With family or friends	5 (17.2)	1 (7.1)	4 (26.7)
With non-abusing spouse or partner	4 (13.8)	--	4 (26.7)
Independently	13 (44.8)	6 (42.9)	7 (46.7)
People in household (when not in shelter), mean (SD)	3.6 (1.5)	3.3 (1.6)	3.9 (1.4)
Marital status			
Single, separated, or divorced	26 (89.7)	14 (100)	12 (80)
Married	3 (10.3)	--	3 (20)
Education completed			
< Grade school	6 (20.7)	--	6 (40)
> Grade school < high school	6 (20.7)	--	6 (40)
> High school < college	14 (48.3)	11 (78.6)	3 (20)
College (bachelor's)	2 (6.9)	2 (14.3)	--
College (master's)	1 (3.4)	1 (7.1)	
Income			
< $15K	15 (51.7)	6 (42.9)	9 (60)
> $15K < $25K	7 (24.1)	3 (21.4)	4 (26.7)
> $25K < $50K	7 (24.1)	5 (35.7)	2 (13.3)
Counseling (at time of interview)			
IPV individual counseling	10 (34.5)	5 (35.7)	5 (33.3)
IPV group counseling	15 (51.7)	5 (35.7)	10 (66.7)
Both group & individual	3 (10.3)	3 (21.4)	--
Other*	1 (3.4)	1 (7.1)	--
Counseling length, months, mean (SD)	2.7 (1.5)	2.7 (1.7)	2.7 (1.3)
Length of abuse, years, median (range)‡	5 (13.2)	5 (13.2)	7.5 (12.5)
Last experience of abuse (No. months prior to interview), median (range)§	6.75 (215)	7 (119)	5.75 (213)
Abused by substance abusing perpetrator(s)	24 (82.8)	11 (78.6)	13 (87)
Type of abuse			
Psychological & emotional†	29 (100)	14 (100)	15 (100)
Physical	27 (93.1)	13 (92.9)	14 (93)
Sexual	15 (51.7)	3 (21.4)	12 (80)

* Participant received legal and housing assistance but not counseling.

‡ Three African American participants did not or were unable to report length of abuse, while five Hispanic participants did not or were unable to report length of abuse.

§ One African American participant did not report last experience of abuse, while five Hispanic participants did not report last experience of abuse.

† Inclusive of verbal abuse, financial abuse, isolation, and stalking.

Section B: Barriers to Formal Help-Seeking

The 12 themes emerged in relation to barriers to formal help-seeking and are organized under three categories, or formal theoretical constructs derived from the IMB model: informational barriers, motivational barriers, and behavioral skills barriers (Table 2)

Table 2: Formal help-seeking barriers

Barriers by formal theoretical categories	Themes	Description
Informational barriers	Lacking knowledge about IPV and IPV help-seeking	Lacking fundamental (or basic) knowledge regarding forms of IPV—including whether those forms were understood to be abusive—and help available for survivors
	Receiving advice from informal supporters not to seek help	Misinformation and/or ill-informed opinions received from friends, family, or other informal supporters
	Coming across little information	Finding little information distributed in or broadcast to one's surroundings
Motivational barriers	Feeling like being in a hole	Feeling unmotivated to escape one's abuser due to depression
	Still loving the partner	Feeling personally motivated to remain with one's abuser out of love
	Avoiding judgment	Keeping abuse private to avoid censure and/or mocking from friends, family, neighbors, or church members
	Experiencing abuse as the norm	Complying with socio-cultural and/or community norms and attitudes regarding male to female IPV, women's roles, and marriage
	Protecting herself and others from the abuser and the authorities	Keeping abuse private to avoid retribution from one's abuser or feared consequences from authorities, i.e., DCS or ICE
	Lacking confidence in others for help	Believing formal support will be withheld or ineffective
Behavioral skills barriers	Being trapped without resources to escape	Feeling unable to enact help-seeking abilities, due to isolation, monitoring, and childcare obligations
	Taxing the support system	Asking informal supporters repeatedly for help without making meaningful changes, resulting in informal supporters becoming frustrated and pulling away
	Receiving little or unhelpful support from formal supporters	Having one's calls for help dismissed or misunderstood

Informational Barriers

Participants conveyed they lacked relevant knowledge or specific facts about IPV (e.g., initially knowing that what they were experiencing was abusive), and they disclosed they lacked knowledge regarding formal support resources (e.g., knowing that legal and counseling support

were available). The IPV knowledge participants and their informal supporters possessed appeared to be influenced by socio-cultural, community, and family beliefs. These beliefs constituted simple rules to guide decisions (heuristics) as well as more complex conceptions of both IPV and formal supporters (implicit theories), both of which seemed to inhibit or delay some participants' formal help-seeking. African American and Hispanic participants also reported an absence of public awareness information about IPV or IPV services in their communities, which they partly attributed to delayed formal help-seeking.

Given the bidirectional association between motivation and information in the IMB model, cases where motivation served to inhibit acquisition of help-seeking information are discussed here under informational barriers.

Lacking knowledge about IPV and IPV help-seeking

Both African American and Hispanic participants reported not recognizing IPV as abuse, specifically emotional and psychological abuse, prior to entering counseling. Consequently, participants reported delaying formal help-seeking until either their physical abuse became extremely severe, their depression became severely debilitating, or both. Lacking relevant knowledge regarding formal support resources emerged as the most common barrier to help-seeking for both African American and Hispanic participants either living with an abuser or living alone with IPV sequelae, specifically depression and PTSD:

> *I thought that there was no help at all. I really felt like there was no sort of help, just nothing. Just call the police, wait for him to get back out. That was basically our help, that's what I thought. I had no idea.* [African American participant AB232]

Furthermore, members of both groups explained they did not know how to seek help to either escape their abusive relationships or address their emotional and psychological needs:

> *The only thing that I know that I can do is call the police, and like they going to take him away, but I didn't even know that there were agencies that help women after, or during that process.* [Hispanic participant HL352]

Participants inferred their lack of relevant knowledge and specific facts regarding formal support resources and how to access those resources inhibited them from engaging in formal help-seeking. Some women reported delaying formal help-seeking for 10 years or more.

Receiving advice from informal supporters not to seek help

Some participants from both groups stated they received advice not to seek help—to remain with their abusers—from some family members and friends. Receipt of such advice left some survivors feeling trapped:

> *[My friends] always say, "No, you have your children. …Those who suffer are the children." And that, there it is crushed again. Putting up with more.* [Hispanic participant HL256]

A few African American Hispanic participants were told to keep quiet about their abuse to avoid embarrassment. Two Hispanic women were told the preservation of marriage took precedence over their IPV, while African American participants were made to feel abnormal during periods they chose not have an intimate male partner in their lives. Participants inferred that such social pressures and cultural mores, communicated to them as simple rules to guide decisions (heuristics), delayed their formal help-seeking. The receipt of advice not to seek help also narrowed the number of informal supporters upon whom participants felt they could rely for informational support.

Some participants received impractical advice, e.g., to "just leave" or not "allow it." Two participants inferred such comments were aggravatingly naïve in their lack of basic knowledge about IPV. Additionally, these participants stated the purveyors of this advice offered no tangible support to help them leave, further adding to their aggravation.

Coming across little information

Participants of both groups noted seeing little to no advertising of IPV formal support agencies, programs, or services in the community:

> *...Like I said, a lot of women don't know what help is out there at all. I didn't know, you always see things about drugs or alcohol, getting help with those things, but...* [African American participant AB232]
>
> *...But the truth is all women don't know there's such a place like this. There are no ads, I think, I don't know what it is.* [Hispanic participant HL414]

African American participants suggested positioning promotional campaign materials, e.g., posters, with specific facts about IPV at sites women visit to meet basic needs, including clothes closets, food pantries, and the local SNAP office. African American participants mentioned seeing a lot of information for homeless services but nothing for women experiencing IPV, so they suggested placing IPV services ads wherever homeless services ads are already located. Additionally. Hispanic participants suggested educating families about IPV and related services through churches and schools. Hispanic participants also recommended distributing help-seeking information through websites, newspapers, and social media.

Participant responses, in general, indicated frustration with the absence of relevant knowledge in their communities, most conveying that if they had seen awareness materials they would have sought formal help sooner. Consequently, participants were eager to share

suggestions for more effective dissemination of information, e.g., via websites. African American participants suggested placing information around bus exteriors, at clothes and food pantries, in human resource departments and SNAP offices, and on television. Hispanic participants suggested placing information in churches, social media posts, and newspapers. One Hispanic participant suggested implementing a school-based IPV education program.

Motivational Barriers

Participants discussed personal motivations and social motivations to avoid or delay formal help-seeking. IPV and IPV comorbidities (e.g., anxiety, depression, hunger) as well as consequent PTSD were commonly reported personal motivational barriers. Protective responses to threats also inhibited and delayed participants' personal motivations to confide in informal supporters or seek help from formal supporters. Fear of judgment as well as family and community abuse normalization negatively impacted participants' social motivations to seek help, as they perceived informal supporters were likely to mock them or think they were weak.

Feeling like being in a hole

Prior to formal help-seeking, African American and Hispanic participants described feeling unmotivated to seek the help they needed, with statements indicating they lacked personal motivation due to depression, confusion, and feeling sick:

> *Mentally, I wasn't there. I was there physically, but like – I was just – I was depressed. Wouldn't do anything but go to work.* [African American participant AB306]
>
> *For a year I had already been feeling very bad, that I only wanted to sleep, I didn't want to go out. I was very depressed.* [Hispanic participant HL430]

Participants also stated they were unable to think clearly and felt overwhelmed. Hispanic participants reported being depressed more so than African American participants and described the debilitating, sometimes immobilizing, effects of depression. Few African American participants mentioned depression. Financial dependence seemed the greater concern for African American participants, and this concern was also prevalent among Hispanic participants. Both groups reported insufficient funds to leave their abusers, with housing emerging as the primary concern affecting participants' personal motivations to leave. Participants appeared to evaluate the financial consequences of leaving, chiefly inability to meet basic needs, as too great a risk. Consequently, participants were not motivated to seek help for IPV cessation or trauma recovery.

Still loving the partner

Some participants stated or inferred that their feelings of love for their partners inhibited their personal motivations to leave their partners. Feelings of love, therefore, delayed participants' help-seeking, even when valued informal supporters urged them to leave. For one participant, personal motivation based on love dominated social motivations to leave:

> *I just, I thought that I loved him so much that [my friends and family] didn't know any better; that I could change him, and that I could fix our relationship. Yeah, they care, but I know better.* [African American participant AB193]

Participants' were personally motivated to help their partners recover from addiction and even adverse childhood experiences. They explained that if leaving caused their partner to feel hurt, they would feel hurt as well. Crucially, participants desired a two-parent household for their children, a desire that combined their love for their abusive partners with their love for their children, further solidifying their personal motivations to remain:

You love your partner and you don't want your children to grow up without a father. [Hispanic participant HL294]

Avoiding judgment

African American and Hispanic survivors confided they were "ashamed" and "embarrassed." Feelings of shame and embarrassment persisted through their help-seeking experiences but were mitigated as participants continued to engage informal and formal supporters for help. Participants' feelings of shame and embarrassment appeared to derive from fears others would judge them harshly if the abuses they suffered were ever revealed.

The chief concern among African American participants was being judged "weak." They explained many people in their lives were dealing with difficult challenges without relying on anyone else for help. Consequently, survivors worried if they asked for help, others would think they could not handle life's difficulties and would conclude they were weak:

... My mind wasn't stronger than everyone else's and they be like you're stupid, you're dumb and say stuff like that, for dealing with it. [African American participant AB489]

African American participants were hesitant to trust even family members for fear they would gossip, which they worried would lead to strangers denigrating them behind their backs. The chief concern among Hispanic participants was being mocked or taunted. Survivors reported they told almost no one about their abuse, because they expected to be laughed at or taunted for being abused as well as for seeking help, particularly psychological counseling:

I thought that if people knew that I was looking for psychological help, I mean, people will start talking about it and ask themselves "why is she looking for psychological help?" [Hispanic participant HL392]

One Hispanic participant explained the topic of IPV is taboo in her church community, adding potential context to why Hispanic participants received little to no informal support from church leaders or fellow church members. Participant responses inferred that fear of judgment dramatically and negatively affected their social motivations to seek help.

Experiencing abuse as the norm

Participants' negative perceptions of potential helpers were rooted in community contexts of abuse normalization. African American and Hispanic participants described a context in which IPV was so common, and treated so consistently as a normal part of life, IPV did not seem wrong so much as something women are expected to endure:

> *In my particular situation, what I can see in my family is normal. You don't even know that anything is wrong with it because that's the way you were raised. So, you don't know that… that it's not okay.* [African American participant AB153]
>
> *… Many times it's the custom that people tell you, "if you married him, stay with him."* [Hispanic participant HL294]

Hispanic participants, all of whom immigrants, were deeply critical of permissive attitudes towards IPV in their countries of origin. They further reported living in close proximity to fellow immigrants who retained permissive attitudes towards IPV:

> *What a lot of people say, well, what's typical for Mexicans to say is, "She had it coming. The man hit her because she misbehaved. She disobeyed him."* [Hispanic participant HL284]

Yet Hispanic participants also found living in the United States facilitated access to a wider community, one with informal and formal supporters who did not treat abuse as normal. Nonetheless, Hispanic participants explained their upbringing and the widespread cultural

acceptance of IPV among Hispanic immigrants, including traditional beliefs about the roles of wives and mothers, made it difficult for them to recognize or pursue help-seeking as an option. Experiencing abuse as the norm meant tolerating IPV without complaining, remaining so children have their two biological parents in the same household, accepting fault for abuse received (being hit for "misbehavior" or disobedience) from the husband, and believing that marriage is forever.

African American participants inferred if IPV is acceptable in their communities, then community members will accept no justification for seeking help:

> *Back then I just really didn't feel comfortable asking for help. Because where I'm from, domestic violence is not made to be a major issue. It's either you stay there and you deal with it or you leave, but it's not always this simple.* [African American participant AB 344]

African American participants also felt bound by norms, particularly by beliefs about intimate relationships:

> *It's almost like it's okay because it's so common now. People just deal with it, and it's almost like almost cool, or you don't feel like you're loved if you're not hit. So, it's kind of so abnormal. It's so backwards. It's almost accepted because people don't, like women, don't leave. They stay and deal with it. So, if you're going to stay and deal with it you must accept it so everyone else is fine with it.* [African American participant AB193]

While specifics varied, statements regarding abuse normalization were strikingly similar across both participant groups. The influence of community norms and attitudes appeared to

create a strong social motivation that supplanted, for a time, participants' personal motivations to seek help.

Protecting herself and others from the abuser and the authorities

Participants continued to keep their IPV secret, fearing reprisals, particularly severe physical violence, from their abusers if they were to reach out for help. African American participants also feared abusers' making good on threats to financially cut them off and aggressively sue for child custody:

> *I was in this fear because he would say these things to me which is that, "I'm going to cut you off financially," "I'm going to take my son from you," "I'm going to put you out of the house," "I'll spend every dime I have to take him from you if I have to and to put you out of the house." ... I knew this place was here but still that was cemented in my mind; don't do anything to make this worse or don't do anything that's going to make him try to make good on his threats.* [African American participant AB447]

Another African American participant reported her abuser threatened to kill her, her children, and her entire side of the family. Common fears among Hispanic participants included physically violent retaliation and abusers' making good on threats to take their children or to kill them, their children, or other family members:

> *... He said he was going to take away the children, and he also said he was going to kill my family if I left.* [Hispanic participant HL342]

Due to perpetrators' many threats and prior behaviors, both groups viewed formal help-seeking as high risk, with the potential to escalate violence if abusers learned of their help-seeking attempts. Some African American participants also confided they worried agencies

would blame them for the IPV they suffered, conclude they were bad parents, and take their children—an implicit theory that inhibited their motivations to engage in formal help-seeking. Relatedly, a salient concern among Hispanic participants considering the consequences of help-seeking was being deported, which for some would result in separation from their US-born children:

> *... I would call the police. But sometimes I didn't want to call the police anymore because I thought, "If I keep on calling the police, I'm going to be taken to jail." I was scared of the police. And since my status is not legal, I was afraid they would deport me because of all these problems and my kids would be kept here.*
>
> [Hispanic participant HL284]

Participants' fears were personal motivational barriers to help-seeking rooted in the concerns they had at the time, but those same fears also motivated survivors to protect themselves, their children, and other family members. Their protective behavior—keeping their abuse secret—came at the cost of further enduring IPV, a consequence they viewed at the time as preferable to risking further harm to their loved ones and themselves.

Lacking confidence in others for help

Misinformation and lack of relevant knowledge about eligibility for formal assistance inhibited participants' formal help-seeking motivations. Concomitantly, beliefs regarding discrimination negatively impacted participants' conceptions (implicit theories) about help-seeking outcomes and the extent to which those outcomes would serve their best interests—further inhibiting their formal help-seeking motivations. Both African American and Hispanic participants worried formal support agencies would fail them. African American survivors were

doubtful the support offered would be effective in addressing their needs, which would leave them in a more precarious situation than before:

> *I was like "What if they say no? Then what am I going to do?" Because on this end my kids have somewhere to stay, you know, they're being fed every night. They're being taken care of. I'm going to leave this and then I'm just going to jump into thin air. And just not have anything to follow. I'm just there. Just floating in thin air.* [African American participant AB306]

> *What were you biggest worries when you sought external help for domestic violence?* [Interviewer]
>
> *Maybe that it wouldn't work. They wouldn't help me. That it wasn't what I was hoping for.* [Hispanic participant HL364]

Hispanic survivors believed the help they needed might not exist for or be refused to immigrants and Spanish speakers. Concerns over discrimination against immigrants emerged as the dominant barrier in this theme among Hispanic participants and ranged from general feelings of inequality to concrete concerns over deportation and fears they would be suspected of lying about their abuse to obtain a US visa:

> *Yes, that they were going to think that "she's only here to get her papers." It seems my case wasn't strong enough to be granted papers.* [Hispanic participant HL294]

Members of both groups also doubted formal support resources applied to them. One African American participant and one Hispanic participant stated they thought their abuse was not severe enough to qualify them for help. Another African American participant thought her abuse was too far in the past for help to be pertinent. A third African American participant

thought she had to be physically abused, as opposed to verbally abused, to qualify for help. Two Hispanic participants believed help was available only to "legal immigrants." Legitimate concerns combined with misinformation appeared to negatively affect participants' motivations to engage in formal help-seeking.

Participants of both groups also held low perceived support, believing others could not or would not be understanding. Some African American participants believed that anyone who had not experienced IPV did not know enough about IPV to help them recover—a view, voiced as a defense, that seemed to stem from their feelings about being judged:

> *I didn't feel like they knew or understood what I was going through. So I was like, "How can they help me? They don't know what I'd been through."* [African American participant AB231]

Hispanic participants did not state or infer they believed supporters needed direct IPV experience to be effective helpers. Hispanic survivors did, however, explain that community members, particularly church leaders and fellow congregants, were too uniformed about IPV, due to taboos against speaking on the topic, to be useful helpers. Participants' lack of confidence in others' knowledge inhibited their motivations to confide in others.

For both groups, negative perceptions of informal supporters also owed to the disregard with which fellow community members—neighbors, family, friends, and fellow church members—treated IPV survivors. Some Hispanic participants drew a direct line from low perceived informal support to low perceived formal support. These participants described how informal supporters did not care about their suffering and concluded formal supporters would feel likewise.

While most participants—African American and Hispanic—stated they were not concerned about being turned down for formal help due to racism, a few Hispanic participants did articulate this concern:

> *Well, before I get help, that was the feeling I had, that maybe they will not help us, maybe they will say to us that there was no help for us, do you understand? Because, simply because we come from another race, we are kind of different. So, they treat us, because we are different to them.* [Hispanic participant HL143]

Lacking confidence appeared to stem from participants' personal motivations, specifically beliefs that informal and formal supporters would fail them—an outcome that participants logically seemed to evaluate as risky and undesirable.

Behavioral Skills Barriers

Participants described influences that inhibited their acquisition or activation of help-seeking abilities (behavioral skills). Such influences affected not only the abilities participants objectively possessed but also their perceived ability, or perceived self-efficacy, to use those abilities—or to form plans to use those abilities. Abusers' use of multiple forms of IPV, including isolating, threatening, and stalking their intimate partners, constituted significant barriers to participants' acquisition and activation of help-seeking abilities. Furthermore, participants explained how IPV eroded their sense of self-worth and capability, which diminished their self-efficacy to enact both the help-seeking abilities and the help-seeking planning abilities they objectively possessed. Complicating matters further for some participants, taxed informal supporters and unhelpful formal supporters inhibited and delayed participants' opportunities to activate their help-seeking abilities or execute help-seeking plans.

Given the directionality of association from information and motivation to behavioral skills in the IMB model, certain aspects of cases where information and/or motivation served to inhibit acquisition or activation of help-seeking abilities are discussed here under behavioral skills barriers.

Being trapped without resources to escape

Prior to formal help-seeking, African American and Hispanic participants described feeling unable to enact help-seeking abilities, due to isolation, constant monitoring, and the disproportionate burden of child and household responsibilities.

> *You feel scared, you feel trapped, you don't know how you're going to get out, you don't know how to make a safety plan, and if you do, you're scared to attempt to follow it, you know, to make it manifest, so.* [African American participant AB167]

> *Well, I think that many of us do not search for help, sometimes because of lack of information, sometimes fear, sometimes because of the fear of being left economically helpless, and sometimes you got three, four children, and you don't want them to finish up wandering, rolling, you know that after that you cannot give them attention, because you are working. … Also, because I didn't know the language, so there were not many Spanish people here, so that is why.* [Hispanic participant HL143]

Participant responses inferred low perceived self-efficacy to enact either help-seeking abilities or help-seeking planning abilities while living with IPV perpetrators. Employment, household, and parental demands often fell disproportionately on the shoulders of IPV survivors,

especially those with substance-abusing partners. Participants stated they had little time to look for help given their many responsibilities and little privacy when they did have time.

Taxing the support system

A small number of African American and Hispanic participants discussed how they had taxed their informal support systems. Four African American participants and three Hispanic participants explained some family and friends pulled away and refused further assistance, because they returned to their abusers, often many times:

> *... I had taken him back a lot of times and [my friends and family] didn't think I was going to actually quit messing with him…. It was like, "Ah, you're going to go back to him this day and the other day"; like they didn't care.* [African American participant AB231]

> *My friends, they used to support me, the last time he had hit me. When I went back with him, they pulled away from me.* [Hispanic participant HL269]

Taxing one's support system may pose a serious risk to the availability of any informal supporters, given the small number of trusted informal helpers from whom participants received support. In turn, absence of informal supporters would likely reduce survivors' opportunities to enact help-seeking abilities.

Receiving little or unhelpful support from formal supporters

The majority of African American participants credited police with providing valuable assistance and information. Two African American participants, however, recounted how responding officers dismissed their calls:

I was calling the police and they would always tell me to just leave, "You just need to go cool off." They would just dismiss it like it's not a big issue…. [African American participant AB447]

Hispanic participants, all of whom later connected with a network of formal supporters, recalled contacting the police for intervention during violent events, including the last event that led them to leave their abusers. In one Hispanic participant's case, the police officer arrested her instead of her abuser. The officer did not speak Spanish and mistook the participants' self-defense and panic attack as signs she was the perpetrator. The language barrier may have also extended to the previously observed disparity in police provision of information regarding sources of formal support:

And a policeman told me there was not much to do, because he had not hit me. [Hispanic participant HL256]

Hispanic participants appeared to limit their interactions with police due to fears of deportation, a precaution that inhibited participants from enacting their formal help-seeking abilities. Hispanic participants were quick to contrast their experiences with law enforcement and support agencies in the US with experiences in their countries of origin. Mexican-born participants were particularly critical of police and other formal supporters in their country of origin compared to police and other formal supporters in the US. Even so, negative interactions (and fears of negative interactions) with police seemed to impede some participants' receipt of information regarding sources of help (i.e., police referrals to domestic violence service agencies) and participants' motivations to seek help, potentially resulting in delayed use of help-seeking abilities.

Section C: Facilitators to Formal Help-Seeking

The 27 themes emerged for facilitators to formal help-seeking and are organized under three categories, or formal theoretical constructs, derived from the IMB model: informational facilitators, motivational facilitators, and behavioral skills facilitators (Table 3).

Table 3: Formal help-seeking facilitators

2. Facilitators	Themes	Description
Informational facilitators	Receiving informational support from informal supporters while leaving the abuser	Receiving information regarding sources of formal support for abuse cessation and trauma recovery from friends, family, or other informal supporters
	Receiving informational support from formal supporters while leaving the abuser	Receiving information regarding sources of formal support for abuse cessation and trauma recovery from police, lawyers, medical doctors, therapists, or other formal supporters
	Informing self	Searching information resources to learn about IPV and locate formal supporters
	Seeking other services for the children	Learning about help for IPV while seeking help for children's related trauma symptoms
	Seeking other services for self	Learning about help for IPV while seeking help for an unrelated trauma
	Becoming more aware of IPV and its effects	Learning about forms of IPV and related trauma
	Changing thinking	Changing thinking about formal support resources, one's role in IPV, self-image, and one's future
Motivational facilitators	Experiencing more severe and frequent IPV	Becoming motivated to seek help due to extreme abuse
	Feeling increasingly depressed	Becoming motivated to seek help due to extreme trauma
	Tiring of IPV and its effects	Becoming motivated to seek help due to extreme physical, mental, and emotional fatigue
	Seeking help for children's sake	Becoming motivated to seek help to protect one's children and improve their circumstances
	Feeling supported by informal supporters	Experiencing emotional support from informal supporters
	Feeling supported by formal supporters	Experiencing emotional support from formal supporters
	Deciding what I want	Deciding what help-seeking outcomes one values and wishes to pursue
	Becoming more aware of IPV's effects on the children	Learning through facilitation what one's children witnessed and how they were affected
	Feeling safer and more at peace	Enjoying a safer and more peaceful home and life

Table 3 (Continued)

2. Facilitators	Themes	Description
Behavioral skills facilitators	Making up mind to be completely done	Deciding to leave one's abuser and/or deciding to seek help for IPV trauma recovery
	Escaping the abuser	Using help-seeking planning and help-seeking skills to escape one's abuser
	Receiving tangible support from informal supporters while leaving the abuser	Receiving help from informal supporters to escape one's abuser
	Receiving tangible support from formal supporters while leaving the abuser	Receiving help from formal supporters to escape one's abuser
	Remaining safe	Employing newly learned safety plans and skills to keep oneself and one's children safe while continuing to seek help
	Learning to use the justice system	Learning how to obtain orders of protection, a divorce, child custody, and child support
	Covering basic needs and family responsibilities	Managing day-to-day necessities independently and/or with support from informal and/or formal supporters
	Drawing on personal strengths	Recognizing, valuing, and using one's personal characteristics and abilities to cope
	Resisting manipulation	Resisting threats or other manipulation tactics employed by one's abuser to extort legal concessions to escape charges and/or one's feelings to facilitate a reunion
	Learning and employing coping skills	Learning from formal supporters ways to cope with trauma and other stressors
	Feeling empowered	Finding one's voice and a sense of purpose

Informational Facilitators

Informal and formal supporters contributed to participants' relevant help-seeking knowledge and help-seeking decisions by sharing information regarding sources of formal support. Participants also informed themselves, building their relevant help-seeking knowledge through self-directed information searchers. Some participants also unexpectedly received relevant knowledge of formal support resources from unrelated formal supporters, typically while seeking help for other counseling needs. In addition to acquisition of relevant knowledge and specific facts, participants discussed changes in thinking (implicit theories), describing their new understandings of IPV and the relevance of IPV help-seeking.

Receiving informational support from informal supporters while leaving the abuser

Participants shared relevant formal help-seeking knowledge they sought independently as well as formal help-seeking knowledge they received from informal and formal supporters. Participants described the many instances of informational support received—support that provided relevant knowledge and specific facts that helped them make the transition from (1) living with abusers to remaining independent of abusers and (2) struggling without formal support, e.g., counseling, to receiving formal support. African American and Hispanic participants reported informational support received from family and friends regarding where to access formal supporters, including where to locate legal and counseling support, i.e., government victims' services agencies and domestic violence counseling agencies:

> *All of a sudden, during a chat with a friend, it came up and she said, "They can help you over there, don't suffer anymore. Go seek help. There is help."* [Hispanic participant HL293]

The marked difference between groups in sources of informational support was support from churches. No Hispanic participant reported receiving informational support from churches. Meanwhile, African American participants received informational support from churches in the forms of domestic violence forums and presentations, knowledgeable advice, and names and contact information of formal supporters—all of which provided basic knowledge to inform formal help-seeking:

> *I had one church member who had said, "You're going to have to do something legally with him because he's fearless like he feels like he can do whatever he wants," and you're going to have to put a restraining order and you're just going to have to get a divorce from him and you've got to prove that he's abusive to you*

and your son" to protect him because he's young and innocent. [African American participant AB447]

Friends emerged as the primary source of informational support for both groups. Most Hispanic participants explained they were separated from family due to immigration. African American participants cited complex family dynamics and family members' lack of financial and other resources as reasons for their limited number of familial supporters. Notably, most participants received informational support from very few, trusted individuals. In most cases, one or two caring individuals were the only informal supporters participants felt they had or could trust. Participants' trust seemed to be placed in the more informed among them, which may have helped counter the effects of advice other informal supporters gave them not to seek help.

Receiving informational support from formal supporters while leaving the abuser

Very few participants went directly to a shelter or a recovery program. Despite their prior decision-making and advanced planning, participants' abuse cessation and engagement in trauma recovery services were often instigated by a violent event (see *Escaping the abuser*). Consequently, most participants reported police intervention, which subsequently led to orders of protection. In many cases, police served as an information conduit between survivors and domestic violence services agencies, providing relevant help-seeking knowledge:

So, you found out about [the domestic violence services agency] through [the police]? [Interviewer]

Yes. And the hospital. [African American participant AB466]

African American participants reported receipt of service agency referral information from police more so than Hispanic participants by a wide margin. Some Hispanic participants stated police did not speak Spanish, which may have contributed to the disparity in information

provided. Alternatively, one agency counselor confided Hispanic survivors did not trust and in fact deeply feared the police, so participants may not have perceived information given, if given, as help.

Most African American and Hispanic participants communicated that much of the information they received from agency staff was completely new to them:

> *Everything [the domestic violence counseling agency] told me are nice and new, I didn't know, like I said, I didn't even go to school so I knew nothing, and everything I don't understand I ask [the counselor] and she tells me again what she means because what if I say something and I don't know what's that about.*
>
> [Hispanic participant HL293]

Service agencies served as another information conduit, connecting survivors with legal assistance, safe housing, basic needs assistance, and counseling support—all relevant help-seeking knowledge. However, many different formal supporters—police, medical doctors and psychologists, lawyers, judges, service navigators, shelter staff, and counselors—provided informational support (i.e., referrals and contact information). Provision of informational support at key points, i.e., police intervention, hospitalization, order of protection completion, court appearance, and new client intake, facilitated survivors' help-seeking behaviors. Once participants were inside this system of formal supporters, they described the process of obtaining the help they needed as much easier than expected, altering implicit theories they previously held regarding formal support and formal supporters.

Informing self

African American and Hispanic participants sought information from a variety of sources and media, including web, print, radio, and television. Survivors reported accessing information

for relevant help-seeking knowledge and specific facts prior to and after their last experience of IPV:

> *I would do a lot of research on the Internet. … I was searching for shelters and domestic violence help and help for single moms and stuff like that.* [African American participant AB344]
>
> *At that time, I didn't know there was any help available, but I started to do some research and ask who could help me because I didn't know how to get out of that situation by myself.* [Hispanic participant HL414]

Both groups were similar on information sources accessed, specifically human resource departments, the Internet, television programs, and the YWCA. Television programs consisted of dramas and soap operas in which one or more female protagonists experienced IPV. One African American participant accessed specific television programs and movies to learn how to handle IPV. One Hispanic participant related to a soap opera protagonists and learned IPV was real but believed formal supporters were fictional. Radio and newspapers emerged as important media for Hispanic participants, likely due to the presence of Spanish-language radio programs and a Spanish-language newspaper in an otherwise English-dominated media market. Hispanic participants also made use of social media and information available through the regional health department.

Certain information sources, i.e., churches, help lines, the Internet, libraries, health departments, and YWCA, were accessed deliberately to obtain relevant help-seeking knowledge. Other sources, i.e., newspapers and radio, were accessed as part of daily routine, but participants deliberately retained their IPV-relevant messages for subsequent use. Relatedly, one African American participant recalled seeing a sign for a women's resource center on her daily commute.

She retained this information. Her partner attacked her sometime later. She rushed back to the place where she saw the sign and from there was referred to a shelter.

Participants who accessed or retained information did so to inform their escape plans and seek help from formal supporters. Such information was reportedly obtained prior to receipt of information from formal supporters but may have been accessed contemporaneously with receipt of information from informal supporters. Regardless, participants independently sought relevant help-seeking knowledge prior to leaving their abusers and used that knowledge to facilitate formal help-seeking.

Seeking other services for the children

Formal help-seeking did not begin with help-seeking for IPV in all cases. One African American and five Hispanic participants shared how either interventions from social workers or their own efforts to locate help for their children's mental and behavioral health needs led them to subsequently engage in formal help-seeking for IPV. The connection between their children's challenges and their children's witnessing of IPV did not initially seem apparent to these survivors (except for one Hispanic participant). Rather, the children's clinicians made the connection during screening and then made referrals to counseling programs:

> *We were referred here because of issues that my children were having that lead us [to an inpatient mental and behavioral health facility], and from [the inpatient facility] referral they referred us to the [counseling agency]. … The intake counselor suggested that we do the domestic violence portion because the anger that my children was experiencing was direct result of the child – the abuse that they saw growing up.* [African American participant AB153]

Relevant knowledge about the causes of children's trauma symptoms led, indirectly, to participants' formal help-seeking for IPV.

Seeking other services for self

As above, formal help-seeking did not begin with help-seeking for IPV in all cases. Two African American participants sought recovery services for drug addiction and were later referred by their recovery centers to a year-long residency program that also addressed their IPV trauma recovery needs:

> *Well, along with abuse I used drugs. So, I would just really numb myself to want to deal with anything. And so, when I decided to get help with that then I wanted freedom from a lot of things that were holding me down, and keeping me embodied, so.* [African American participant AB193]

One other African American participant first sought help for depression and through reflection facilitated by that counseling experience realized she needed counseling for IPV.

Two Hispanic participants sought help for unrelated victimization, were screened for IPV trauma, and entered individual counseling for IPV trauma:

> *I found out about [this agency] because I suffered a crime, an assault. Since that day, from that day on I have been living restlessly. I live bad. Since that day, I spent about two weeks without sleeping, with a lot of fear.* [Hispanic participant HL392]

One Hispanic participant sought counseling over her mother's murder by an intimate partner, was screened for IPV trauma, and entered individual counseling for IPV trauma. Again, screening for IPV led to participants receiving information regarding IPV services, subsequently leading to their utilization of those services.

In one particularly complicated case involving both *seeking other services for the children* and *seeking other services for self*, a participant took her child to a local university psychology clinic to test for learning disabilities. During the testing, the participant disclosed the family was traumatized by a recent robbery. The clinic referred the participant to a government agency assisting victims of violent crime. There the participant further disclosed her experience of IPV during a past relationship, for which she then received counseling from one of the agency's clinicians.

Screening for IPV led to participants receiving specific facts about IPV services, which subsequently led to their formal help-seeking for IPV trauma recovery.

Becoming more aware of IPV and its effects

Relevant knowledge gained in trauma recovery led African American and Hispanic participants to similar understandings about forms of IPV and the toll IPV took on their lives. Participants shared how they became aware, through counseling, of forms of IPV other than physical abuse. Participants who initially sought help for their children but not themselves remarked how counseling helped them realize they needed help, too.

Members of both groups attributed remaining in counseling to hearing other survivors' stories, though Hispanic participants' responses were more emphatic in this regard. Learning other survivors had endured the same or similar experiences appeared to provide participants with feelings of validation and comfort that facilitated their willingness to share their own stories. Participants inferred that learning other survivors' experiences helped them better understand their own experiences and the effects those experiences had on their lives, altering their implicit theories—chiefly that they were alone in their experiences. African American and Hispanic participants emphasized the importance of no longer feeling alone:

Yeah, we have group. We have counseling one on one, and we have different classes where we share. So, we're in like 13 different classes during the week, and so we get to share often, and hear each other, and how I'm not alone, and how certain things I've experienced I'm not the only one. [African American participant AB193]

But sometimes I would say, "That's what I was going through! That's what happened to me!" That happened over several [group counseling] sessions. [Hispanic participant HL404]

The new information participants received from counselors and fellow survivors seemed essential to their continued engagement in trauma recovery: the new, relevant knowledge about the important of help-seeking and specific facts about IPV helped participants form connections with their own experiences. This new knowledge seemed to engender in participants feelings of being understood as well as an appreciation for the relevance of the counseling services offered. Participants explained they became more cognizant of how perpetrators affected their thinking, quality of life, and sense of self-worth.

Changing thinking

Participants shared how their thinking about formal support resources, their own role in IPV, self-image, and future changed as they engaged in abuse cessation and trauma recovery services. African American participants emphasized formal support, i.e., individual or group counseling, aided their trauma recovery, while Hispanic participants emphasized the large amount of formal support resources available in the US compared to that available in their countries of origin. Each group's emphasis is consistent with their prior lack of confidence that others could or would help.

African American participants previously lacked confidence the support offered would work but now shared positive changes they were experiencing to the quality of their lives as they engaged in counseling:

> *Yeah, so it's been good, and I'm glad – I hope it helps somebody because it'll help somebody known that it can change their life and that's what I'm always telling people. You can change your life, and not have to allow fear of the unknown, and the what-ifs because what if life is better, and you don't get to experience that because of fear, and staying in what you know. Just step out there and see what happens….* [African American participant AB153]

Hispanic participants previously lacked confidence resources existed—or existed for immigrants—but now discussed the many resources available to them and their positive impressions of the counseling support they were receiving:

> *…When one reports someone to the police, it doesn't just remain there, but there are also [the domestic violence services agency]: they also helped me there. They gave me so much information; then they sent me here [to the domestic violence counseling agency]. Here they have been helping a lot, a lot, they have helped me so much.* [Hispanic participant HL352]

African American participants further remarked how the formal support they received and the service facilities they used were better than anticipated. Hispanic participants remarked all survivors need help and can all help each other, evidencing new implicit theories regarding IPV and IPV recovery.

African American and Hispanic participants shared the realization that they were not to blame for the abuse they received, overturning prior implicit theories that had delayed their

formal help-seeking. Realizing they were not to blame appeared crucial to participants' decisions to remain independent of their abusers. Relatedly, African American and Hispanic participant responses aligned on feeling worthy, important, and valuable. For both groups, recognition of self-worth seemed to engender positive perceptions of their futures:

> *Well, the help I have now, the therapy they are giving me, is helping me to know that I have self worth, to recognize feelings that I must not keep, help me feel better, to grow as person.* [Hispanic participant HL143]

Additionally, respondents from both groups described becoming more aware of their own thoughts and feelings. Information received in counseling appeared to strongly influence participants' changes in thinking. New thoughts were positive and constructive and appeared to promote participants' decisions to remain engaged in formal help-seeking.

Motivational Facilitators

Participants discussed personal motivations and social motivations to initiate and maintain formal help-seeking. As participants' experiences of IPV intensified in severity and frequency, and/or seemed protracted without end, their personal motivations changed: their concerns regarding the efficacy of formal support gave way to new assessments of potential outcomes. Participants, fraught with a sense of life or death urgency, saw greater benefits in leaving than staying. Other participants, for whom abuse experiences took place years past, tired of living with IPV's traumatic effects and evaluated formal support as preferable to continued anxiety and depression. Chief among participants' personal motivational influences to seek help, however, were their children. Participants conveyed strong beliefs that formal support, specifically counseling for trauma recovery, would benefit their children now and into the future. Social motivations to seek help were derived from the aid of informal supporters, who

recognized and expressed the value of formal support, and from the emotional and tangible support provided by both informal and formal supporters.

Given the bidirectional association between information and motivation in the IMB model, cases where information served to facilitate help-seeking motivations are discussed here under motivational facilitators.

Experiencing more severe and frequent IPV

African American and Hispanic participants who were living with their abusers at the time they engaged in formal help-seeking shared similar experiences of increasing frequency and severity of IPV. African American participants described an escalation of abuse from verbal to physical and emphasized sensing that circumstances had become life or death:

> *... In certain situations in the physical abuse, I feel like I was going to die. I mean I didn't know if it was going to be me or him type of situation. So I know I had four kids to live for, so I had to do what I had to do to try to—when I finally figured out I don't want this no more, I don't want to keep going through this.* [African American participant AB231]

Hispanic participants described experiencing more severe injuries, more frequent IPV, and more forms of IPV as their abuse worsened and emphasized their frustration:

> *After a while I had enough because the last time he hit me on my face and he broke my nose.* [Hispanic participant HL342]

These violent episodes served to further reinforce participants' convictions they needed to seek help. While they were not yet sure of the outcomes, they decided the potential benefits of formal help-seeking had to outweigh the potential risks.

Feeling increasingly depressed

Both African American and Hispanic participants attributed depression to living with ongoing abuse and trauma:

> *… It was eating me up. It started making me disintegrate. Slowly. And I could see it, and I could feel it. But I just bottled it up, so everybody "Shh, don't say nothing" and I just kept that in. And it has practically killed me up to this point.* [African American participant AB466]

> *I was at a point where I wanted to die, and I didn't know why because it's not like I was living with those men anymore.* [Hispanic participant HL294]

Hispanic participants attributed severe depression to the increasing severity and frequency of IPV they experienced as IPV intensified. African American participants did not infer a similar contribution of IPV severity or frequency to depression. Perhaps in part due to this difference, Hispanic participants, but not African American participants, communicated a strong desire for psychological counseling. Hispanic participants' pressing need for formal counseling support appeared to increase their personal motivations to seek help, believing that without help their health would continue to deteriorate.

Tiring of IPV and its effects

African American and Hispanic participants voiced similar concerns regarding how the length of their abuse affected their decisions. Participants reached a point where they could not take it anymore, realized their partners were never going to change, felt they had accumulated far too many indignities, and were simply sick and tired of living with IPV perpetrators:

> *At this point now I felt I got to get out of this because this is too much, and it's been too long.* [African American participant AB167]

When I came back here, it was the same; he hadn't changed. It was the same thing. And he's still the same. So I said, "I'm not going to live the rest of my life with a man like this." [Hispanic participant HL293]

One Hispanic participant who had experienced IPV in her country of origin and the US stated she was now living in a society where she no longer had to tolerate IPV. Although still potentially unclear about the specific outcomes of formal help-seeking, participants' conditions had become insufferable. They felt they had no choice but to seek help.

Seeking help for children's sake

The most salient reason many participants believed they needed to end living with abuse was their children. Protecting and pursuing a better life for their children were survivors' primary personal motivations for engaging in formal help-seeking:

I was determined that I would not allow my children to endure the lifestyle, the home that I was raised in. They would not go through that, and again I didn't know a lot about emotional and verbal abuse and that type of thing. But once it became physical it was time for me to end that relationship. I would not allow them to see that. [African American participant AB153]

The last time, he wanted to grab me. And he fought with my oldest son. And I saw that they were fighting violently, and I said my God, what can I do? I called the police, my sister helped me. [Hispanic participant HL256]

Wanting to break the cycle of IPV was the dominant subtheme for both groups. Participants did not want their sons to become perpetrators or their daughters to become victims. Responses from participant groups also aligned on protecting children from violence and utilizing counseling resources to help their children heal. African American and Hispanic

participants further explained they wanted to feel happier, calmer, and "OK" so they could be more focused parents for their children.

For both groups, children's needs for protection, education, and trauma recovery formed powerful motivations to seek help; these were outcomes participants explicitly and repeatedly stated they valued.

Feeling supported by informal supporters

Participants' positive appraisals of received informal support contrasted sharply with their statements regarding perceived informal support (see the category, *Keeping my business private*, above). Nearly all study participants felt supported, contrary to some participants' expectations:

> *At first, I went against everything [my family and friends] said because I didn't feel like they were for me like they were on my side, but after them just being truthful and honest with me about how they felt about him then I knew. "Okay, well why just you didn't say anything or tell me." But they, like I said, they thought they were going to lose me if they said anything … I actually had a support system because I didn't think I had one.* [African American participant AB231]

> *What did you think your friends and family would think if you got help or went to a professional?* [Interviewer]
> *Oh, that it's a good thing because when I was with the psychiatrist, they supported that. Of course, I don't tell all of them.* [Hispanic participant HL269]

Participants found their conviction to leave their abusers and intentions to seek formal support were met by emotional support from informal supporters. Participants attributed receipt

of emotional support primarily to family. African American participants also referenced church leaders, church members, and friends as emotional supporters. One African American participant mentioned neighbors. Second to family, Hispanic participants referenced friends. One Hispanic participant mentioned her parish priest and fellow parishioners. Participants' assessments of received support centered on the positive appraisals they received from informal supporters while initiating formal help-seeking:

> *Like, you know, my job, my employers, they've been very good. They've been very understanding through this whole thing. I'm talking about from 2016 up until now they've been more than, they've really just helped me through it all. I've been able to talk to my supervisor, and the HR person, the director, about it.* [African American participant AB167]
>
> *My mom is happy that I am getting help, because she knew I needed it.* [Hispanic participant HL352]

The positive appraisals and emotional support survivors received as they talked with family, friends, and church members about enrolling in counseling, for example, seemed to boost participants' social motivations to continue using formal support resources. Note, however, participants were referring only to those few individuals in their lives who stepped forward. Much of their motivation was still personal motivation.

Feeling supported by formal supporters

Receipt of emotional support was an "eye opener" for many survivors interviewed. Their formal help-seeking, particularly for trauma recovery, turned out far better than they envisioned. African American and Hispanic participants shared how much they liked and appreciated their counselors and caseworkers:

They don't make you feel as if you're in a fishbowl or something like that. They just treat you like a normal person, you know. [African American participant AB232]

Yes, I got happy because I said hey, they're going to try to help me on what happened to me and that's how I realize there's help for women who've experienced domestic violence, well, for everybody. [Hispanic participant HL293]

African American participants further indicated they did not feel judged by service agency, counseling agency, or shelter staff. Both groups inferred positive affect derived from the way they were treated by agency staff. While African American participants explicitly described this positive affect as a stress reliever, the PI's direct observations at agency locations suggest both groups experienced this benefit.

Participants' positive appraisals of support received appear to have strengthened their beliefs in the positive outcomes of formal help-seeking. Participants' explicit statements regarding their positive evaluations of help-seeking outcomes further indicated their personal motivation to remain engaged in IPV trauma recovery.

Deciding what I want

African American participants hoped help-seeking would lead to overcoming shame, dealing with their feelings, getting to know themselves again, overcoming depression, finding peace, and becoming happier people and parents:

What did you think you would get out of [the domestic violence counseling agency's services]? [Interviewer]

How to cope, how to deal with my feelings, how to just kind of come to terms that this did happen to me, but it's not just me. I'm not the first to go through it. So,

yeah. You know, learning and knowing that, and that don't be ashamed of it of what you went through. [African American participant AB167]

So and the outcome also is for me, for [my child] to see me in a healthy environment. For me to just it's almost like you have to come back to yourself behind all of this and I was independent before I got married. So all that working without distractions or fears, that's what I want. [African American participant AB447]

Hispanic participants—almost without variation—stated they wanted psychological counseling to address their depression, whether their abuse occurred years ago or very recently:

Well, in that moment I wanted more than anything supports from the family, psychological support, that I was feeling like there was anyone who can help me to get out of this hole. [Hispanic participant HL143]

I wanted someone to help me go out of the trance I was going through, that was really driving me crazy. There I was going crazy. [Hispanic participant HL392]

As African American and Hispanic participants continued to receive formal support, particularly counseling, their beliefs that formal help-seeking would lead to mitigated, if not ameliorated, anguish seemed to strengthen, motivating participants to remain engaged in help-seeking for trauma recovery.

Becoming more aware of IPV's effects on the children

The effects of IPV that appeared to worry participants the most were the effects their children experienced. African American and Hispanic participants became more aware of IPV's effect on their children's health as formal supporters intervened:

So, I didn't know who – what the [domestic violence counseling agency] did for anger management is what they referred us here for – and as we started doing the intakes the intake counselor suggested that we do the domestic violence portion because the anger that my children was experiencing was direct result of the child – the abuse that they saw growing up. So, there was a lot of anger and stuff that was going on with them that had just manifested over the years. [African American participant AB153]

I was shocked when they called me from school and said I'd get a visit from a social worker because I thought everything was okay after the violence was over, but there we were because it eventually affected my daughter, so it was through her that we both got sent here, to the Center. [Hispanic participant HL368]

African American and Hispanic participants' children reportedly experienced anger, depression, anxiety, and trouble focusing in school. Additionally, two Hispanic participants' children reportedly experienced sexual abuse, with one participant's sexually abused child attempting suicide. Participants expressed guilt they were previously unaware how dramatically IPV had affected their children. Direct observations revealed a substantial amount of counseling time, for both mothers and children, dedicated to ameliorating self-blame by helping participants recognize perpetrators' culpability.

African American and Hispanic participants, already motivated to seek help for their children's sake, found further motivation as new information regarding the traumatic effects of IPV on their children came to their attention. Their children's improved wellbeing remained a consistent personal motivation throughout participants' formal help-seeking. As participants became more aware of their children's needs and the efficacy of the counseling their children

were receiving, participants' beliefs in positive outcomes for their children seemed to strengthen. Their beliefs in positive outcomes for their children further motivated participants to remain engaged in formal help-seeking for their children's trauma recovery as well as their own.

Feeling safer and more at peace

Participants described feeling safer, calmer, and more at peace, attributing these feelings to support received from counselors and fellow clients. Descriptions of positive affect differed only semantically between groups. Members of both groups explained they felt happier, because they could see the counseling was aiding their trauma recovery. They felt relief from fear and stress and saw the benefits of this relief at home with their children:

> *I have help now I know. I feel better. I feel safe. And I know they like if this program doesn't help there is other programs out there.* [African American participant AB489]
>
> *So I feel happy being here, I get a load off my shoulders when I am here.* [Hispanic participant HL293]

Feeling safe and feeling at peace emerged as two help-seeking outcomes important to African American and Hispanic participants. The benefits they saw in these outcomes appeared to motivate participants to remain engaged in formal help-seeking for trauma recovery.

Behavioral Skills Facilitators

Participants described help-seeking behavioral skills they already possessed and abilities they acquired, typically through the aid of formal supporters, to initiate and remain engaged in formal help-seeking. Participants' beliefs in their self-efficacy seemed to increase as they saw their determination to leave their abusers result in meaningful changes. Participants made help-seeking plans, often using help from informal and informal supporters to execute their plans.

Participants acquired new help-seeking abilities, e.g., using the justice system. Participants also enacted new abilities to remain safe while they continued to pursue formal help-seeking for trauma recovery. Greater belief in their self-efficacy was further evident in participants' accounts of meeting basic needs, drawing on personal strengths to establish independence, and desires to help other women in similar situations.

Given the directionality of association from information and motivation to behavioral skills in the IMB model, certain aspects of cases where information and/or motivation served to facilitate acquisition or activation of help-seeking abilities are discussed here under behavioral skills facilitators.

Making up mind to be completely done

African American participants found they needed to feel convinced they were done with their abusers before they could feel confident in their abilities to resist returning to their abusers. For these participants, feeling convinced they were done with their partners was critical to their self-efficacy to enact help-seeking abilities:

> *The first thing I did was I left the situation way before I even came here. Like, I had to make my mind up to be completely, completely done. And that was the first time I had done it and I saw how much better I felt behind it, but I also knew that just me saying, "I'm done with it" wasn't enough. And this is part of me getting away from that, being here.* [African American participant AB344]
>
> *Realizing that that situation wouldn't end even after I separated from him, the situation would remain the same or get worse. That gave me the determination to take that risk. To take the risk, like we say, to let it be whatever it may.* [Hispanic participant HL404]

Length, type, frequency, and severity of abuse all seemed to play a role, likely cumulative, in causing African American survivors to reach this stage of conviction.

Hispanic participants did not convey a similar need to feel convinced they would not return to their abusers. Rather, Hispanic participants explained they reached a point where they had enough and were not going to tolerate IPV any longer. Some Hispanic participants did, however, disclose they had previously returned to their abusers. As with African American participants, Hispanic participants' conviction to be completely done with their abusers seemed due to the cumulative effect of length, type, frequency, and severity of abuse.

Participants of both groups exhibited abilities requisite to seeking help, i.e., making plans to leave, but their self-efficacy to enact these abilities appeared to hinge on their conviction that they would not return to their abusers or would not tolerate another instance of IPV.

Escaping the abuser

For those participants still living with their abusers, making up their minds to be completely done was most often determined by a violent event. Survivors or their family members or neighbors called police in the large majority of cases. Police intervention resulted in a range of outcomes, including flight, arrest, no arrest, and deportation of perpetrators and filings of orders of protection against perpetrators.

Regardless of police intervention, African American survivors recalled having to abruptly leave their perpetrators. Many had, however, made plans and preparations to leave, such as locating an apartment and employment, gradually saving money, and hiding clothes and other necessities where they could be accessed as or after they left:

And every Sunday when I used to come home from work I used to go to Target. The stuff that I want I packed it up and took it up at my mom's house. Because I

knew it was going to be a fight. So, the stuff that I knew I wanted so I wouldn't have to be trying to – I pre-packed because I can do that, because we didn't share a closet. So I can slowly pack my clothes away. [African American participant AB383]

Plans centered on finding a location where the abuser could not track them, which often ruled out staying with family members. Several African American participants used shelters to help facilitate their escape. No Hispanic participants used shelters. Direct observations and discussions with shelter staff confirmed no Hispanic shelter residents during the study's nine-month recruiting period.

Hispanic survivors used a variety of strategies to leave their abusers, including subterfuge to escape their abusers long enough to locate help, going to stay at a friend's house, and saving money from the profits of garage sale items and homemade dishes:

Next Monday I told him I was going for the kids' vaccines and like he never went with me. And I went to the Capitol with my sister and never came back. I didn't take any clothes or anything. I left just like I was, the same with the children. [Hispanic participant HL342]

Participants clearly evidenced actual, objective abilities to seek help. Despite their low perceived ability, and perhaps due to the high stakes involved, participants nonetheless enacted planning abilities. Even as participants shared astonishingly brave accounts of endurance and escape, most did not seem to think they had exhibited impressive abilities.

Receiving tangible support from informal supporters while leaving the abuser

Participants described the many instances of tangible support received. African American participants reported tangible support received from family and friends to leave and remain

independent of their abusers, including places to stay, money to pay bills, help with childcare, and use of transportation:

> *My family did help me. When they finally, everybody knew what was happening they did give me money like if my phone bill needed to be paid. They didn't want me to be without a phone in case something happened.* [African American participant AB167]

Hispanic participants also reported tangible support received from family and friends to leave and remain independent of their abusers, including places to stay and money to move away from abusers, and transportation to doctors' offices:

> *A friend of mine took me to a doctor, to a psychiatrist to help me.* [Hispanic participant HL269]

The marked difference between groups in sources of tangible support was support from churches. African American participants received tangible support from churches in the forms of money (for bills, rent, and groceries) and counseling. No Hispanic participant reported receiving tangible support from churches. Family members emerged as the primary source of tangible support for both groups. Participants' use of familial supporters for tangible support is at odds with their prior statements regarding the lack of familial supporters under *receiving informational support from informal supporters while leaving the abuser.* It remains unclear why participants said they could not rely on family, or did not have family to rely upon, only to describe later the important roles family members played in the provision of tangible support.

Informal supporters were key facilitators to participants' enactment of help-seeking abilities: informal supporters provided the opportunity to find formal support (e.g., by providing rent money and childcare), and, in some cases, the means (e.g., transportation to formal support

agencies or doctors). Notably, most participants received tangible support from very few, trusted individuals.

Receiving tangible support from formal supporters while leaving the abuser

One non-profit and one governmental services agency connected participants with the courts, which provided temporary orders of protection. Participants and agency staff reported that staff accompanied survivors to court hearings. Both groups of informants explained how agency staff served to bridge participants' abuse cessation needs (i.e., orders of protection) and abuse recovery needs (i.e., counseling):

> *... I learned how they counseled other women that were coming here about the different things that they have like being able to safe exchange, and being able to allow their children, and their – to be dropped off here where they could exchange if they were having co-parenting situations so they did not have to be in a space alone with their abusers. I didn't know that they did that here. I didn't know there was anywhere that did that.* [African American participant AB153]
>
> *... The policeman where I reported that, they sent me out to the [domestic violence services agency]. ...They helped me to get the order of protection. ...And they helped me to get a lawyer to represent me in court.* [Hispanic participant HL352]

Participants shared their pleasant surprise at the quantity, types, and quality of support available and often stated they had no idea so much help was available. Formal supporters—police, medical doctors and psychologists, lawyers, judges, service navigators, shelter staff, and counselors—provided tangible support (i.e., specific goods and services). Provision of tangible support from formal supporters reduced stressors that were overwhelming participants and thus

affecting their perceived self-efficacy to enact help-seeking abilities. Their circumstances gradually became more manageable, particularly as basic needs were met.

Remaining safe

African American and Hispanic participants shared very similar statements about how they learned to keep themselves and their children safe from past abusers, as well as potential new abusers, while in counseling:

> *Then you know about, even if you start a new relationship that you know, they let you know if you need to do a background check.* [African American participant AB383]

Participants learned through counseling programs to develop safety plans in case of emergency. Participants also remarked how, if abuse occurred again, they would return to formal support agencies for further help:

> *Now I know that if I ever were with anyone else and I became involved in a violent situation again, I don't think I'd let it happen again. I'd seek help because I now know there's places like this program that I can reach out to.* [Hispanic participant HL368]

The PI observed some African American and Hispanic participants returned to counseling after experiencing subsequent abuses. Participants and counseling staff alike recognized survivors needed to remain safe at home and en route to services in order to access counseling services. Remaining safe therefore emerged as a crucial ability to maintaining engagement in formal help-seeking.

Learning to use the justice system

Participants in both groups emphasized the need for temporary orders of protection and longer-term restraining orders to protect themselves and their children against their abusers. Participants learned they needed a police report to file orders of protection and found assistance completing those orders at a domestic violence services agency or a crime victims agency. African American participants worried they would lose child custody to their abusers, since men had more money to hire tenacious lawyers:

> *The only thought I was concerned about was like him being a man and him having the income and me being totally dependent that that would put me at a disadvantage somehow because he has the money for the big time lawyer that's known for getting people released from their domestic violence cases.* [African American participant AB447]

This concern arose in clinical debriefing sessions attended by the PI; certain local lawyers held reputations for successfully representing IPV perpetrators. In contrast, some Hispanic participants worried their spouses would be deported, leaving them without child support payments. This fear was corroborated during clinical debriefing sessions. Furthermore, Hispanic participants pursued legal help to remain in the US, per their rights under the Violence Against Women Act. Achieving legal status was crucial to Hispanic women's safety; many recounted death threats from abusers if they were to return to their countries of origin. Remaining in the US was also critical to Hispanic participants' ability to establish their independence, given the formal support resources available in the US, but not, as they stated, in their countries of origin, to facilitate their transition to an abuse-free home.

African American and Hispanic women faced fears of going to court, e.g., for child custody hearings and criminal proceedings. African American participants described their fears of facing their abusers in court. Hispanic participants described their overall fear of police and the courts, one mentioning recent changes in US immigration policy as additional cause for alarm. Notably, Hispanic participants had reached a point where, as they stated, their fears of police and the courts were outweighed by their conviction to end their abuse. Participants' fears also appeared to be mitigated by a greater sense of self-efficacy:

> *... I'm learning a lot of things. And I'm less afraid now to call the cops or go to court. I always used to get very nervous about that.* [Hispanic participant HL294]

With the aid of agency staff, African American and Hispanic participants learned how to use the justice system—an essential ability for seeking help to end their abuse. Moreover, participants exhibited the self-efficacy, despite their aforementioned fears, to enact this help-seeking ability.

Covering basic needs and family responsibilities

African American and Hispanic participants used their independent resources as well as help from informal and formal supporters to meet basic needs (i.e., food and housing) and family responsibilities (i.e., caring for children and maintaining a household) while seeking help for abuse cessation and engaging in trauma recovery services. Informal supporters helped African American and Hispanic participants cover basic needs by providing transportation and sharing housing and living expenses.

The two groups, however, differed on their emphasis of informal supporters' roles in assisting with basic needs and family responsibilities. African American participants emphasized their independence and use of personal resources. Half of the study's African American

participants reported no change in the financial and family responsibilities they managed now that they were separated from their perpetrators:

> *He really wasn't helping financially; all his money went to drugs, liquor, women, whatever. He really didn't help with the kids so I was doing the both of everything already so nothing just really changed. … It didn't hurt financially or anything like that because I was still, I've been working at the same place for 15 years so everything just kind of stayed the same. The only difference is he left.* [African American participant AB231]

These participants stated they had always managed the same financial and family responsibilities, crediting their work ethic and years as their children's primary caregivers.

Hispanic participants emphasized their use of informal support, often pooling resources with family and friends. Even so, Hispanic participants also credited their work ethic for managing without a partner, stating confidently their abilities to work hard had always seen them through challenging periods:

> *Well, I've always worked, so that was a huge help for me because I've always worked, but when I got to this country I wasn't working, so that was hard because I needed to get a job and I didn't have a car, I didn't have a cell phone or a place to live, so it was difficult, but as soon as I got a job, the house, the money, and the car came along, as did supporting the kids. The external help offered me a place to stay, but I had already come up with a place, so I declined the offer.* [Hispanic participant HL414]

African American participants reported accessing more forms of formal support than Hispanic participants. African American participants reported using Federal programs

(Supplemental Nutrition Assistance Program and the Special Supplemental Nutrition Program for Women, Infants, and Children; Section 8 housing; Tenant-Based Rental Assistance; and Temporary Assistance for Needed Families) and local emergency shelters:

> *They got me emergency housing. They sent me to a hotel for a couple of days and then I got an apartment. Then they gave me a tenant-based rental assistance voucher. It's kinda like Section 8, but you have to pay a portion of your rent. And then they helped me with my light bill; they help you find jobs.* [African American participant AB306]

In contrast, Hispanic participants reported using only the SNAP and WIC programs. One participant mentioned her child used the State's free and reduced price lunch program, but this program was available to all public school students in Tennessee regardless of income.

Participants from both groups explained they were either living independently prior to or shortly after separating from their abusers or were transitioning to independent living using their personal earnings and help received from formal and informal supporters. Separately, the PI observed many women enrolled in counseling services were seeking legal help to obtain child support payments, another stressor complicating their efforts to cover basic needs. Clinical debriefing sessions consistently involved discussions of clients' challenges meeting basic needs and managing family responsibilities, as these challenges posed potential barriers to program attendance and thereby trauma recovery.

For those who experienced IPV from substance abusers, the absence of perpetrators meant relief from financial drain. Unfortunately, as one participant shared, her substance-abusing partner left her with significant debts. Still, she was able to better focus on her children without

what she described as constant chaos living with an alcoholic and suspected illegal drug user. She was also able to focus on her own recovery.

Participants' use of personal resources and informal and formal support illustrate not only the resources but also the abilities they used, i.e., seeking employment and pooling resources, to address these challenges and thereby remain engaged in formal help-seeking. Ironically, abilities used to cover basic needs and meet family responsibilities, specifically seeking employment and working, interfered with some participants' attendance at counseling sessions. These participants remained in counseling, but their attendance was sporadic.

Drawing on personal strengths

The two groups of participants differed on the personal strengths they explicitly attributed to establishing and/or maintaining their independence. African American participants emphasized their persistence while Hispanic participants again emphasized their work ethic. The difference seemed partly semantic: working long hours at a demanding job certainly requires persistence, just as persistence requires a strong work ethic. Implicitly, then, the common denominator between groups appeared to be perseverance:

> *I think he thought that I would tire and just say forget it because there were so many times where court dates were reset because of something he pulled, and here I missed work, and you go and fake something, or change something.* [African American participant AB167]

> *… And even going through that, you noticed how many things you can actually do – that even having two jobs but you can move ahead.* [Hispanic participant HL364]

African American participants further stressed that the opinions of others—friends, family, and community members—would not stop them now they had decided what they wanted. Members of both groups felt proud of their abilities and exhibited self-efficacy to enact help-seeking skills required to overcome barriers to establishing and/or maintaining their independence from abusers.

Resisting manipulation

Participants faced multiple forms of manipulation from their abusers, including stalking on foot, in cars, and through mobile devices; stealing participants' only modes of transportation; threatening to kill participants, their children, and relatives; and threatening to take children, commit suicide, publicly shame participants, or call police and/or immigration and customs enforcement (ICE). These threats, which began well before participants sought formal help for IPV, followed participants' through help-seeking for abuse cessation and trauma recovery. Clinical debriefing sessions consistently revealed perpetrators attempts to manipulate their former partners. One directly observed form of manipulation included manipulating children to blame their mothers for the abuses, arrests, and separate households.

African American participants emphasized perpetrators' attempts to manipulate them through making emotional appeals, putting terms on changing their abusive behaviors, stealing or destroying property, and threatening to harm or take children:

> *My kids walked back and forth to school when they were in high school and middle school and he had a, it was a domestic violence situation with my older two kids and him. So, I was scared that he was going to do something to them to retaliate.* [African American participant AB231]

Hispanic participants shared the same experiences as African American participants but added deportation threats and death threats:

> *He had a rifle behind the door. And he grabbed the rifle and pointed it at me and said he was going to kill me. And I told him I didn't care, that that was preferable than living with someone like him.* [Hispanic participant HL294]

Hispanic survivors described death threats aimed at them, their children, and relatives. Death threats occurred prior to participants' attempts to leave their abusers and continued throughout their formal help-seeking experiences. Some Hispanic participants also reported their partners tried to prevent them from leaving by threatening to call ICE. Deportation threats occurred in relationships where male perpetrators, but not female survivors, possessed US citizenship. One participant reported that her stepchildren did call ICE on behalf of her abuser.

Members of both groups described how perpetrators shifted manipulation tactics. For example, one African American participant described how her abuser switched from threatening her to humbly apologizing to get her to drop charges:

> *He wanted me to drop charges, and he had a warrant against him, and we went from threatening to humble, you know. He was very apologetic, and I didn't go for any of that because when I talked to a family member who was an officer. He was like don't. Don't do that. They lose control over you so that's what happens.* [African American participant AB167]

One Hispanic participant recounted her abuser employed six different manipulation tactics as she accessed services for abuse cessation and trauma recovery and worked to establish her independence. As participants explained, abusers switched tactics as survivors moved from dependence to independence. Abusers, recognizing their old threats were proving less effective,

switched to exploiting other vulnerabilities. An abuser who threatened to kill his partner at gunpoint to no effect, for example, switched to threatening to kill their children.

Participants continually resisted their perpetrators manipulation tactics as they progressed through trauma recovery. African American participants emphasized their determination, while Hispanic participants, no less determined, emphasized their resolve to accept whatever consequences may come, some preferring deportation and death over continued IPV. Remaining safe, seeking legal assistance, covering basic needs and family responsibilities, and drawing on personal strengths helped participants resist perpetrators' manipulation tactics, which in turn helped participants establish and/or maintain their independence and continue to engage in formal help-seeking for trauma recovery.

Learning and employing coping skills

Receipt of formal support in the form of counseling for trauma recovery resulted in similar benefits for African American and Hispanic participants. Participants described learning how to relax, reflect, and cope with anger and sadness. Participants talked about feeling less alone and more comfortable sharing their experiences with counselors and other survivors. Participants inferred trauma recovery services were helping them acquire abilities to cope with IPV sequelae, such as depression and anger, which they inferred would strengthen their self-efficacy to resist returning to their abusers or entering into new abusive relationships:

> *Yeah, I no longer feel that way, and it's only been four months, but a lot of those, because if I don't deal with all of it then when I leave here I just go back to it. So, I have to deal with those things, and I have, and it has helped tremendously. It's helped a lot.* [African American participant AB193]

These same coping skills appeared to further enable participants to focus and to continue to engage in seeking help for trauma recovery:

> *... Since they teach us a lot in the talks at the group, they teach me in my life to be strong, right? And that life goes on. It's normal that sometimes you get sad because of your problems because the same thoughts keep coming back, but the group has helped me and my [child].* [Hispanic participant HL368]

Feeling empowered

Formal support for trauma recovery seemed to provide African American and Hispanic participants with greater self-efficacy. This enhanced self-efficacy was evident in participants' regained ability to trust, ability to share their abuse stories, and desire as well as perceived abilities to help other IPV survivors. Feeling comfortable with counselors and fellow clients helped participants trust them with their abuse narratives:

> *I found somebody that I can trust and get out things that I had inside that tortured me. Regardless of what happened to me, it's a set of feelings that I was able to get out.* [Hispanic participant HL392]

Participants recounted how sharing their stories for the first time represented a critical turning point in their abuse recovery. Putting aside years-long fears of judgment to share intimate details of the abuses they suffered required a level of trust and confidence new to participants. Participants described sharing their stories as healing and validating experiences:

> *So it definitely, the more I talk to people and even the more I talk to women in my group, even the person that they had who was, she was some sort of civil advocate or something but it was like you have power there, you have a voice.* [African American participant AB447]

Sharing stories showed participants they could be vulnerable without being shamed, feel validated by others rather than judged, and ask for help when needed without fear of rejection. These experiences of sharing seemed to motivate participants' desire to help other women affected by IPV—an endeavor they appeared confident they could eventually undertake:

> *... I feel like I have something to offer and I feel like when it's time, I want to be in a position to where I am able to help and reach out to people in a way that I can.* [African American participant AB344]
>
> *But if I know someone, if I knew someone who's going through a situation, a domestic violence situation, I could counsel them on points we've seen here. But I need to learn so much more.* [Hispanic participant HL269]

Several participants were already helping others. One participant started a domestic violence awareness campaign at her place of employment, another formed a domestic violence support group, others counseled friends and family members how to leave their abusive relationships and seek help, and one participant used Facebook to broadcast her identity as an IPV survivor and advocate for any other survivors wishing to contact her. Participants' empowerment provided the self-efficacy required to further enact and maintain their help-seeking abilities. Furthermore, participants' empowerment motivated them to share their help-seeking abilities with others.

Chapter 5: Discussion

This study explored barriers and facilitators to formal help-seeking for IPV among minority women survivors in the Mid-South of the United States. African American and Hispanic participants appeared to share similarities as well as important differences in the way they conceived of, were affected by, and responded to formal help-seeking barriers and facilitators. (Please see Table 4 in Appendix A for a summary of similarities and differences described in Chapter 4). Key barriers and facilitators discussed in this chapter were identified by their salience to participants, relevance to the literature, and implications for intervention. Formal help-seeking barriers and facilitators, including group similarities and differences on barriers and facilitators, are explicated with respect to their implications for the literature, grounds for future research, and implications for IPV help-seeking interventions. This chapter concludes with study limitations and strengths.

Key Barriers to Formal Help-Seeking for IPV among Minority Women

Informational barrier – Lacking knowledge about IPV and IPV help-seeking

Lacking relevant knowledge about IPV formal support resources emerged as a key barrier to formal help-seeking. This finding is consistent with the literature. Prior studies found IPV survivors were unaware of, or possessed limited knowledge about available formal support resources (Bauer et al., 2000; Brabeck & Guzmán, 2008; Crandall et al., 2005; Few, 2005; Krishnan et al., 2001; Raj & Silverman, 2002; Rizo & Macy, 2011; Sabina et al., 2012; Shuman, 2014). Adding to the literature, participants in this study voiced frustrations over the lack of IPV public service information present in their communities, stating they would have sought help sooner if they knew of resources sooner. Consequently, participants' lack of relevant knowledge about IPV formal support resources available to them may have delayed their formal help-

seeking. Further study of associations between information availability and intent to seek formal help and/or initiation of formal help-seeking is needed.

Not only did participants lack relevant knowledge regarding the existence and location of formal support resources, many did not believe they needed help. Many participants recalled they were initially unaware their relationships were abusive. Most participants were unaware of the multiple forms IPV takes or how abusers use IPV to manipulate their partners. These findings are consistent with the literature in which IPV survivors were found to lack awareness regarding the definition and nature of IPV (Davis et al., 2001); their communities were also found to lack the same awareness (Davis et al., 2001; Flicker et al., 2011; Fraser et al., 2002; Rose et al., 2000). These findings may indicate the need for a dual impact approach to dissemination of information or social marketing interventions, given that two audiences—survivors and their communities—may both require relevant knowledge to seek support (messaging directed to survivors) and relevant knowledge to support survivors and address community-level acceptance of IPV (messaging directed to community members and leaders).

African American and Hispanic women in this study did not appear to differ on either relevant knowledge about resources or relevant knowledge about IPV. However, differences observed between groups on the motivational barriers *avoiding judgment* and *experiencing abuse as the norm* (discussed next) appear to be relevant to tailoring health promotion messages to each group. Additionally, Hispanic participants explained they were not aware they could apply for a US visa much less aware of laws intended to protect women who have suffered assault, consistent with the literature (Adams & Campbell, 2012; Bauer et al., 2000; Crandall et al., 2005; Raj & Silverman, 2002). Hispanic participants in this study believed, mainly due to their immigration status, they did not qualify for services. Their belief may have inhibited their

information seeking and/or caused them to delay formal help-seeking. Further examination of the association between this belief and activation of Hispanic survivors' formal help-seeking is needed.

Motivational barrier – Avoiding judgment

Prior to seeking help, participants felt ashamed and embarrassed they experienced IPV and wanted to avoid judgment, consistent with other studies' findings regarding survivors' fears of judgment from family and friends (Bent-Goodley, 2007; Brabeck & Guzmán, 2008; Evans & Feder, 2014; Lucea et al., 2013). Adding to the literature, this study observed nuanced but distinct differences between African American and Hispanic participants' concerns regarding others' judgment. African American participants experienced this barrier as a fear of being judged weak by family and friends or talked about behind their backs by a community-wide rumor mill. Consequently, African American participants concluded anyone who had not experienced IPV could not understand why they had endured abuse or needed help. They were reluctant to share their experiences with informal supporters (potential sources of informational, emotional, and tangible support). They also were reluctant to share their experiences with formal supporters (e.g., caseworkers and therapists) until they were convinced they would receive appropriate understanding and relevant information. Participants did not want to risk embarrassment by disclosing their abuse and the fact they needed help only for the help to fail because the formal supporters lacked the requisite experience to understand them. Information campaigns promoting formal support resources may need to consider African American survivors' heuristics (e.g., one must experience IPV to understand IPV) in order to help survivors evaluate formal help-seeking as worth the risk of exposing themselves to embarrassment.

Hispanic participants worried they would be mocked or taunted by community members as well as agency staff members, a treatment of women they had witnessed in their countries of origin, consistent with prior studies (Bent-Goodley, 2007; Bloom et al., 2009). Consequently, Hispanic participants felt they had nowhere to turn. They were doubtful formal support resources existed in any meaningful form and, if they existed, they doubted they would be allowed to use those resources. Furthermore, their lack of confidence in and fear of formal supporters covered the gamut, from police and the courts to victims' services agencies. Hispanic participants' fears of being mocked and lack of confidence in formal supporters appeared to delay their engagement in formal help-seeking. The inhibitive force of fear of mockery combined with lack of confidence in formal supporters, derived from experiences in their home countries, appeared so strong that women delayed help-seeking even after being screened for IPV (e.g., after hospital admission) and told bluntly by medical professionals their lives were at risk. Conversations with Hispanic women who screen positive for IPV may need to center more on the supportiveness of help in the US (a fact Hispanic participants mentioned with great enthusiasm) and less on the dire consequences.

Hispanic participants were also concerned about being judged by church leaders and fellow church members. They explained speaking about IPV at church is considered taboo. African American participants, in contrast, found church leaders and fellow church members to be important sources of informational, emotional, and tangible support. Community-based IPV interventions for minority women should consider how predominantly African American and predominantly Hispanic congregations respond differently to the topic of IPV.

Prior research suggests African American and Hispanic women's fears of being stigmatized owes to their lack of awareness regarding the prevalence of IPV in their communities

(Bent-Goodley, 2007). Many of my participants, however, explicitly stated their awareness of IPV's high prevalence in their communities. Their recognition of IPV's prevalence in their communities appeared to delay, not hasten, their realizations that IPV was abuse and something they did not need to tolerate. Furthermore, lack of relevant knowledge about IPV or IPV resources did not appear to infer lack of awareness about IPV's community-wide prevalence. Participants indeed may have underestimated IPV's prevalence, since many did not consider verbal abuse a form of IPV, but they readily understood physical violence as IPV and perceived such violence as extremely common.

Motivational barrier – Experiencing abuse as the norm

Abuse normalization seemed to influence both African American and Hispanic participants to comply with community norms and attitudes and thus remain in their abusive relationships. This finding is consistent with the literature (Adams & Campbell, 2012; Barnett, 2001; Bauer et al., 2000; Krishnan et al., 2001; Rose et al., 2000). Further consistent with prior research (Alaggia et al., 2012; Brabeck & Guzmán, 2008; Crandall et al., 2005; Evans & Feder, 2014; Hien & Ruglass, 2009; Morrison et al., 2006; Overstreet & Quinn, 2013; Rizo & Macy, 2011), participants confided that abuse is perceived as normal in their communities. Previous research has demonstrated that this communal conception of IPV as a normal part of intimate relationships is common across African American and Hispanic survivors (Brabeck & Guzmán, 2008; Morrison et al., 2006; Rizo & Macy, 2011). The same was found for white women in the UK (Evans & Feder, 2014). Adding to the literature, abuse normalization promoted characteristically different social motivations in this study's African American and Hispanic participants. African American participants seemed to experience this social motivation to comply as a pull to remain in or return to their abusive relationships. Participants believed their

communities regarded the dangerousness of abusive relationships as secondary to possessing the relationships. Consequently, participants felt trapped between personal motivations to leave and social motivations to stay or return. Hispanic participants appeared to experience this social motivation to comply as feeling duty bound to protect the integrity of the marriage and preserve the two-parent home. This sense of duty appeared to delay, in some cases by several years, participants' formal help-seeking. One prior study observed Hispanic women survivors endured abusive relationships longer than African American or White women survivors (Gondolf et al., 1988). Relatedly, fear of shaming one's family if help was sought was present within one primarily Hispanic sample (Krishnan et al., 2001) and another sample of immigrant (Latina, South Asian, Korean) women in the US who also feared ostracism if they were to divorce their husbands (Raj & Silverman, 2002).

Implications of abuse normalization are similar for both groups: beliefs that abuse is normal and something women are expected to endure appears to delay, in some cases by years, formal help-seeking. While African American and Hispanic participants experienced this barrier in ways unique to values espoused in their communities, community expectations regarding women's gender roles formed a common denominator. This finding is consistent with prior studies (Bauer et al., 2000; Raj & Silverman, 2002; Rizo & Macy, 2011; Rose et al., 2000; Sayem et al., 2015), in which IPV survivors found it difficult to seek help due to cultural or community expectations regarding gender roles (i.e., dutiful wife, mother).

While participants' attributed delayed formal help-seeking to community normalization of IPV, in addition to other barriers identified in this study, members of both groups also found countervailing points of view in the few trusted individuals to whom they turned for informal support. Further study is needed to determine the extent to which points of view from trusted

informal supporters countervail community normalization of IPV and to what extent, if any, that countervailing force produces a net positive association with formal help-seeking.

Participants' responses appear to indicate two groups of "significant others" with whom survivors may feel socially motivated to comply: an abstracted "they" representing the community and a concrete "they" representing trusted informal supporters. Participants' responses appeared to shift from positive appraisals of support to negative appraisals, depending on which "they" was meant. Interventions aimed at mitigating the influence of abuse normalization on formal help-seeking may need to explore ways to promote the positive influence of trusted informal supporters over the negative influence of community norms and attitudes. Additionally, IPV survivors living in this study's region have launched efforts that, with further support, could establish a corps of informal supporters much in the vein of community health workers. The latter approach, which has received some prior supporting evidence (Shuman, 2014), could be useful to survivors who have taxed their existing informal supporters or who reside too far from family and friends, due, e.g., to immigration, to access trusted informal supporters. This corps of informal supporters could serve as an informational and emotional support bridge to formal support. Prior studies have noted the importance of dissemination of information to informal supports as further means to improve survivors' formal help-seeking (see Brabeck & Guzmán, 2008; Bradley, Schwartz, & Kaslow, 2005; Evans & Feder, 2014; Fanslow & Robinson, 2010; Flicker et al., 2011; Fraser et al., 2002; Liang et al., 2005; Raj & Silverman, 2002; Sabina et al., 2012; Sylaska & Edwards, 2014).

Behavioral skills barrier – Receiving little or unhelpful support from formal supporters

Receiving little or unhelpful support from formal supporters emerged as a barrier specific to participants' interactions with police. This barrier appeared to affect Hispanic participants to a

greater extent than African American participants. Despite the similarity of circumstances involving police intervention and the apparently equal extent to which both groups solicited police intervention, most African American participants reported police provided them with formal support information (i.e., where to find legal, housing, and counseling services) while most Hispanic participants reported police did not provide them with such information. Consequently, Hispanic participants received less information about where to find help. Furthermore, this meant Hispanic participants received less information during a crisis violent enough to warrant, in their eyes, police intervention.

Prior studies (Gondolf et al., 1988; Marianne R. Yoshioka et al., 2003) have observed African American women to be hesitant to call police due to concerns of unequal treatment of African American males by the justice system. My findings indicate that fear of abusers' reprisals against survivors, their children, or relatives—but not the justice system's treatment of African American male IPV perpetrators—delayed African American participants' use of police intervention. Some Hispanic participants, on the other hand, were concerned their abusers would be deported, leaving them without child support payments. Consistent with previous findings (Bauer et al., 2000; Rizo & Macy, 2011), Hispanic participants also worried they would be deported. Hispanic participants, unlike African American participants, also feared the police. Participants attributed this fear of police to fear of deportation.

Police are a critical resource in information dissemination regarding formal support resources. For some participants, police served not just as first responders but also first informers. Relatedly, police facilitated some participants' access to safe housing (shelters). Police provided transportation to shelters and protected survivors while they removed belongings from their homes. However, this facilitation, like the provision of information, appeared to

support African American participants but not Hispanic participants. Direct observations revealed no Hispanic residents occupied the region's primary shelters for IPV survivors during the nine-month period of data collection, while White and African American women did occupy these shelters. Hispanic participants require more information from police about formal support resources for IPV survivors. Furthermore, Hispanic participants may require safe spaces not currently known or accessible to them (though legally available to documented and undocumented survivors alike). The language barrier is one likely impediment, along with fears of speaking to police and, potentially, getting into a police car to go to a shelter.

Key Facilitators to Formal Help-Seeking for IPV among Minority Women

Informational facilitator – Informing self

Prior to initiating formal help-seeking, several participants from each group reported self-directed searches for relevant knowledge, as well as intentional retention of relevant knowledge, regarding IPV and formal support resources available to IPV survivors. To my knowledge, this finding constitutes a unique contribution to the literature. The existing literature largely focuses on survivors' lack of formal resource information as a help-seeking barrier (see, for example, Adams & Campbell, 2012; Bauer et al., 2000; Bloom et al., 2009; Brabeck & Guzmán, 2008; Crandall et al., 2005; Davis et al., 2001; Krishnan et al., 2001; Rizo & Macy, 2011; Shuman, 2014). Nearly half of this study's participants reasoned they could not be the only women experiencing abuse and that resources of some sort must exist. Participants used a variety of media, stated in the results, to inform themselves about IPV and where to go for formal support resources. Participant recommendations regarding the information sources they searched are the same as or similar to those found in other studies: medical providers and community health workers (Bauer et al., 2000; Evans & Feder, 2014; Shuman, 2014), social service agencies

(Bauer et al., 2000; Evans & Feder, 2014), police and other members of the justice system (Ammar et al., 2005; Brabeck & Guzmán, 2008), clergy (Barnett, 2001), employee assistance programs (Barnett, 2001; Bloom et al., 2009), shelters (Brabeck & Guzmán, 2008; Few, 2005), and support groups (Brown, 1997).

Only a few studies (Brown, 1997; Petersen et al., 2005a; Randell et al., 2012) have offered support for information as a help-seeking facilitator: participation in support groups provided information that helped women end their abuse (Brown, 1997); new information provided by formal supporters helped motivate women to seek help (Petersen et al., 2005a); and Hispanic immigrant women sought formal help after receiving information that help-seeking would not lead to deportation (Randell et al., 2012). In this study, acquisition of relevant knowledge informed participants' plans to escape their abusers and seek formal help. Further adding to the literature, this study observed different media preferences between groups. For example, African American participants preferred help lines and the library while Hispanic participants preferred Spanish-language radio and newspapers. Further research is needed to assess whether significant differences exist in media preferences and which media carry the most import for each, or both, groups. Such evidence would be useful in developing and tailoring information and information sources to group preferences in order to promote access to and use of relevant knowledge.

Motivational facilitator – Seeking help for children's sake

Concern for children's wellbeing emerged as a key formal help-seeking facilitator for both groups. Consistent with prior studies, participants were adamant about protecting their children from harm (see Davis et al., 2001; Evans & Feder, 2014), breaking the cycle of IPV (see Petersen et al., 2005a), and addressing their children's trauma recovery needs (see Randell et al.,

2012). Adding to the literature, this study observed a surprising caveat, corroborated by some participants' counselors, that while participants were motivated to seek help out of concern for their children's wellbeing, they also were unaware the extent to which their children witnessed IPV or how traumatized their children were by what they witnessed. Family counseling provided an important opportunity for participants to learn what their children experienced, which in turn appeared to motivate participants to remain engaged in help-seeking for their children's sakes. The literature does not distinguish between these two potential stages of child-related motivations—initial motivations and maintenance motivations. More research is needed to determine if learning the full extent of children's exposure to IPV does indeed motivate mothers to maintain engagement in counseling. Another possibility is that hearing their children's stories may be too painful for some mothers, motivating them to exit counseling. More evidence regarding children's influence on mothers' initiation and maintenance of formal help-seeking is needed to inform clinical interventions for IPV trauma recovery for both mothers and children.

African American and Hispanic participants did not appear to differ on motivations to seek help for their children's sakes. However, direct observations revealed far fewer African American survivors with children using family counseling than Hispanic participants. Of the African American survivors directly observed in family counseling, most did not complete their counseling program. African American survivors may require more assurances of family counseling efficacy. Shelter caseworkers and agency social workers, formal supporters who help navigate survivors towards other available services, including counseling, were perceived by survivors in this study as trustworthy and may then be logical sources of such assurances.

Behavioral skills facilitator – Making up mind to be completely done

Making up their minds to be completely done with their abusers helped participants break free of their abusive relationships. Consistent with the literature, participants' decisions to be completely done appeared motivated by increasing abuse severity and frequency. Abuse severity and frequency are commonly identified help-seeking motivators (see, for example, Ammar et al., 2005; Petersen et al., 2005b; Randell et al., 2012; Shuman, 2014; Sylaska & Edwards, 2014). Relatedly, preventing abuse recurrence (Evans & Feder, 2014) and fearing harm from or fearing causing harm to the abuser (Randell et al., 2012) also are previously identified help-seeking motivators. Findings were similar across studies regardless of the race/ethnicity of study participants. However, these findings from prior studies are more applicable to this study's Hispanic participants than its African American participants: Increasing IPV severity and frequency did appear to influence, along with concerns for their children, Hispanic participants' decision to be completely done with their abusers. Distinct from Hispanic participants and prior findings in the literature, increasing IPV severity and frequency were conveyed by African American participants as necessary to convincing themselves not to return to their abusers. African American participants, in other words, added a requirement to their decisional process. Being convinced to leave required more than wanting to escape current abuse; it required wanting to escape all potential further abuse. Since survivors often return to their abusers, African American participants' self-imposed requirement could be considered proactive thinking. This thinking does appear, however, to inhibit the motivational influence of this facilitator on activation of behavioral skills. African American participants' described their fears of returning to their abusers essentially like a fear of failure. This ties back to African American participants' earlier concern that formal support would fail to improve their circumstances.

Consequently, African American survivors may require more assurances regarding their decisions to leave, and early in their receipt of formal support, in order to improve their confidence in the decisions they made to leave and their self-efficacy to remain independent.

Additionally, this study found that for both groups the decision to be completely done was cemented by a particularly violent event, usually involving police intervention. Although already certain they wanted to leave, participants typically did not leave until conditions became extremely dangerous. Requiring life-threatening violence to motivate activation of help-seeking behavioral skills—or to feel confident in one's decision to do so—does not make for an ideal facilitator—at least not one that health researchers or practitioners wish to promote. The obvious implication for intervention is to help survivors seek help before circumstances become life threatening. But this is a challenging question in all IPV research studies and interventions and not one that can be answered by any single study or project. My findings may actually contribute more insight for what not to do. Survivors are keenly aware of the dangers they face; their abusers are constantly reminding them. Creating more posters of "battered women" or more TV commercials showing a man beating a woman only serve to insult survivors' intelligence and stereotype their experiences as consisting only of physical abuse. Survivors want to be convinced they are making the right decisions, but this means they want to be assured help will *actually help* while also feeling convinced they will not regret the loss of a relationship that has been extremely important to them.

Informational facilitator – Changing thinking

Participants described positive changes in their thinking that they attributed to formal help-seeking. To my knowledge, prior studies of IPV help-seeking have not investigated changes in participants thinking over the course of their help-seeking process. One prior study observed

changes in motivation based on receipt of new information: Petersen (2005a) observed information regarding the definition and nature of IPV motivated some survivors to seek help. However, Petersen's finding is not specific to receipt of formal support but rather receipt of relevant knowledge. In this study, African American participants changed their doubts about formal supporters and formal support services as they began to experience the benefits of services like counseling, i.e., feeling validated and less anxious. Hispanic participants changed their doubts about formal supporters and formal support services as they encountered more supportive helpers and more services than expected. The differences between groups revealed assurances each group required in order to evaluate formal help-seeking as worth the risk and effort. New client intake appears to be an important moment for practitioners to offer these assurances and in a manner tailored to each group. A great deal of further study is required to explore survivors' thinking over the course of their formal help-seeking experiences, including factors that promote and factors that inhibit positive changes in thinking regarding formal support. Such information is needed to further inform efforts to retain new clients in IPV cessation and recovery services.

Furthermore, members of both groups also changed their thinking about their responsibility for the abuse they suffered. Participants attributed this change in thinking to listening to other survivors' stories and counselor-facilitated trauma recovery curricula while enrolled in formal counseling programs. Participants explained they became more aware of their thoughts and feelings, came to realize they were not to blame for their abuse, and began to recognize their own self-worth. Such programs typically require survivors to be living independently of their abusers. Private counselors, however, may be able to assist survivors with this change in thinking in order to help facilitate survivors' formal help-seeking to leave their

abusers before circumstances become life threatening. This intervention would involve routine IPV screening. As some participants in this study confided, they previously sought private, individual counseling for depression but never disclosed their abuse to their therapists—and their therapists never asked.

Behavioral skills facilitator – Resisting manipulation

Further adding to the literature, observations revealed participants resisted manipulation in order to remain free of their abusers and continue to engage in formal help-seeking, particularly help-seeking for trauma recovery. For example, some participants were stalked, threatened with reprisals, and manipulated through their children after they had left their abusers and were engaged in counseling services. (Direct observations and discussions with counselors corroborated participants' accounts.) Consequently, participants had to resist manipulation to first leave their abusers and then continue to resist manipulation in order to focus on their and their children's trauma recovery. Survivors' efforts to resist manipulation in order to engage and remain engaged in formal help-seeking has not, to my knowledge, been reported in the literature. In fact, few studies have considered survivors' personal strengths at all. Alaggia et al. (2012) observed survivors exerted considerable effort to evaluate the consequences of their decisions in spite of suffering PTSD. Brabeck and Guzmán (2008) observed Hispanic survivors' use of spirituality helped them withstand abusive relationships and even motivate some to leave their abusive partners.

African American and Hispanic participants in this study exhibited both actual and perceived abilities to resist manipulation, though they often did not award themselves due credit. African American participants recounted how they resisted pleas to drop charges. Hispanic participants narrated how they resisted death and deportation threats. Both groups resisted

perpetrators' attempts to manipulate by using emotional appeals, putting terms on changing their behaviors, stealing or destroying property, and threatening to harm or take children. African American participants attributed their abilities to resist threats to their determination to succeed. Hispanic participants attributed their abilities to resist threats to their resolve to accept whatever consequences may come. The group differences reveal unique styles of resistance and therefore ways to recognize and reinforce the abilities of members of both groups while promoting their self-efficacy and sense of empowerment.

Resisting manipulation appears consistent with participants' earlier use of protective behaviors, in which they placed themselves at risk in order to protect their children and other family members from abusers making good on their threats. The difference is participants' prior protective behaviors constituted a barrier that delayed leaving their abusers and consequently their formal help-seeking. Characteristically, however, survivors' protective behaviors and their manipulation resistance behaviors were similar: they both involved survivors' protecting their loved ones, particularly their children. More research is needed to investigate the validity of this observation. Further evidence permitting, if survivors can be helped to recognize their protective behaviors derive from the same objective abilities as their manipulation resistance behaviors, this realization may improve survivors' perceived self-efficacy. Ideally, such an intervention would help survivors facilitate an earlier shift in protective orientation, potentially obviating survivors' needs for a life threatening violent event to motivate them to make up their minds to be completely done with their abusers.

Resisting manipulation seemed critical to participants' abilities to follow through on their decisions to leave and remain engaged in formal help-seeking. Participants' caseworkers and counselors also played a critical role by teaching coping skills to augment participants' objective

abilities. Concomitantly, meetings with caseworkers, counselors, and fellow survivors appeared to enhance participants' perceived abilities, which helped them engage their objective skills to resist ongoing manipulation. Leaving their abusers did not necessarily end abuse for some study participants. These participants continued to be stalked and harassed while in counseling. Even deported perpetrators continued to exert manipulation tactics, specifically threats, across thousands of miles. Technology has made it all the easier for perpetrators to track survivors and exert control remotely. Survivors need to be as technologically savvy about their privacy, and their children's privacy, to protect themselves from the perpetrators.

Behavioral skills facilitator – Covering basic needs and family responsibilities

Financial abuse was a common means abusers employed to manipulate participants. Abusers cut participants off from bank accounts, property equity, and child support payments. Some participants worried they would not be able to make ends meet, which delayed participants' formal help-seeking. Similar effects of financial abuse are reported in the literature (see Brabeck & Guzmán, 2008; Hien & Ruglass, 2009; Liang et al., 2005; Petersen et al., 2005b). Adding to the literature, this study explored ways survivors did indeed make ends meet and thereby overcome this common barrier to formal help-seeking. African American and Hispanic participants used their personal earnings, financial help from informal supporters, and help from formal supporters to access government assistance to establish their independence and remain independent of their abusers. Members of both groups prided themselves in their abilities to work hard, which seemed to promote their perceived self-worth and self-efficacy. After years of being made to feel dependent and incapable, participants expressed determination to stand on their own. Importantly, survivors' drive for independence from their abusers did not appear to preclude their receptivity to financial support from informal and formal sources to augment their

personal income, though Hispanic participants appeared more open to living with others in order to pool resources. However, undocumented Hispanic participants had fewer options obtaining a house or apartment of their own, which may explain why they pooled resources with others. While African American participants used other forms of government assistance, both groups were equally adamant about their personal contributions to achieving independence. The self-worth and self-efficacy participants derived from their efforts seemed important to fostering their perceived abilities to resist manipulation and continue to pursue formal help for trauma recovery. Combined, covering basic needs and resisting manipulation meant less chaos and stress for participants, which in turn seemed to produce fewer obstacles to attending individual and group therapy sessions.

More research is needed to investigate the potential relationship between the benefits of survivors' efforts to establish their independence and survivors' objective and perceived abilities to resist manipulation. With respect to intervention, the potential association between establishing independence and resisting manipulation could indicate the need for further linkages between economic empowerment initiatives, in which survivors' self-supportive abilities are enhanced, and counseling services, in which survivors' coping abilities are enhanced. Given the group differences observed on use of federal programs, Hispanic participants may require additional informational support regarding federal assistance available to all (e.g., WIC, disability services, and child care assistance), to "battered immigrant-qualified aliens" (Title IV), and to victims of crime (U visa). Bilingual formal supporters (e.g., agency staff and lawyers) are particularly needed to help survivors understand their rights, complete the requisite forms, and interact with the courts.

Behavioral skills facilitator – Feeling empowered

Feeling empowered emerged as a key facilitator to maintaining engagement in formal help-seeking for trauma recovery (i.e., group and individual counseling), which is not, to my knowledge, reported in the literature. The closest related finding is Ammar et al.'s (2005) observation that speaking to at least one person about their abuse motivated Hispanic IPV surviving women to seek help from police, which may or may not have to do with empowerment. In this study, survivors demonstrated empowerment through their desire to use lessons they learned from their own experiences to help other survivors. The salience of this facilitator was impressive: most participants conveyed a strong intention to share their knowledge with other IPV survivors. Their growing sense of empowerment appeared to motivate these participants to maintain engagement in counseling: they wanted to learn more in order to help others, and they wanted to attend group-counseling sessions so they could assist new clients by helping them feel less alone. Some participants put their intentions into action through independent advocacy, i.e., launching a company-wide IPV awareness day at their place of employment, forming an independent support group of their own, volunteering as a public speaker during domestic violence awareness month, and advertising their availability through social media to anyone who needs a listener. The current literature is relatively silent on this issue of self-empowerment with the intent to empower others among IPV women survivals.

Feeling empowered revealed participants' need to give purpose to their pain and use their own experiences to help counsel others. Participants described their empowerment as a natural outcome of the help they received from formal supporters, specifically caseworkers and counselors, but their empowerment also appeared to owe to their successes in resisting

manipulation and meeting their family's needs. Though at their highest point of perceived self-efficacy, participants were surprisingly understated about their accomplishments, perhaps because they were still clearly in states of grief and psychological distress. Remarkably, and yet consistent with prior strengths identified, participants moved gracefully from tearfully sharing their experiences to resolutely stating their intentions to serve others. Notably, empowerment was equally evident in both groups of participants. However, empowerment was observed only among those women who maintained engagement in group- or individual counseling for several weeks. Direct observations and discussions with counselors revealed many clients did not maintain engagement beyond a few weeks and likely did not reach this stage of empowerment, given circumstances surrounding their departures and loss to follow up.

Study Limitations

This study employed qualitative methods. Consequently, the results are not generalizable, but neither is that the purpose of qualitative research. The findings are, however, transferable to other similar sites and groups with similar sample characteristics. Detailed reporting of participant characteristics and records of study sites were used to promote transferability. Differences exist in formal support resources accessed between African American and Hispanic participants. While most members of both groups sought and received counseling support, receipt of such was more varied across African American participants in terms of provider qualifications. While all Hispanic participants received counseling from licensed professionals, half of the African American participants received counseling from licensed professionals while the other half received counseling from caseworkers. This difference owes to the difficulty recruiting African American women from counseling agencies, where African American women exhibit much lower enrollment and much higher loss to follow up than Hispanic women. This

limitation did, however, result in the inclusion of more study sites (five total) and thereby an ostensibly more representative, albeit still purposive, sample of formal help-seekers. The inclusion of more sites also elicited a more comprehensive understanding of formal support resources available as well as barriers and facilitators to accessing these resources. For example, differences in police interactions and shelter access would have been missed without the inclusion of the additional sites.

Social desirability bias is an important concern, given participants' reported sense of shame and embarrassment. However, most of this study's participants were recruited after they received several weeks of counseling to address these feelings and other concerns previously inhibiting their readiness to share their stories. Interview recordings document the positive rapport participants and I established. Additionally, many of the participants were already familiar with me because I helped facilitate their children's group therapy sessions each week. Establishment of a comfortable level of rapport generally took 15 minutes, while the interviews lasted an average of 66 minutes. Perhaps the most compelling evidence of lack of social desirability bias was what the participants disclosed. Simply put, the degree of intimate personal detail in their accounts, documented in the recordings and transcripts, certainly felt to me like they were not holding anything back.

Though sample selection was purposive by design, selection bias is a potential limitation because a few survivors declined to participate or did not show up for their scheduled interviews. The main aspect in which they differ from women who did participate is that women who declined or did not attend were likely still dealing with crises. However, this actually describes how survivors who met the ethical bar for inclusion differed from survivors who did not meet the ethical bar for inclusion, as stipulated in my IRB-approved protocol. Apart from the specific

inclusion and exclusion criteria, I could not recruit women in crisis. Crises, often being unpredictable, arose even among women who met the study's inclusion criteria. Consequently, women who declined to participate were likely dealing with circumstances similar to women who were not recruited because they were either in crisis or had not been enrolled in services long enough to address the demands of recent crises.

Semi-structured interviews with individual participants constituted this study's primary data collection method. To help address this limitation, I employed participant-observation, which consisted of working as a volunteer staff member once per week for 24 months at the region's largest non-profit IPV counseling services provider. This work facilitated direct observation through weekly client service hours (assisting with children's group facilitation) and attendance at weekly clinical debriefing sessions regarding client families. Additionally, I routinely spoke with clinical staff about their observations of client families. Direct observations and discussions with clinical staff contributed to source triangulation and thereby helped address the limitations of my primary data collection method. Data from direct observations and discussions were documented and added to the study's audit trail for reference during coding.

With respect to data analysis, peer debriefing was limited and member checking was not possible. Formal peer debriefing sessions were replaced by ad hoc conversations with participants' counselors. As questions arose during data analysis, I spoke with counselors and caseworkers to clarify issues pertinent to my coding of themes and categories. I did not, however, have the opportunity to hold at-length discussions of emergent themes or engage multiple coders. Member checking was not practicable, because safety and privacy concerns limited my access to each participant to one occasion. Focus groups consisting of other survivors

could have provided a solution to this limitation, but challenges recruiting the requisite number of individual participants precluded this option.

Study Strengths

The IPV help-seeking literature lacks definitive explanatory models to guide investigation and understanding of factors influencing IPV survivor's formal help-seeking behaviors (see Sylaska & Edwards, 2014). A theoretical framework informed this study from the design of the interview guide to final data analysis, addressing a critical gap in the literature and revealing important differences between groups and consequent implications for intervention. Indicated by the results of this study, the IMB model may help address this gap and provide new insights in the IPV literature. My use of the IMB model helped uncover potential facilitators: informing oneself about IPV and formal support resources; changing one's thinking about formal support resources, one's role in IPV, one's self-image, and one's future; resisting manipulation tactics employed by one's abuser; covering basic needs and family responsibilities; and feeling empowered (e.g., finding one's voice and a sense of purpose). As demonstrated in Chapter 2, prior studies have largely overlooked behavioral skills facilitators, which may explain why three of this study's five novel findings are behavioral skills facilitators. Resisting manipulation, covering basic needs and family responsibilities, and feeling empowered influenced participants' perceived abilities to activate their objective abilities to perform formal help-seeking tasks, particularly tasks associated with maintaining help-seeking once initiated. The use of the IMB model provided a set of sub-constructs for information (i.e., relevant knowledge, heuristics, and implicit theories), motivation (i.e., personal motivations inclusive of outcomes beliefs and outcomes evaluation as well as social motivations inclusive of perceptions of others' support and motivations to comply), and behavioral skills (i.e., perceived abilities and objective abilities).

These sub-constructs, or concepts constituting each of the three main constructs, helped highlight similarities and differences between groups by providing a level of specificity to the analysis of each emergent barrier and facilitator. For example, attention to personal motivations was important to identifying group differences with respect to avoiding judgment, while attention to social motivations was important to identifying group differences with respect to experiencing abuse as the norm Consequently, had I not employed a detailed operationalization of motivation in my analysis, such as provided by IMB, I may have missed these important differences, which have implications for advancing the knowledge on IPV as well as intervention. The use of the IMB model also provides an analytical structure for considering the associations between information, motivation, and behavioral skills as well as their collective influence on help-seeking behavior. Examination of these associations is beyond the aims of this study, but this chapter's discussion of key findings identified grounds for future research in this area. To my knowledge, this study is the first to use the IMB model in IPV-related research.

Data collection and subsequent analyses deliberately focused more on facilitators to formal help-seeking, given the dearth of research on facilitators compared to barriers, addressing another obvious gap in the literature while providing grounds for future research and implications for intervention. The greater emphasis on facilitators also helped identify novel contributions to the literature that foreground survivors' strengths and abilities. Comparisons are made between African American and Hispanic participants on each barrier and facilitator, identifying key similarities and differences relevant to tailored interventions. Furthermore, these specific group comparisons contribute to the literature: only two papers used samples consisting of African American and Hispanic survivors (El-Bassel et al., 2001; Gilbert et al., 2012), and these studies did not perform racial/ethnic group comparisons.

Selection of participants currently enrolled in formal support services limited recall bias. Participants were literally in the middle of their formal help-seeking process. Furthermore, experiences of living with IPV were recent events for participants, which also limited recall bias. Additionally, selection of formal help-seekers (versus survivors who had yet to seek formal support), enabled observations of facilitators, since help-seeking survivors had obviously succeeded, at least to the point of interview, in both initiating and maintaining formal help-seeking. Careful attention was paid to ensuring rigor throughout the study. Credibility was promoted through prolonged engagement (Lincoln & Guba, 1985), mitigation of social desirability bias (Kirk & Miller, 1986), bracketing (Giorgi, 1985), memoing and maintaining a journal (Lincoln & Guba, 1985), and transcript quality assurance. Adherence to these rigorous methods promoted confirmability (Lincoln & Guba, 1985), or the neutrality of the data. Furthermore detailed records were maintained of every aspect of the study to promote dependability (Lincoln & Guba, 1985), or the repeatability of the study.

Concluding Remarks

Much of the IPV help-seeking literature to-date has contributed to the decades-long effort to convince policymakers that IPV survivors need comprehensive resources to end their abuse, recover from trauma, and remain free of IPV recurrence. IPV researchers, practitioners, and advocates have brought about significant improvements in formal resources available to survivors, particularly since the initial 1994 passage of the Violence Against Women Act. The unintended consequence, however, is a body of literature that focuses mainly on barriers, and therefore survivors' deficits. There is, of course, more to survivors' experiences than victimhood, and understanding their roles in their own abuse cessation and trauma recovery, and their powerful intentions to help others, requires more than a semantic turn from "victim" to

"survivor." More research is needed to understand survivors' transitions in thinking, motivations, and behavioral skills over the course of their formal help-seeking experiences and the intrapersonal strengths they bring to bear in those transitions. Such understanding may inform how formal supporters can further use their resources to foster and build upon survivors' strengths in order to promote earlier formal help-seeking initiation as well as retention in formal support services and programs.

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Appendix A: Group Comparisons

Table 4: Group similarities and differences in formal help-seeking barriers and facilitators

Barriers and Facilitators by formal theoretical categories and themes	**Group similarities and differences** (Differences shown juxtaposed in gray boxes)	
Barriers		
Informational barriers	**African American**	**Hispanic**
Lacking knowledge about IPV and IPV help-seeking	Lacked knowledge regarding formal support resources; did not recognize IPV as abusive or wrong; believed they did not know how or were otherwise unable to find help	
Receiving advice from informal supporters not to seek help	Some received impractical advice; told to keep quiet to avoid embarrassment	
	Made to feel abnormal if they chose not to have an intimate male partner	Advised their role was to preserve marriage
Coming across little information	Noted seeing little to no advertising of IPV formal support agencies, programs, or services in the community; recommended websites	
	Recommended bus wraps, Internet, and television as media; clothes closets, food pantries, and SNAP offices as sites; human resource departments as communicators/program facilitators	Recommended Internet, newspapers, and social media as media; churches and schools as sites; churches and schools as communicators/program facilitators
Motivational barriers	**African American**	**Hispanic**
Feeling like being in a hole	Described feeling unmotivated to seek help due to depression, confusion, and feeling sick; felt financially trapped or dependent	
	Did not emphasize depression but did emphasize financial dependence as barrier	Emphasized depression and financial dependence as barriers
Still loving the partner	Feeling personally motivated to remain with one's abuser out of love	
Avoiding judgment	Confided they were ashamed and embarrassed; feared others would judge them harshly	
	Chief concern was being judged weak	Chief concern was being mocked/taunted
Experiencing abuse as the norm	Reported IPV did not seem wrong so much as something women are expected to endure	
	Felt a pull to comply with community norms and attitudes regarding intimate relationships	Felt a pull to comply with traditional beliefs about the roles of wives and mothers
Protecting herself and others from the abuser and the authorities	Kept abuse private, fearing physically violent reprisals from abusers for seeking help; viewed help-seeking as high risk	
	Feared abuser would gain child custody	Feared abuser would abduct or kill children
	Worried DCS would blame them and take their children	Worried ICE would deport them, forcing them to leave their children behind in the US

Table 4 (Continued)

Barriers and Facilitators by formal theoretical categories and themes	Group similarities and differences (Differences shown juxtaposed in gray boxes)	
Lacking confidence in others for help	Worried formal support agencies would fail them; doubted formal support resources for IPV applied to them; held low perceived support due to treatment received from some community members; most were not worried about racial discrimination	
	Worried formal supporters would be ineffective and leave them in a more precarious situation	Worried formal support did not exist or worried existing support would be denied to immigrants
	Some believed anyone who had not experienced IPV did not know enough to help	Did not state or infer supporters needed direct IPV experience
	Some confided in church members and leaders	Stated church members and leaders were too uninformed to help
Behavioral skills barriers	**African American**	**Hispanic**
Being trapped without resources to escape	Described feeling unable to enact help-seeking skills, due to isolation, constant monitoring, and disproportionate burden of child and household responsibilities	
Taxing the support system	Returned to abusers, leading informal supporters to withhold further support	
Receiving little or unhelpful support from formal supporters	Some reported police dismissed calls for help	Some reported police misunderstood calls for help, due to language barrier
	Did not report fearing police	Reported fearing police primarily due to fearing deportation
Facilitators		
Informational facilitators	**African American**	**Hispanic**
Receiving informational support from informal supporters while leaving the abuser	Received information from family and friends regarding where to access formal supporters for legal and counseling assistance; friends were the primary source of informational support	
	Reported receipt of informational support from churches	Did not report receipt of informational support from churches
Receiving informational support from formal supporters while leaving the abuser	Reported police intervention; police connected survivors to a domestic violence services agency; information received from agency staff was completely new; reported service agency information directed them to tangible support; described the process of obtaining help much easier than expected	
	Most reported receiving service agency referral information from police	Few reported receiving service agency referral information from police
Informing self	Accessed human resource departments, Internet, television programs, and YWCA	
	Used church, help lines, library, and signage as information sources	Used radio, newspaper, health department, and social media as information sources
Seeking other services for the children	Efforts to locate help for children's mental and behavioral health needs led to IPV counseling	
Seeking other services for self	Two referred to IPV counseling from drug rehabilitation programs	Four referred to IPV counseling after presenting for an unrelated trauma, i.e., aggravated robbery

Table 4 (Continued)

Barriers and Facilitators by formal theoretical categories and themes	**Group similarities and differences** (Differences shown juxtaposed in gray boxes)	
Becoming more aware of IPV and its effects	Became aware of forms of IPV other than physical abuse and need for counseling; emphasized importance of no longer feeling alone; attributed remaining in counseling to hearing other survivors' stories; became more cognizant of how perpetrators affected their thinking, quality of life, and sense of self worth	
Changing thinking	Thinking about formal support resources, their role in IPV, self-image, and future changed; realized they were not to blame for the abuse they received; recognized self-worth; became more aware of their own thoughts and feeling	
	Emphasized efficacy of formal support received	Emphasized number of formal support resources available in the US vs. CoO
	Previously lacked confidence the support offered would work	Previously lacked confidence resources existed—or existed for immigrants
Motivational facilitators	**African American**	**Hispanic**
Experiencing more severe and frequent IPV	Shared experiences of increasing frequency and severity of IPV; increasing severity and frequency reinforced motivation to seek help	
	Described how abuse escalated from verbal to physical	Described how abuse escalated to include more severe injuries, more frequent IPV, and more forms of IPV
	Emphasized situation felt life or death, due to intensifying abuse	Emphasized situation felt intolerably frustrating, due to intensifying abuse
Feeling increasingly depressed	Attributed depression to living with ongoing abuse and trauma	
	Did not infer a connection between severe depression and increasing severity and frequency of IPV experienced as IPV intensified	Attributed severe depression to increasing severity and frequency of IPV experienced as IPV intensified
	Did not report a strong desire for psychological counseling	Reported a strong desire for psychological counseling
Tiring of IPV and its effects	Reported reaching a point where they could no longer tolerate living with IPV, due to duration of abuse	
Seeking help for children's sake	Motivated to seek help for children's protection and future QoL; wanted to break the cycle of abuse; wanted to be more focused parents for their children	
Feeling supported by informal supporters	Felt supported, due to received support, contrary to expectations of some; identified family as primary emotional supporters, followed by friends; positive appraisals and emotional support promoted motivations to seek formal support	
	Cited church leaders and fellow church members as sources of emotional support	One participant cited a church leader as source of emotional support
Feeling supported by formal supporters	Shared how much they liked and appreciated their formal supporters; inferred positive affect derived from the way agency staff treated them	
Deciding what I want	Hoped help-seeking would lead to overcoming shame, dealing with their feelings, getting to know themselves again, overcoming depression, finding peace, and becoming happier people and parents	Wanted psychological counseling to address their depression

Table 4 (Continued)

Barriers and Facilitators by formal theoretical categories and themes	Group similarities and differences (Differences shown juxtaposed in gray boxes)	
Becoming more aware of IPV's effects on the children	Worried most about IPV's effects on children; became more aware of IPV's effect on children's health as formal supporters intervened; children reportedly experienced anger, depression, anxiety, and trouble focusing in school; felt guilty their children suffered	
Feeling safer and more at peace	Felt safe and more at peace; attributed feeling safer, more at peace, and calmer to support received from counselors and fellow clients	
Behav. skills facilitators	**African American**	**Hispanic**
Making up mind to be completely done	Deciding to be completely done was a necessary condition to ensure against returning to abusers after seeking help	Deciding to be completely done was an outcome of increasing IPV severity and duration that promoted seeking help
Escaping the abuser	Violent event prompted call to police; gradually saved money to facilitate escape; made plans to leave and seek help	
	Some used shelter services	None used shelter services
Receiving tangible support from informal supporters while leaving the abuser	Informal tangible support helped facilitate transition from living with abusers to remaining independent of abusers; informal tangible support helped facilitate formal help seeking; family members were primary source of tangible support	
	Reported receiving tangible support from churches	Did not report receiving tangible support from churches
Receiving tangible support from formal supporters while leaving the abuser	Helped by agency staff to bridge abuse cessation needs and abuse recovery needs; pleasantly surprised at the quantity, types, and quality of support available	
Remaining safe	Learned through counseling programs to develop safety plans in case of emergency	
Learning to use the justice system	Emphasized the need for temporary orders of protection and longer-term restraining orders to protect against abusers; feared going to court; learned how to use the justice system and exhibited self-efficacy using the justice system	
	Emphasized help of formal supporters to obtain child custody and child support	Emphasized help of formal supporters to remain in the US for their children's sakes
	Feared facing their abusers in court	Feared courts generally, due to immigration status
Covering basic needs and family responsibilities	Used their own resources as well as help from informal and formal supporters to meet basic needs; informal supporters helped cover basic needs; either living independently prior to or shortly after separating from abusers or transitioning to independent living using personal earnings and help received from formal and informal supporters; emphasized work ethic and ability to work hard	
	Emphasized independence and use of personal resources to cover basic needs	Emphasized both independence and pooling resources with informal supporters to cover basic needs
	Reported using several Federal programs	Reporting using two Federal program (SNAP and WIC)
Drawing on personal strengths	Emphasized perseverance; felt proud of abilities and accomplishments; exhibited self-efficacy to enact help seeking skills	

Table 4 (Continued)

Barriers and Facilitators by formal theoretical categories and themes	**Group similarities and differences** (Differences shown juxtaposed in gray boxes)	
Resisting manipulation	Resisted perpetrators' attempts to manipulate through emotional appeals, putting terms on changing abusive behaviors, stealing or destroying property, and threatening to harm or take children; described how perpetrators shifted manipulation tactics, replacing failed tactics with new threats	
	Resisted pleas to drop charges	Resisted perpetrators threats to call deportation officials
	Emphasized determination to succeed	Emphasized resolve to accept whatever consequences may come
Learning and employing coping skills	Described learning how to relax, reflect, and cope with anger and sadness; felt less alone; inferred trauma recovery services helped build skills to cope with depression and anger; believed use of coping skills would reduce chances of returning to abusers or entering into new abusive relationships; coping skills further enabled continued to engagement in help-seeking	
Feeling empowered	Reported greater self-efficacy, renewed ability to trust others, and ability to speak about IPV experiences; wanted to help other women IPV survivors	

Appendix B: Interview Guide

Interview Guide
Exploring help-seeking behavior among minority women survivors of intimate partner violence (IPV) in the Mid-South of the United States

Participant ID:_____ Date:_____

Interviewer's name:_____

A. Demographic information

Age: Race/Ethnicity:

Marital status: Living with: #of people in the household:

Number of children: # Weeks receiving services?

Education: Personal income: <$15K; >15K to <25K; >25K to <50K; >50K to <75K; >75K

Please think back to the period before you came to the Center.

B1. Information Domain

1. A. For how long did you experience domestic abuse?
   B. When did you last experience domestic abuse?"
   C. What form(s) of abuse did you experience (e.g., physical, psychological or emotional, or sexual)?
   D. For Spanish speakers only: "Did you experience domestic abuse in your country of origin, here in the US, or both?"

2. What types of help or support were you getting back then in dealing with domestic violence?

3. At that time, what did you know about help available for women dealing with domestic violence?

4. What information about sources of help did you find useful?

C1. Motivation Domain

1. At that time, what did you think would happen if you asked for help from someone outside of your family and friends?

2. How did those thoughts affect your feelings about seeking help from these outside sources?

3. Back during that period of time, what did your family and friends think about these sources of outside help?

4. How did you feel about your family and friends' opinions? *(Prompt: Did feel you needed to agree with them or do what they thought you should do?)*

D1. Behavioral Skills Domain

1. Back then, did you think you would have the ability to find outside help for domestic violence?

2. Before you talked to anyone outside of friends and family, did you make plans to find outside help? *(Follow-up**: If yes**, state, "I have a follow up question about abilities for making plans. For example, abilities include being able to find information, like on the Internet or at the library. Abilities also include things like being organized, focused, or good at finding ways out of tough situations. What abilities helped you make plans to find outside help?"*
***If no**, state, "I have a follow up question about abilities for making plans. For example, abilities include being able to find information, like on the Internet or at the library. Abilities also include things like being organized, focused, or good at finding ways out of tough situations. What abilities do you think would have helped you make plans to find outside help?")*

3. Before you talked to anyone outside of family and friends, to what extent were you able to get resources like food, a place to stay, and money if you wanted to leave your partner?

4. If you didn't have these resources from family and friends, who could you ask for help?

5. Was anyone involved with alcohol and/or drug abuse in the family? If yes, how did it play into domestic violence?

Please think back to the period <u>when you first came to the Center</u>.

B2. Information Domain

1. How did you learn about the Center and other resources available to you?

2. During that period, you were talking to a lot of new people and being given a lot of information. What information was new to you?

3. How did the new information change your thoughts about help available for domestic violence?

4. Do you think the new information influenced your decision to participate in the Center's services? *(Prompt: **If so**, ask, "How did the new information influence your decision?"*
"What information helped you make up your mind to participate in the Center's services?")

5. Why do you think some women wait to seek help, or never seek help, for domestic violence?

C2. Motivation Domain

1. As you thought about using outside help, what did you think would happen after you received the help? *(Prompt: What did you think you would get out of it, and what did you think your children*

would get out of it?)

2. Were those outcomes important to you? Why or why not?

3. Once you decided you were going to participate in the Center's services, what did your friends and family think? *(Prompt: Were they supportive? Unsupportive? In what ways were they supportive or unsupportive?)*

4. What were your biggest concerns about seeking outside help for domestic violence?

5. What are some of the main things you think helped you deal with those concerns?

6. What are some of the benefits you experienced after your sought help?

7. What kind of support or pressure led you to seek help?

D2. Behavioral Skills Domain

1. How did your responsibilities (e.g., taking care of children, working) affect how easy or hard it was to get outside help?

2. How did needing to take care of the basics, like food and housing, affect how easy or hard it was to get outside help?

3. Looking back now, what were some of the main things (including people) that made it possible, or even just easier, to get the outside help you needed?

Now I would like finish with a few questions related to your community.

E. Community Domain

1. Your community could be your neighborhood, your church, or people who share the same culture, language, and background as you. What attitudes or opinions does your community have about domestic violence?

2. How did your community's attitudes or opinions make you feel about seeking help for domestic violence?

3. How did your community's attitudes or opinions affect who you asked for help?

4. When you started looking for outside help, what, if any, concerns did you have about being discriminated against?

5. How do you think these concerns affected your willingness to seek help?

F. Interviewer Assessment (to be completed immediately after the interview)

1. Was the interview completed? If not, why not?
2. How did the interview go?
3. Were there particular questions that the interviewee did not want to respond to? If so, which ones?
4. Describe the interviewee's emotional & mental state (if s/he seemed high, got agitated, got upset, etc.)
5. Other comments: