

**THE MENTAL HEALTH HELP SEEKING EXPERIENCES OF FEMALE VICTIMS
OF INTIMATE PARTNER VIOLENCE**

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Submitted to the Graduate Faculty of
The School of Social Work in partial fulfillment
of the requirements for the degree of
Doctor of Philosophy

University of Pittsburgh

2007

UNIVERSITY OF PITTSBURGH

SCHOOL OF SOCIAL WORK

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This mixed-method study examined the influence of intimate partner violence (IPV) on the mental health help seeking experience of twenty-two women who received domestic violence services at a local Women's Domestic Violence Center and Shelter. The volunteer convenience sample completed the Conflict Tactic Scale 2 Short Form (CTS2S), Patient Health Questionnaire (PHQ)-9, Post-traumatic Stress Disorder Checklist-Civilian (PCL-C), and the Social Support from Others (SFO) scale along with a qualitative interview based on the Health Belief Model (HBM) assessing their experiences of mental health service acquisition outside of the shelter. Findings revealed high rates of psychological abuse (95%), physical assault and injury (82%), and sexual coercion (64%) by an intimate partner in past year. Reported PTSD was 62% and depression 55%. Identified themes related to the women's perceived need for mental health care, barriers to care, and benefits of care. Perceived need related to feelings of fear, anxiety, isolation, and concern for children. Barriers included difficulty trusting and forming a therapeutic alliance with mental health providers and finding appropriate mental health response to IPV. Perceived benefits of mental health treatment related to receiving validation and improved self-regard. Mixed-method analyses revealed a significant relationship for perceived need with both depression and PTSD. Higher perceived barriers significantly related to PTSD and depression. Lower perceived benefit significantly related to PTSD but not to depression. Social support

negatively correlated with depression, PTSD and IPV. The majority of the women cited shelter staff and residents as primary providers of support. Implications include the need for increased understanding of IPV among mental health providers and increased flexibility of services for IPV victims. Further research is suggested on the mental health implications of psychological abuse and trauma associated with IPV and increasing effective provider and treatment strategies to engage IPV victims in mental health treatment.

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PREFACE

I would like to thank those whose interest, assistance and support contributed to this project. To my dissertation chair, Catherine Greeno, Ph.D., thank you, Katie, for your intelligence, feedback, practicality, and enthusiasm for my achievements and for this project. To Lynn Hawker, Ph.D., and the counseling and front desk staff of the Women's Center and Shelter of Allegheny County (WC&S) who facilitated this project, thank you for your assistance and the example of stewardship of the WC&S program and its clients that you provided. You modeled a standard of respect for the dignity and integrity of the women receiving services at the WC&S and I hope that I emulated that standard in carrying out this research. To Pat Cluss, MD, Ph.D., thank you for your feedback and encouragement. To Bert Maguire, Ph.D., thanks for your insights and contributions to this dissertation. To Esther Sales, Ph.D., thank you for your support and assistance throughout the doctoral program and for your knowledge and gentle prodding during this project. Thank you all for your contribution as members of my dissertation committee.

To the women who participated in this study, thank you for your willingness to discuss difficult events in order to document your experiences and to help others. Your open and engaging manner and commitment to recovery from abuse contributed to my comfort and motivation in conducting this research. You are the ones who give meaning and importance to this study.

I would also like to acknowledge Gary Koeske, Ph.D. for his responsiveness and support throughout my doctoral education. I send my best wishes to you and Randi. I want to thank my professors from the MSW program. Dr. George McClomb, thank you for providing a challenging academic experience and a listening, supportive ear. Dr. Arden Meltzer, thank you for your insight and support. Thank you both for your encouragement and engaging conversation. To Cheryl Bartko, thanks for looking out for me. Marcia Piel, thanks for your support and always knowing where to find the answers to my questions.

My parents, Janet & Terry, who have always wanted the best for me and encouraged me to do what I thought was right and my sisters, brothers, and their families, for the support and the fun that I have with them. Thanks Kim & Fred, Kathy & Rachel, Marty & Amy, David, Beth, Joe, Ben, & Lena. Ben, I finally “beat” college. To my friends and colleagues whom I met through the doctoral program and feel like I’ve known much longer, thanks for your encouragement and support. Christine & Emmett, Micki, Jee-Sook, and George, we made it! To friends who are on their way to finishing, Jaysharee, Grace, and Hanai, good luck to you! Knowing all of you has enriched my experience here at Pitt.

Thank you to The Women’s Studies Department of The University of Pittsburgh for the dissertation fellowship award that helped me to conduct this research. To Community Care Behavioral Health Organization (CCBHO) and John Lovelace, I appreciate your interest in and support of this study. Also, to The University of Pittsburgh School of Social Work, for providing the supportive environment, finances, and educational experience that made this work possible.

1.0 INTRODUCTION

1.1 INTRODUCTION

This mixed-method study investigates the influence of intimate partner violence (IPV) victimization on the mental health help-seeking process of female victims of IPV. The Health Belief Model (Rosenstock, 1960) is applied to examine the mental health help-seeking process of 22 women with a history of IPV victimization who have obtained or considered accessing mental health services related to their IPV victimization. The women in this study have received or were receiving domestic violence services at the Women's Center and Shelter of Greater Pittsburgh (WC&S), the setting of this study, at the time of their participation. The Women's Center and Shelter of Greater Pittsburgh (WC&S) is a local, urban domestic violence service agency that provides both residential and non-residential services including advocacy, education, and support to female victims of IPV and their children. While the WC&S does not provide psychological counseling to its clients, it does refer clients to outside providers for psychological counseling.

This study seeks to expand on current knowledge regarding the influence of IPV victimization on mental health help-seeking. The need for increased information in this area is supported by the national agenda to improve the quality of research, knowledge, and services related to women's mental health and the role of violence victimization in women's mental health (NIMH, 1986, SAMHSA, 1994). Russo (1990) identifies the need for increased knowledge and involvement of professionals regarding the provision of effective mental health

treatment for female victims of violence, especially for victims who are disadvantaged or marginalized in society.

This study was also encouraged by an expressed need on the part of the Women's Center and Shelter of Greater Pittsburgh (WC&S) to clarify and inform anecdotal information regarding the mental health help-seeking experience of their clients. The WC&S staff provided support for this study by participating in a pre-test of the study measures, referring study participants, and providing physical space for conducting the study interviews. The WC&S was interested in obtaining empirical information in order to better assist their clients in accessing appropriate mental health care. This study contributes to the knowledge base on the mental health help-seeking process of female victims of IPV.

In understanding the current relationship between IPV and mental health help-seeking it is necessary to identify the extent and consequences of IPV and mental illness in society, particularly as they impact women. National data from the Center for Disease Control (CDC) indicates that 1.5 million women a year are assaulted by intimate partners. Physical violence, in the form of assault, injury, rape, and death at the hands of an intimate male partner is the leading type of assault experienced by women in the United States. As the primary victims of IPV, women bear the direct physical, economic, and psychological burden of this victimization.

Although IPV occurs within all socio-economic groups in society, victimization is highest among young, low-income women with less formal education (DOJ, 2003). This population represents a vulnerable group in society that is also at higher risk for developing psychiatric disorders (Blazer, Kessler, McGonagle, & Swartz, 1994). The impact of IPV on individual victims and society is often costly and long-term.

IPV victimization has been found to be associated with increased rates of chronic mental illness (Coker et al., 2000). The physical and psychological difficulties associated with IPV victimization impair role functioning and increase the need for health care services. Medical care utilization is high among IPV victims for years following the battering (Bergman, 1991). The National Research Council [NRC] (1996) reports that female IPV victims lose more time from work, spend more days in bed, and suffer more from stress and depression than non-victims. Nationally, health care costs of intimate partner violence and stalking are estimated at about 6 billion dollars a year (Center for Disease Control and Prevention [CDC], 2003). Despite the increased presence of mental health problems among female victims of IPV, few seek or follow through with mental health treatment (Henning & Klesges, 2002). Individuals with mental health diagnoses who do receive treatment often delay treatment contact for years after their initial diagnosis (Wang, Berglund, Olfson, Pincus, Wells, & Kessler, 2005).

Identification of the extent and consequences of mental illness in society is also relevant to understanding mental health help-seeking. It is estimated that 20% of Americans suffer from a diagnosable mental disorder and many people suffer from more than one mental disorder (National Institute of Mental Health [NIMH], 2001). Mental illnesses constitute several of the leading causes of disability burden in the United States (Murray & Lopez, 1996). Disability burden refers to the social costs of disability related to health care and morbidity (Wells et al., 2002). Decreased productivity, role functioning difficulties, and the chronic nature of mental disorders result in high economic, social, and personal costs for victims and society (U.S. Department of Health and Human Services [DHHS], 1999).

In light of the impact of mental health problems in society, it is important to address the issue of service utilization and disparity in access to mental health treatment. Less than one-half

of adults diagnosed with a mental disorder receive treatment (Kessler et al., 2001). Cultural and ethnic diversity, age, race, gender, income, education, attitudes, and appropriateness of care have been identified as factors relating to disparity in access to mental health treatment (DHHS, 1999). Although both women and men underutilize mental health treatment, women are less likely to seek help from mental health specialists (Fellin, 1996). The underutilization of mental health services suggests incongruence between mental health need and available mental health services.

This incongruence between mental health need and services may be rooted in the nature and provision of service delivery to IPV victims. Traditionally, Women's Shelters have been the primary service providers to women victimized by IPV. Women's shelters originated in the 1970s within the context of the second wave of feminism and focused on increasing societal awareness of IPV, victim advocacy, and providing for the immediate shelter and security needs of victims. Women's Shelters tend to view IPV as a social problem rooted in a patriarchal society. Their treatment approach emphasizes safety, empowerment, education, and access to resources, with a goal of social reform.

Shelters provide a safe environment where women can heal and grow through supportive interactions with other women who can validate their experiences of abuse (Lundy & Grossman, 2001). Today, as in the past, services are generally provided by counselor/advocates, women who have been victims of intimate partner violence and want to help others recover from abuse. Counselor/advocates are typically not mental health professionals. They offer non-professional counseling emphasizing empowerment and personal choice. This counseling consists of education to increase understanding and awareness of violence, allowing women to make their own decisions and choose their own goals regarding their abusive situations, and connecting

women to resources in the community. Women who require mental health treatment to address issues of trauma or other psychological issues are usually referred to agencies or professionals outside of the shelter.

In their role of referring women to professional mental health services outside of the shelters, Women's Shelters represent a point of entry to mental health services. This role is increasingly relevant as evidence indicates a change in the demographics of women seeking shelter services. As society expanded options for IPV victims, women of means, in particular, gained increased access to additional resources to address IPV. In the legal system, for example, criminal and civil actions could be brought against abusers, allowing victims who could access the court system to pursue resources for finances, health insurance, housing, and counseling related to IPV victimization. This has contributed to the trend of women with fewer resources, more negative lifetime experiences and more mental health need seeking shelter services (Warshaw et al, 2003). These mental health needs may interact with lifetime experiences of poverty, drug and alcohol abuse, and the impact of multiple and complex trauma. As Women's Shelters often do not have the resources or service orientation to provide professional mental health counseling, they typically refer clients to mental health care outside of the Shelter.

In this transition from the service environment of the Women's Shelter to that of the mental health system, particularly the public mental health system, there is concern regarding the nature of the understanding and response to IPV within the mental health system. Tierney (1998) argues that services provided within the mainstream social service delivery system do not support the feminist, self-help orientation of Women's Shelters. In a national survey of family therapists, Hansen, Harway, & Cervantes, (1991) found that when presented with scenarios of actual cases of severe partner abuse, 40% of the therapists did not identify the violence as an

issue to be addressed in their conceptualization of the cases. Fifty –five percent of the therapists reported that they would not provide an immediate intervention to address the violence. The traditional family systems approach to treatment of domestic violence has been criticized because it implicates the behavior of all members of a family, including the victims of abuse, in the occurrence of abuse and it minimizes the issue of violence in the family. From a systems approach, violence is seen as a secondary issue that underlies the primary issue of a dysfunctional system (Bograd, 1984).

Although there is historical precedence for these concerns, the mental health field has responded to concerns regarding the understanding and treatment of women's mental health issues. Policy agendas established at the executive level of the United States government and among professional organizations such as the American Psychological Association (APA) have issued agendas to increase the understanding of sex bias in research and practice, to improve understanding of the relationship between violence against women and mental health, and to promote integration of this new knowledge into the practice of women's mental health treatment (Fellin, 1996). These agendas recognize the need to improve the mental health system response to the needs of women, particularly the needs of women of color, low-income, and victims of violence.

Advances in feminist scholarship and knowledge related to gender issues have provided insight and offered therapeutic applications in the mental health treatment of women. These approaches apply feminist philosophies to examine the role of external factors such as the reduced power and autonomy of women in society as influences on mental health and mental health treatment. As such, they offer a critique of gender inequality in society and identify the need for social as well as personal change (Fellin, 1996). Awareness of the mental health issues

of women in relation to the experiences of poverty, multiple roles, stress, affective disorders, IPV and trauma has contributed to an improved response to women's needs within the mental health system. Despite an increase in the understanding of women's mental health issues and in available treatment, there is recognition that traditional mental health services have not adequately addressed the mental health needs of special populations of women. These populations include women of color, women living in poverty, and women who have experienced violence and other traumatic life events.

This study examines the mental health help-seeking experience of female IPV victims by applying The Health Belief Model (HBM) (Rosenstock, 1960). The HBM identifies three dimensions of help-seeking; need, barriers, and benefits; need refers to a recognition of the severity of and susceptibility to symptoms, barriers refers to the negative consequences of help-seeking, such as stigma or side-effects of treatment and benefits refers to the belief that seeking help will be beneficial and will outweigh the barriers to treatment. Identifying clients' mental health help-seeking experiences will assist to clarify the unique perspective of IPV victims and perhaps help bridge the gap in mental health service provision to victims of IPV.

This research topic is particularly relevant to social work practice. The values and ethics of the social work profession promote the importance of access to adequate resources and services, quality of life, and client self-determination (Levy, 1976). These principles are exemplified in this study through its focus on the identification of IPV victims' experiences and perceptions regarding mental health help-seeking in an effort to promote congruence between need and service delivery.

In a study of the market influences on the provision of effective mental health care, Schoenbaum et al. (2004) found that insurance providers, mental health agencies, and employer

insurance purchasers do not assume responsibility for improving access to mental health care. Social workers however, do have a role to play in improving access to care. Social workers are trained in a person-in-environment approach to problem-solving. This approach identifies the need for appropriate social resources in order to support individual functioning. Social workers act as advocates and mediators as they negotiate access to community services for their clients. This role places social workers in a position to facilitate bridging the service gap between the mental health needs of IPV victims and available services.

In examining the relationship of IPV and mental health help-seeking, this study utilizes a mixed-methodology. Quantitative measures were used to assess treatment history, demographic information, intimate partner violence, depression, PTSD, and social support among the sample. The measurements were examined to provide an overview of the characteristics of the study population. The outcome of the measures of IPV, depression, and PTSD were examined to identify any relationships among these measures (Pearson correlation) and between these measures and the qualitative measures used in the study (t-tests). This comparison of the outcome data obtained by the quantitative and qualitative measures is a method of data analysis known as triangulation (Patton, 2002) and refers to the examination of data from more than one perspective in an effort to enhance understanding of the findings and reliability of the data collection.

A qualitative interview based on the three dimensions of the HBM was developed for this study. The interview consists of open-ended questions designed to elicit information from the women's perspective regarding their mental health help-seeking experience. The questions follow the format of the HBM in their inquiry into the perceived need, barriers, and benefits experienced by the women as they engaged in the mental help-seeking process. This inquiry was

primarily retrospective, as the majority of the women had already accessed mental health services. However, as the majority of the women were also currently receiving mental health services, they discussed both their recollection of their prior help-seeking experiences as well as their current help-seeking experiences. This situation provided a unique opportunity for the women to compare their previous and current experiences and contributed to the enrichment of the data collection process.

Qualitative data analysis consisted of a content analysis of the interviews for the purpose of the identification of themes relevant to the research questions. Themes were identified, categorized, coded, and counted. The results of the qualitative assessment on the three dimensions of help-seeking were also transformed into category variables in order to conduct t-test to determine significance among the relationships of the qualitative measures of the dimensions of need, barriers, and benefits with the quantitative measures of IPV, depression, and PTSD. These tests were conducted for the purpose of data enrichment as well as for the purpose of enhancing validity and reliability in data collection. The main research objectives of this study are as follows: 1) Identify the characteristics of perceived need for mental health care among female victims of IPV, 2) Identify the perceived barriers to mental health care for female victims of IPV, and 3) Identify the perceived benefits of mental health care for female victims of IPV. The mixed-method approach also examined the relationship of the outcomes of the quantitative and qualitative measures. The purpose of this study was to examine the influence of IPV victimization on the mental health seeking experience of female victims of IPV in order to inform the issue of underutilization of mental health services by female victims of IPV.

2.0 REVIEW OF LITERATURE

2.1 INTRODUCTION

This study examined the influence of IPV victimization on the mental health help-seeking experience of female victims of IPV. In doing so, it addresses concerns regarding the current status of mental health service provision to female victims of IPV. The current environment of mental health service provision to female victims of IPV is grounded in the historical experience of mental illness and intimate partner violence in American society. As such, this chapter reviews the history of the social recognition and response to the issues of IPV and mental illness in the United States. Awareness of the historical context of these issues in society allows for an appreciation of the evolution of social understanding of IPV and mental illness. This understanding provides insight into the historical legacies that helped shape and continue to influence social response to these issues and offers evidence on the interaction of social understanding and service provision.

2.2 HISTORICAL PERSPECTIVES ON IPV

The social understanding of IPV has developed over time in response to changing social conditions. As exemplified in the current definition of IPV provided by the Center for Disease

Control (CDC), intimate partner violence is recognized as consisting of a variety of behaviors, within diverse intimate relationships, that serves to intimidate and dominate a current or former partner. The Center for Disease Control (CDC) defines intimate partner violence as “physical, sexual, or psychological violence or threatened violence by a current or former partner or spouse”. This definition applies to both heterosexual and same sex couples, whether or not there is sexual intimacy in the relationship. Violence, by this definition, includes violent or threatening behavior directed at the intended victim as well as the manipulation of resources, possessions, or significant others of the intended victim in order to control or intimidate the intended victim.

IPV is also included within the definition of domestic violence provided by The Department of Justice (DOJ). The DOJ incorporates the CDC definition in its description of domestic violence, which includes an additional category for economic violence. The DOJ defines domestic violence as a pattern of abusive behavior used by one intimate partner to gain and maintain power and control over another intimate partner in a relationship. While these definitions recognize the range of behaviors associated with IPV, they are less helpful as a guide to estimating the extent of IPV. Data on the incidence and rate of IPV reveal a lack of continuity in the definition of IPV. This ambiguity is reflected in the type of information that is collected on IPV. Part of this inconsistency can be explained by the identification of the source and purpose of the data collection. Law enforcement data for example, generally report only physical violence. Information gathered by law enforcement on reported incidents of physical violence alone, is likely to underestimate IPV.

The Department of Justice (DOJ, 2003) figures, based on reported crimes, indicate that violence at the hand of an intimate partner comprises 20% of all nonfatal violent crime against

women and 30% of female murders. These data are based on the National Crime Victimization Study (The NCVS) and homicide reports from the FBI Uniform Crime Report (UCR). The NCVS results are based on interviews from a national sample of individuals aged 12 and older living in a household. Respondents are asked to complete a crime survey that inquires about their experience as victims of threats, physical assault, and sexual coercion or assault by anyone, including someone they know well. UCR data are dependent upon information collected at the state level and reflects inconsistencies in data collection methods among states. In the case of homicides, for example, data are not consistently collected on the victim-offender relationship.

Under-reporting of intimate partner violence by victims also hinders data collection. NCVS findings indicate that 27% of female victims of intimate partner violence do not report the crime. The primary reason (27%) for not reporting IPV is the view that it is a private or personal matter. Fear of reprisal (15%), to protect the offender (12%), the view that it is a minor crime (6%), and the belief that police response will be inadequate (6% each) are also cited as reasons for not reporting. However, 20% indicate “other” as a reason for not reporting. The National Violence Against Women Survey (NIJ, CDC, 1994-1996) included a random telephone survey of approximately 8,000 women aged 18 and older, conducted over the period of 1995-1996. In this survey, 25% of women reported experiencing rape and or physical assault by an intimate partner in their lifetime. So, a lack of consistency in the definition of IPV, the reluctance to reveal abuse, and the varying purposes and methods of data collection all influence the ability to estimate the scope of IPV in society.

The current understanding of IPV has evolved from an early concept of abuse as excessive physical discipline implemented by a husband towards his wife. This evolution in the understanding of IPV is rooted in the intellectual, social, and cultural changes that have taken

place throughout history. Following is an historical overview of these changing conditions, from the colonial period until the present time.

In Colonial America, intimate partner violence was identified as “wife-beating”. Based on the prevailing consensus of women as subordinate to men in marriage, and the primacy of the nuclear family, there was little social response to the practice of “wife beating” at this time. Gradually, the colonies did begin to address this issue as a legal matter and placed prohibitions on this practice. The colony of Massachusetts first banned “wife beating” in the mid 1600s (Hymowitz & Weissman, 1978). However, while the law prohibited the use of excessive force against one’s wife, a husband’s right to discipline his wife through the use of appropriate force continued to be widely accepted (Feder, 1999). Since married women’s legal rights were subjugated to their husbands, a woman’s ability to pursue legal protection or separation from an abusive husband was limited. Except in cases of excessive force, there was little organized societal response to or assistance offered to women experiencing physical violence at the hands of their husbands.

As America transitioned from an agrarian to an industrial capitalist economy, roles for women in society changed. Industrialization supported a new division of labor among men and women, particularly within the middle class. While men dominated the wage-labor market, women focused primarily on domestic family concerns (Abramowitz, 1996). This separation of areas of activity and influence facilitated the identification of common interests among middle class women and supported an organized effort for social reform regarding women’s issues. (Hymowitz & Weissman, 1978). The awareness, collaboration, and coordination of resources among those favorable towards this reform movement allowed for the emergence of a social and

political agenda based on women's lived experiences. Female leaders emerged to challenge the status quo in the debate for women's rights that identified the first wave of feminism in America.

The women's rights movement at this time was rooted in democratic ideals, facilitated by capitalism, and carried out within the evangelical fervor that characterized this period. In the pursuit of social change and the representation of a feminist perspective, female activists participated in efforts such as the social purity movement (to reform sexual mores and fight prostitution); the temperance movement (with a focus on the negative effect of a husband's drinking on family violence); anti-slavery; suffrage; and improvement of women's legal and property rights (Hymowitz & Weissman, 1978).

Legal changes, such as the passing of the Married Women's Property Acts that occurred throughout the United States between 1839 and 1895, increased options for women. These acts allowed women to take advantage of the legal protections granted to property owners, the potential to accumulate individual wealth, and to pursue independent legal actions in court, thereby expanding their available remedies in response to abusive marital situations (Shammas, 1994). Married women began to have access to the legal status and accompanying resources that would allow them increased independence and autonomy.

Progressive Era (1890s-1920s) initiatives pursued government intervention in response to social problems. One result of the progressive movement was the creation of entities such as the Societies for the Prevention of Cruelty to Children (SPCC). As these societies delved into the issue of child maltreatment, there was an increasing awareness of the impact of marital violence in family life (Pleck, 2004). The criminal justice system responded to family problems by establishing Domestic Relations Courts. Redirecting issues of family dispute away from the

consequences of the traditional criminal system and towards a special court conferred a unique status on the family and signified a state interest and agenda in the regulation of family behavior. As indicated by Pleck (2004), court intervention in family matters focused on mediation, reconciliation, and the promotion of traditional family roles. The nature of this intervention in matters of family disputes illustrates the influence of prevailing social attitudes regarding the importance of the role of family in society on the social response to family disputes.

In the origins of the development of the United States then, there was an acceptance of the use of reasonable violence in controlling women's behavior. This early acceptance of violence against women in the context of marriage was imbedded in the social life of the time and reflected the belief in traditional gender roles that maintained the authority of men and the submission of women, in marriage. The cultural legacy of the acceptance of violence against women, the domination of a husband over his wife, and the lack of an organized social intervention directed at the protection and support of women in abusive relationships underlies and influences the understanding of and response to domestic violence in the United States.

The early feminist movement of the mid-nineteenth century raised awareness of and attempted to address the role of alcohol abuse in marital violence. The Progressive Era brought organized, government intervention to the social problem of child abuse and in the process, revealed the impact of marital violence in the lives of children. Recognition of the importance of the role of the family in society influenced the state response to matters of family discord. The mid-twentieth century saw a shift in perspective towards a medical and public health approach that favored recognition of symptoms, diagnosis, and implementation of scientific principles in the response to social problems.

The social activism that occurred in the United States in the 1960s and 1970s challenged many previously held cultural understandings and social conventions, including the understanding of and response to domestic violence. During this time, the second wave of feminism emerged to challenge gender inequality and the restrictive roles available to women. Women's Shelters developed during this time as grass-roots organizations with a social justice orientation. Increasing support and advocacy of IPV issues resulted in the passing of the first federal legislative response to domestic violence, the Violence against Women Act (VAWA) in 1994. This legislation provided grants to states in support of Women's Shelters, a national domestic violence hotline, and law enforcement efforts to address IPV. This act was reauthorized in 2000.

The social understanding of and response to IPV cumulated in the national recognition of and support for assistance to victims of IPV. While national attention and support is important, concern remains regarding the provision of appropriate services to meet the unique needs of this population. The current nature of mental health service delivery along with the continued need for increased understanding of IPV, are both important issues in meeting the needs of IPV victims.

This study addresses the current status of the social response to the mental health needs of female victims of IPV. The interaction of mental illness with IPV, particularly among those receiving shelter services, presents a challenge to the current service delivery system. As Women's Centers emerged as grass-roots organizations within a feminist philosophy, they responded to the lack of an organized social response to IPV victimization. The orientation and role of Women's Centers in meeting the basic needs of IPV victims along with the trend towards specialization and professionalization in mental health service provision impacts the ability of

Women's Centers to respond to the increasing mental health need among victims seeking shelter services. Within the context of this service environment, professional mental health care providers are increasingly responsible for meeting the mental health needs of female victims of IPV. As this study examines the intersection of IPV and mental health services, the following portion of this literature review focuses on the understanding of mental illness and its relationship to the treatment of those with mental health problems.

2.3 HISTORICAL PERSPECTIVES ON MENTAL ILLNESS

As attitudes and responses towards intimate partner violence have changed throughout history, so have societal attitudes and response to mental illness. Historical changes regarding the understanding of mental illness are reflected in service provision in terms of the types of treatments that are available and access to treatment. For example, early religious beliefs supported the view that mental disorders were due to individual moral weakness and possession by evil spirits. Based on this understanding regarding causality, an individual who exhibited symptoms of mental illness might be physically punished or undergo an exorcism in an effort to release the evil spirits (Deutsch, 1949). Public intervention in response to mental illness occurred when an individual's behavior was viewed as bizarre, threatening, or interfered with the individual's ability to work and financially support themselves. The violent mentally ill were often incarcerated together with other disabled and criminal individuals, in workhouses, correctional institutions, and poorhouses (Trattner, 1994). Care and guardianship of such individuals was usually arranged within the local community (Moran, 1998).

Early references to the mentally ill included such characterizations as “distracted” and “lunatic” (Grob, 1985, p.639). Social response to the mentally ill then, reflected the prevailing knowledge, social needs and perspectives of the community. Religious understanding prompted the view of the mentally ill as morally weak. Small, rural, agrarian communities were primarily concerned with self-sustainment and the ability of its members to be productive, contributing members of the community. In the case of mental illness of an individual, the individual’s ownership of property might be transferred to a financial guardian until the individual’s condition improved (Moran, 1998). The transition from local to state care, particularly for the indigent mentally ill, would eventually strain the capacities of the state mental health system and lead to calls for reform in the treatment and response to the mentally ill.

By the mid-eighteenth century, community care of the mentally ill was supplemented with placement and treatment in institutions known first as asylums and later as mental hospitals. The placement and treatment of the mentally ill outside of the local community was a response to changing population demographics as well as illustrative of the prevailing understanding that environmental stress and maladaptive behavior played a role in mental illness. There was a belief that the mentally ill would benefit from structured, supportive, treatment in a controlled environment away from the stresses of the community (Grob, 1994). The concept of “moral treatment” was introduced to America from Europe at the turn of the 19th century and influenced attitudes toward the treatment of mental illness in the United States (Scull, 1981).

With the goal of recovery from mental illness, moral treatment emphasized behavioral change and learning proper values and self- control. The purpose of this approach was to resocialize and enhance the coping skills of patients (Rochefort, 1997). There was the view that

psycho-therapeutic support could modify the impact of environmental stress and assist in the behavioral adjustment necessary to maintaining appropriate behavior in American society.

As the United States approached the twentieth century, there was declining confidence in the treatment results of the chronically mentally ill and increasing criticism of the conditions of state mental hospitals. These facilities were over-crowded, under-funded, inadequately staffed, and served an increasingly aged, medically needy population (Grob, 1985). The mental hygiene reform movement developed in the early 1900s to promote a return to local, community treatment of the mentally ill (Rochefort, 1997).

The goals of this movement included the prevention and treatment of chronic mental illness through early intervention, outpatient services in the community, and improved discharge planning and follow-up for hospitalized patients. This broader outlook regarding the nature of mental health services was accompanied by a shift in characterization of those with mental illness from the “insane” to the “mentally ill” (Bell, 1989). Advocates of this reform movement supported smaller treatment settings, integrated within general medical services in order to mainstream mental health care. Social workers became increasingly involved in coordination of care for the mentally ill as patients made the transition from hospitals to the community (Vourlekis, Greene, Knee, and Edinburg, 1994). The movement from large residential institutions to smaller outpatient treatment settings in the care of the mentally ill responded to a belief in psychological and psychiatric approaches to treatment. Successful community re-entry of the institutionalized mentally ill and treatment of a community population would require the understanding and development of appropriate community services for this population. This community-based approach established a role for social workers as coordinators of mental health care.

The evolution of social understanding and response to the issue of mental illness illustrates that social beliefs often interact with service provision to meet social needs. It is necessary to examine the nature of this relationship in order to identify the motivations and purposes served by the prevailing treatment response. This relationship can be seen in the movement towards integration of the mentally ill into the general community. This event was supported by economic need as well as an intellectual orientation that supported prevention of and recovery from mental illness. This broader approach to understanding mental illness brought with it new community treatment settings, service providers, and treatment approaches.

Federal government response to the economic depression of the 1930s established a precedent for active federal involvement in meeting social needs, as exemplified in the New Deal and Social Security policies. World War II influenced public awareness of and attitudes toward mental illness. The military was influential in its identification and treatment of mental illness as well as in the advocacy of its leaders in promoting a public, federal response to this problem. The military contributed knowledge and experience in its use of short-term group treatment and the association of mental illness with soldiers helped to lessen the stigma of mental illness (Rochefort, 1997). In the 1950s, the introduction of anti-psychotic medication allowed for the maintenance of mental hospital patients in the community. The 1960s saw popular and academic critiques of mental institutions, a concern for patients' rights and autonomy, and presidential support for the federal direction and support of national community based mental health services. These social changes help to set the stage for the deinstitutionalization movement (Rochefort, 1997). The 1970s saw increased advocacy among mental health service users and their families in the form of the consumer/ survivor movement, reflecting a desire for client empowerment and participation in decision-making (Cook & Jonikas, 2002).

From the 1980s on there was a shift from federal to state support of mental health services and a preference for privatization of services. The desire to decrease dependence on the federal government and the disability rights movement has supported recent federal legislation such as the Americans with Disabilities Act of 1990 (ADA) promoting inclusion of the mentally ill in mainstream society. This current social environment, with a focus on consumer empowerment, managed health care and social inclusion of the disabled, impacts the status of the mentally ill as well as victims of intimate partner violence. Understanding the help-seeking attitudes and experiences of female victims of intimate partner violence with mental health concerns is instrumental to functioning within this new social environment. This information would enhance the ability to target appropriate mental health outreach and treatment to female IPV victims and the effort to bridge the gap in mental health service to this group. Unmet mental health need among this population group as well as others in society represents a national health care concern. Following is an overview of the scope and impact of unmet mental health need in society.

2.4 UNMET MENTAL HEALTH NEED

Access to mental health care has been identified as an important goal (United States Department of Health and Human Services, 1999). Less than one-half of adults diagnosed with mental disorder receive treatment (Kessler et al., 2001). Individuals with mental health diagnoses who do receive treatment often delay treatment contact for years after their initial diagnosis (Wang, Berglund, Olfson, Pincus, Wells, & Kessler, 2005). Individuals with a mental disorder miss more days of work and function at reduced work capacity for more days than those without a mental

disorder (Kessler & Frank, 1997). Cultural and ethnic diversity, age, race, gender, income, education, attitudes, and appropriateness of care have been identified as factors relating to disparity in access to mental health treatment (DHHS, 1999). Unmet need is greatest for traditionally underserved groups such as the elderly, racial-ethnic minorities, low-income, those lacking insurance, and those in rural areas.

Members of the general public express concerns regarding the lack of available mental health care, inadequate insurance coverage, high costs, a lack of knowledge regarding appropriate care, and confusion over when to seek mental health care. As managed care becomes the dominant form of health care delivery, consumers fear an impersonal health care system and a loss of personal control in decision-making (Farberman, 1997). Consumers of mental health care report negative treatment experiences including stigma, gender bias, and ineffective treatment response to violence and abuse issues (Glass & Arnkoff, 2000).

2.5 MENTAL HEALTH AND IPV

Women who experience IPV often report mental health concerns as well (Coker et al., 2000). In their epidemiological study of a representative birth cohort from 1972-1973, Danielson, Moffitt, Caspi, & Silva, (1998) found that at age 21, 56% of women reporting IPV victimization in the past year also had a mental health diagnosis. Dinemann et al. (2000) found a 61% lifetime prevalence of IPV among women with depression. In a nationally representative sample of women aged 18-64 years, Plichta & Falik, (2001) report that 35% of women indicate an experience of IPV in their lifetime and that those among this sample who report intimate sexual violence are 4-5 times more likely to experience depression and anxiety than those women who

did not experience violence. In national data on intimate violence, African –American women with lower income report more partner violence, greater depressive symptoms, lower life satisfaction, and lower self-esteem. Among those within this group who experience intimate sexual violence, there are increased difficulties with interpersonal relationships and lower perceived health care quality (Russo, Denious, Keita, & Koss, 1997).

2.5.1 DEPRESSION

Depression affects approximately 19 million adults, the majority (12 million) of whom are women (Kessler et al. 1994). According to Miranda & Bruce (2002), women may experience more of a burden from depression than men. Women are more likely to have multiple role demands and more likely to be represented among the poor. This may complicate their experience of depression and increase their barriers to care. Research has identified a relationship between depression and IPV. This relationship reveals particularly high rates of depression among IPV victims residing in shelters.

In a meta-review of 18 studies of mental health problems indicating prevalence rates for depression among female victims of IPV, Golding (1999) identified higher rates of depression among IPV victims in shelter samples (60%), followed by psychiatric settings (39%), emergency medical settings (41%), primary care (44%), and samples solicited by flyer advertisement (18%). The severity of depression among IPV victims has been related to the severity of IPV abuse (Dinemann et al., 2000), recency of IPV experience (within the past five years), length of exposure to IPV (Pico-Alfonso, Garcia-Linares, 2006), and the experience of childhood abuse (Hegarty, Gunn, & Chondros, 2004). Reduced depressive symptoms among female IPV victims in both a community medical and shelter sample have been associated with higher levels of

social support (Coker, Smith, Thompson, McKeown, 2002). However, Levendosky (2004) found that when severity of violence was controlled, emotional support was not a significant predictor of mental health among a shelter sample of women. Calvete, Estevez, & Corral (2007) found a mediating role for cognitive schemas in the relationship of intimate partner violence and depression; violence was associated with the cognitive schema of disconnection and rejection (the expectation that one's need for security, respect, and acceptance will not be predictably fulfilled) which was associated with depression. Similarly, Campbell, Sullivan, and Davidson (1995) report that the a sense of powerlessness associated with abuse contributes to depression. In summary, depression among female IPV victims has been found to be highest in those women who reside in shelters, have more recent, severe, and longer episodes of abuse, are childhood abuse victims, and have lower levels of social support.

2.5.2 POST-TRAUMATIC STRESS DISORDER

Posttraumatic stress disorder (PTSD) is also commonly associated with IPV victimization and with depression among IPV victims. Posttraumatic stress disorder (PTSD) first appeared in the DSM-3 in 1980. Originally recognized primarily in association with military stress, the diagnosis of PTSD currently applies to exposure to a perceived life-threatening traumatic event that elicits an emotional response that may include intense psychological distress, increased arousal, intrusive memories, emotional numbness, and functional impairment. Lifetime prevalence of PTSD in the general population is approximately 8%. Among women victimized by IPV, rates of PTSD range from 31% to 84%, with victims residing in shelters reporting the highest rates (Golding, 1999).

Intimate partner physical, psychological, sexual, and stalking violence have all been found to be associated with PTSD, with multiple violence exposure (Basile, Arias, Desai, Thompson, 2004) and severity of abuse (Pico-Alfonso, 2005) being associated with increased symptoms of PTSD. The specific techniques or types of abuse employed in violent relationships may be related to differences in PTSD symptomatology. Pico-Alfonso (2005) found that psychological abuse was the strongest predictor of PTSD among abused women, followed by sexual and physical abuse. In this study, fear of further abuse of any type was also most strongly predicted by psychological abuse. Pico-Alfonso (2005) suggests that this state of fear represents a chronic stressor in the lives of abused women and contributes to psychological impairment.

Cascardi, O'Leary, & Schlee (1999) report that the abuser's use of domination/isolation tactics and the level of physical aggression predict PTSD among female victims of IPV. In terms of demographics related to PTSD, Jones (2001) found that younger, unemployed women with more children and less social support are at higher risk for PTSD. McFarlane et al. (2005) report higher rates of PTSD among Hispanic women seeking protection from abuse orders, irrespective of the type or presence of abuse, followed by African-American, and white women. In summary, the research literature on PTSD has identified a higher rate of PTSD among IPV victims than in the general population., the association of all types of IPV (physical, psychological, sexual, and stalking) with PTSD, and more severe and multiple episodes of IPV being associated with higher rates of PTSD.

Psychological abuse has been linked to fear of further abuse in victims. Domination and isolation tactics have been found to predict PTSD among victims. Demographic variables such as younger age, ethnic minority status, unemployment, having more children, and less social support have all been related to higher rates of PTSD.

2.5.3 CO-MORBIDITY

Posttraumatic Stress Disorder (PTSD) often co-occurs with depression among female victims of intimate partner violence (Nixon, Resick, & Nishith, 2004; Stein & Kennedy, 2001). Among a sample of female IPV victims from an urban emergency department, those experiencing PTSD in the last twelve months reported higher current depression scores than those without PTSD. Depressive symptoms were also an independent predictor of PTSD among this sample (Lipsky, Field, Caetano, and Larkin, 2005). Stein and Kennedy (2001) also found significant co-morbidity with MDD and IPV-related PTSD, along with high lifetime rates of MDD and PTSD, and a high correlation for severity of depression and severity of PTSD among female IPV victims recruited from community medical clinics and domestic violence service agencies.

Prior research provides evidence of the negative impact of mental illness and IPV as well as the underutilization of mental health services by victims of IPV. In response to these issues, this study seeks to identify the mental health help-seeking attitudes and experiences of female victims of IPV. Attitudes and beliefs regarding help-seeking have been identified as factors in mental health service utilization and may be particularly relevant to underutilization of services by vulnerable groups in society (Fellin, 1996). Following is an introduction to the concept of mental health help-seeking applied in this study.

2.6 MENTAL HEALTH HELP-SEEKING

Mental health help-seeking refers to an individual's response to a mental health problem. The process of help-seeking refers to the individual's process of accessing mental health services. As certain groups in society, such as ethnic minorities, tend to underutilize mental health services in comparison to their need and in comparison to other groups with similar need, there has been research regarding the reasons for underutilization of services. Available findings related to underutilization of mental health services by ethnic minorities offer insight into factors related to help-seeking. These findings include: the use of alternative help sources, factors unique to the history or social position of the minority group within the mainstream culture, and attitudes towards formal help provision. The final factor, related to the attitudes of help seekers towards providers or systems of care, indicates that there may be factors related to the institutional culture of the help-giving system that present a barrier to accessing help. Aspects of institutional culture that may present barriers to help seekers who belong to groups outside of the mainstream culture include: lack of awareness of the cultural characteristics or experiences of help seekers, cultural bias in diagnosis, lack of cultural compatibility in services, and social class differences between providers and help seekers (Fellin, 1996).

This study responds to the underutilization of mental health services by female victims of IPV through an examination of the impact of IPV on the mental health help-seeking process of IPV victims. The service gap in the provision of mental health services to IPV victims suggests that factors other than the need for mental health service are responsible for the underutilization of mental health services by female IPV victims. An examination of the mental health help-seeking attitudes and experiences of female IPV victims may identify factors relevant to the underutilization of mental health services by female victims of IPV.

Several help-seeking models have been developed to explain the help-seeking process. These include: the Health Belief Model (HBM) (Rosenstock, 1960), a psychological approach to help-seeking that examines the attitudes and beliefs of the help-seeker in the help-seeking process; the socio-behavioral model (SBM) developed by Anderson in 1980 and originally intended to explain and predict family's use of health service; and the theory of planned behavior, based on Ajzen and Fishbein's theory of reasoned action. Each of these models presumes a deliberative approach to decision making and identifies discrete factors that influence help-seeking behavior (Pescosolido & Boyer, 1999). Each model provides a pathway of decision making in help-seeking that considers social and personal influences on the decision-making process. These perspectives differ in their theoretical orientation and in their understanding of the ordinal and temporal nature of the actions and influences involved in the decision-making process. The HBM approach to understanding mental health help-seeking emphasizes the role of psychological factors, specifically attitudes and beliefs in the help-seeking process (Fellin, 1996). Social, demographic, psychological, and environmental variables are considered as influences on the decision making process (Janz & Becker, 1984).

The remaining model two models, the SBM and planned behavior theory derive from the HBM. The socio-behavioral model (SBM) developed by Anderson in 1980 provides a pathway of help-seeking that begins with predisposing factors (age, gender, education, beliefs) and is influenced by enabling factors (geography, income, insurance). In planned behavior theory, the individual's intention (readiness) is the impetus for behavior. Whether or not one forms the intention to act is influenced by one's attitudes towards the behavior, social norms regarding the behavior, and one's perceived self-efficacy (ability to perform the behavior).

The HBM was selected for its helpfulness and explanatory power in addressing the behavior of interest in this study. The primary interest in this study is the women's attitudes and experiences regarding their mental health help-seeking related to intimate partner violence. The women in this study have for the most part already sought mental health services. This study is interested in how the women describe their mental health needs and what factors hindered or facilitated meeting those needs. The three dimensions of help-seeking offered by the HBM seems most suited to this investigation. Identifying these dimensions in regard to the mental health help-seeking experience of female IPV victims will facilitate understanding the relationship between IPV and mental health help-seeking and contribute to identifying areas of congruence and incongruence in this relationship. This information will assist in bridging the gap in mental health service for IPV victims. Following is a detailed description of the HBM.

2.7 HEALTH BELIEF MODEL APPROACH

The HBM was developed from research conducted at the United States Public Health Service in the 1950s by social psychologists attempting to understand the utilization of preventive medical health services, such as vaccinations, in order to avoid illness. Applying the principles of social learning and social exchange theory, this model examines the individual decision making process in accessing health care. The HBM provides a model of help-seeking that examines how one defines one's need for help, and how one evaluates the relationship of barriers and benefits in help-seeking. In assessing the variables of need, barriers, and benefits, the Health Belief Model defines perceived need as a combination of perceived susceptibility (beliefs about the likelihood of being affected by the illness) and perceived seriousness (perceptions of the medical or social

impact of the condition). Perception of barriers is identified as the perceived difficulty or hardship (cost, discomfort, inconvenience, etc.) involved in engaging in preventative behavior or accessing available treatment services. Beliefs regarding benefits refer to whether or not one believes that the treatment will be beneficial in addressing the perceived need.

In the HBM model, perceived need provides the motivation to act and the barriers/benefits assessment determines the course of the action. The model predicts that individuals with higher levels of perceived need and perceptions of benefits of treatment and lower perceived barriers will be more likely to access health care services. A modification of the HBM has also been introduced to examine mental health help-seeking. Fellin (1996) presents a health belief model approach that addresses symptom recognition, severity, a cost/benefit analysis of treatment, and provider choice (the availability of a provider who can offer appropriate treatment). Inclusion of provider choice as a dimension of help-seeking suggests that help seekers assess the characteristics of available treatment as they make their decision to access help. As help seekers perceive available and appropriate care, they are more likely to access or continue to receive services. In this respect, the evaluation of the perceived benefits of treatment included in the HBM can serve as a guide to perceptions regarding appropriate treatment and as a factor in the decision to obtain or maintain treatment.

Prior research on the HBM focused on the model's predictive value in an individual's decision to utilize available health care such as flu inoculations, diagnostic tests, and medication. Preventive behaviors such as taking available safety precautions have also been examined. In a review of the 46 HBM-related studies conducted up until 1984, Janz and Becker (1984) identified three groups of HBM-related studies. These groups included preventive health care (24 studies), health care actions taken after a diagnosis (19 studies), and clinic utilization (3 studies).

For perceived need, the severity of the condition had the lowest (59%) overall significance across three categories of service use, while perceived susceptibility was the strongest (77%) predictor of preventive health care utilization. Perceived barriers were strongest (91%) in predicting health behaviors across all three categories of studies. Perceived benefits were a stronger (81%) predictor of health care actions taken after a diagnosis. Janz and Becker report that the smaller predictive value of perceived severity may be accounted for by the fact that most of the studies were retrospective designs. Severity may have been minimized because the study participants had already accessed preventive help and therefore presumed that they were protected from experiencing severe symptoms. Following is an overview and discussion of the research related to each dimensions of help-seeking: perceived need, perceived barriers, and perceived benefits.

2.8 DIMENSIONS OF THE HBM

2.8.1 PERCEIVED NEED

Perceived need refers to how one understands, evaluates and labels one's need for help. The HBM includes the consideration of susceptibility to a condition and severity of a condition in the determination of perceived need. Susceptibility may be identified by an objective measure such as genetic testing, or by one's subjective attitudes or beliefs regarding whether or not they have or will develop symptoms related to a particular health condition or problem. Severity, the second component of perceived need, refers to how serious the individual believes his or her condition or susceptibility to illness is or will become. Severity may be identified by diagnostic

criteria or by an individual's beliefs regarding the seriousness of the illness. If an individual believes that he or she is susceptible to an illness and that the illness is or will become serious enough to warrant help, then they will initiate the help-seeking process.

The issue of perceived need for mental health care has been inconsistently addressed in the mental health help-seeking literature. One reason for this inconsistency is the use of varied definitions of need. Werner (2004) was the only study located that utilized the HBM concept of perceived need (based on susceptibility and seriousness) in examining mental health related help-seeking. The other studies cited in this literature review on perceived need examined the role of perceived need (based on diagnostic criteria) in relation to help-seeking. Researchers have also examined the role of gender, beliefs, motivations, and perceived social consequences in individuals' perceptions of the need for mental health care. This literature review includes these above-mentioned studies as they contribute to an understanding of the personal and social factors that may influence the assessment of perceived need.

Perceived need as conceptualized in the HBM, was originally intonated to describe one's evaluation of one's likelihood of developing an illness or of the seriousness of one's illness. As applied to mental health issues, this conceptualization might include one's evaluation that they were likely to develop a mental illness or that one's symptoms or problems were serious enough to warrant help. From this perspective, a diagnostic assessment might contribute to one's perceived need or one's personal awareness of the seriousness of symptoms might lead to perceived need. As prior research suggests however, diagnostic assessment alone might not result in one's perceiving the need for help as one's perception of need may be influenced by personal or social factors. As Werner (2004) indicates, reports of perceived need by research study participants may also be influenced by the researcher's choice of methodology.

One study located that assessed both susceptibility and severity in relation to the likelihood of the elderly seeking help for memory problems. In this study, Werner (2004) found higher rates of reported susceptibility when using qualitative interviews than when using quantitative measures. Participants were more likely to report their memory problems when asked about them during semi-structured interviews. In the interviews, participants identified their memory problems as a natural part of aging and therefore, they saw little purpose in seeking help. In regard to severity, Werner found that the psychological consequences of memory difficulties (feelings of shame, fear, and embarrassment) contributed more to perception of severity of need than the physical or cognitive consequences. Severity of need was cited as the most common reason for seeking help. These findings suggest that beliefs regarding the causality of a condition influence the decision to seek help and that qualitative methodology may elicit more information than quantitative measures when assessing perception of needs that have psychological consequences.

In assessing perceived need among a national survey of respondents who had been diagnosed with a DSM-III-R mood, anxiety, or substance disorder for at least a 12 month period, Mojtabai, Olfson, & Mechanic (2002) asked participants, “Was there ever a time during the past 12 months when you felt that you might need to see a professional because of problems with your emotions or nerves or your use of alcohol or drugs in the past year?” In those respondents with mood disorders, co morbid mood and anxiety disorders, and mental disorders, impairment in role functioning and suicidality were strong predictors of perceived need. However, 26% of those who met criteria for at least one disorder did not perceive a need for help despite indicating severe functional impairment in everyday living. This suggests that diagnostic criteria of mental illness alone may not be sufficient for an individual to perceive the need to seek help.

Personal beliefs regarding the nature and consequences of an illness may influence the decision to accept a diagnosis and therefore influence perception of need. Van Voorhees, Fogel, Houston, Cooper, Wang, & Ford, (2005) interviewed young adults (age 16-29) who screened positive for depression using the Center for Epidemiological Studies Depression (CES-D) score in an internet-based public health depression screening program. When asked, “If my doctor told me I had depression, I could accept that”. Twenty six percent of those surveyed indicated that they would not accept a physician’s diagnosis of depression. Health beliefs associated with the decision not to accept a diagnosis were: disagreeing that medications are effective in treating depression, disagreeing that there is a biological cause for depression and agreeing that you would be embarrassed if your friends knew that you had depression.

Gender and racial differences have also been found in studies assessing perceived need for help. Sullivan, Pasch, Cornelius, & Cirigliano (2004) applied the Health Belief Model to the decision- making of couples regarding participation in premarital counseling. In their findings, women were more likely to mention perceived severity (potential for marital problems or divorce) as a motivating factor while men were more likely to cite perceived barriers such as cost in the decision to seek counseling. Couples' participation in counseling was most strongly predicted by level of perceived barriers and whether the counseling had been recommended to them. Sherbourne et al (2001) examined socio-demographic characteristics associated with perceived need. Among a national sample of women with depression or anxiety, Sherbourne found that while SES was related to diagnostic need, it was unrelated to individuals’ perceived need. Additionally, minority women had higher levels of distress, while white women indicated higher perceived need. The HBM identifies perceived need as providing the motivation to seek help.

Entry into the mental health system may be voluntary or involuntary. In the case of involuntary entry and treatment, perceived need may not play a role in accessing mental health care. Pescosolido, Gardner, & Lubell (1998) characterize individuals' mental health help-seeking behavior as active, passive, or hesitant. Among this clinical sample of individuals diagnosed with major depression (47%), adjustment disorder (26%), bipolar (12%) and psychotic disorders (14%), almost one-half of respondents indicated that they played an active role in the decision to seek help whereas about one-third of respondents reported that they did not play in active role in treatment seeking due to being unsure of the need for treatment or using other coping mechanisms. Among the remaining respondents, almost one-quarter indicated that they actively resisted seeking treatment. One may be ambivalent about the need for treatment or not pursue professional mental health treatment because they have found help elsewhere.

Whether or not one is likely to seek professional mental health help may depend on a variety of factors, as indicated in the following study by Greenley and Mechanic (1976). In comparing a randomly selected sample of university students with a sample of students who sought counseling or psychiatric outpatient help, Greenley and Mechanic found differences among the populations in the propensity to seek help for psychological problems, gender, reference group orientation, attitudes toward services, knowledge of other service users, religious affiliation, age, marital status, and level of psychological distress. Blumenthal and Endicott (1996/1997) compared treatment seekers and non-treatment seekers with a history of depression. Treatment seekers had more education, prior treatment, and a longer episode of depression than non- treatment seekers.

In examining the use of specialty mental health care, Mechanic, Angel, and Davies (1991) found that females with more education and individuals at higher risk for dangerous or disruptive behavior, such as suicide, were more likely to utilize specialty mental health care.

According to the HBM, perceived need provides the impetus for the help-seeking process. The decision to seek help can be influenced by internal cues (symptoms) and external cues (advice, media, etc.). Mechanic (2002) found that the decision to seek help involves an evaluation based on current economic situation (costs), social influences (external cues), available public knowledge (external cues) and expectations regarding treatment effectiveness (benefits). According to Mechanic, the characteristics associated with the decision to seek care from a mental health professional include having a positive attitude towards professional mental health care, the presence of psychiatric co morbidity, and insurance coverage.

Prior research indicates that perceived need for mental health care is influenced by socio-demographic characteristics, symptoms severity, and social psychological factors in addition to diagnostic criteria. These studies suggest the need for a multifaceted assessment of perceived need related to mental health help-seeking. The experience and social context of IPV for example, may influence a victim's perception of need. Bard and Sangrey (1986) report that victimization often represents a crisis for the victim, particularly when there is a strong sense of personal violation. A crisis experience generally produces an initial period of disorganization of one's sense of self, followed by gradual reorganization. During this process, victims may feel helpless, vulnerable, and in a state of shock or denial. Victims can also experience stigma, self-blame, shame, and guilt. All of these factors may play a role in the context of the IPV experience of victims and may impact the perceived need for mental health care.

In terms of diagnostic criteria, there is evidence of mental health need among IPV victims. In particular, PTSD and depression are correlated with IPV (Stein and Kennedy, 2001). While evidence based on quantitative measures suggests a diagnostic basis for mental health need among IPV victims, the issue of how victims themselves perceive the need for mental health help remains largely unexamined. It is expected that a qualitative approach will yield information on perceived need that contributes to the understanding derived from quantitative data. This approach is particularly appropriate due to the sensitive nature of the experience of IPV and its physical, emotional, and social consequences for victims. In this study, perceived need will be assessed quantitatively by using standardized measures of mental health symptomology and a qualitative measure of perceived need based on interview questions derived from the conceptual framework of the HBM. While the quantitative measure will provide a numerical representation of perceived severity, it may not be as helpful as qualitative interviewing in eliciting information related to the recognition and acceptance of need within the context of a traumatic victimization experience. This type of experience may be more comfortably expressed in one-on-one setting and more effectively understood within a qualitative or mixed-method framework.

The second dimension of the help-seeking process that is explored in this study relates to the barriers to mental treatment. There is considerable literature related to barriers to treatment. The next section of this literature review presents the previous research findings on barriers to help-seeking.

2.8.2 BARRIERS TO TREATMENT

The HBM considers the barriers to accessing mental health treatment. Barriers refer to the potential negative aspects or consequences of help-seeking. Understanding individuals' perception of the barriers of help-seeking is important in addressing the issue of underutilization of services. The perception or expectation that accessing or maintaining treatment will be difficult or impossible because one does not have the necessary finances, or one expects or finds the treatment to be too painful, unpleasant, or incongruent with one's needs, represents costs associated with treatment influences one's decision to seek treatment. If perceived barriers outweigh perceived benefits, or helpful aspects of treatment, then treatment may be avoided or terminated. Perceived barriers of mental health treatment include concerns regarding finances, difficulties or delays in accessing treatment, and emotional or social concerns associated with seeking help.

Strum and Sherbourne (2001) assessed need by asking a national household sample of 9,541 telephone respondents if they felt that they "needed help for emotional or mental health problems, such as feeling sad, blue, anxious, or nervous in the past twelve months" (p.82). Results indicated that 16% (n= 1,519) identified the need for mental health care and that 12% (n=184) of those indicating need reported receiving no conventional mental health care in the past twelve months. Thirteen percent (n=194) of those indicating need reported having difficulties or experiencing delays obtaining care. Cost was the most cited barrier for those without insurance and for those with private insurance, due to co-pays and coverage limits. Although those with public insurance were least likely to cite cost as a barrier to obtaining treatment, they were more likely to cite difficulties and delays in accessing treatment and were also likely to use self-administered and alternative medical care.

In their qualitative study, Staton, Leukefeld, & Logan (2001) examined health care access and utilization among 34 incarcerated women with a history of substance abuse. A majority of the women also indicated a history of physical, emotional, and/or sexual abuse. The women cited the abusive experiences as influencing their physical and mental health. Low self-esteem, depression, anxiety, and hopelessness were mentioned as mental health consequences of abuse. Although the women were aware of victimization and mental health services, they primarily used these services only in extreme situations, such as when they feared for their life, had no other options, or were mandated by the courts to receive services.

Of the women in this sample, only a few had sought professional mental health care. Some indicated family and friends as a source of help, but also reported difficulties as these relationships became strained if the women decided to return to the abuser. The women reported that they would not seek the help of social workers due to fear of losing their children. Barriers to seeking help for domestic violence included fear, guilt, shame, embarrassment, and stigma. The women feared losing their children, having harm come to their children, having others know about the abuse, and going to jail. They also reported avoiding services because they were not ready to leave their partner or because they were under the influence of drugs or alcohol. It was suggested that mental health services be made available to victims of domestic violence and that these services be gender-specific and sensitive to the needs of victims.

Nehls & Sallmann (2005) identify female victims' experience of living with fear and their desire to control the process of disclosure of abuse. Female victims report being retraumatized by the social service system, emphasize the importance of being listened to without preconceived notions, and express the desire to address the connection between mental health concerns and abuse experiences. In McCauley et al. (1998), female IPV victims identify

shame and self-denial of abuse as obstacles to care and a caring, protective clinician who is easy to talk to and offers a follow-up visit as a facilitating factor in receiving care. The women in this study expressed reservations regarding the use of medication, identifying a fear of dependency and decreased alertness, which might increase the risk for more abuse.

Among those with unmet need for mental health care in the general population, cost, difficulty obtaining appropriate treatment, delays in accessing treatment and beliefs regarding diagnosis and treatment have been identified as barriers to care. For those with histories of IPV victimization, issues regarding the nature of treatment, personal characteristics of the provider, and concerns related to intervention in the family by social service systems have been identified as barriers to care. In making the decision to seek help, one's assessment of barriers influences whether or not one seeks help and what type of care they pursue. The decision of what type of care to obtain also involves a consideration of the benefits or value of treatment. The following section addresses the issue of perceived benefits related to mental health treatment.

2.8.3 BENEFITS OF TREATMENT

There is limited research related to the third dimension of the HBM, benefits of treatment. Fellin (1996) however, adopts a health belief model approach to mental health seeking that includes provider choice as the third dimension of help-seeking. This dimension refers to the perception of the availability of providers that offer appropriate treatment. The belief that appropriate treatment is available will increase the likelihood of accessing help. This invites inquiry into the help seeker's assessment of appropriate treatment. In examining help seekers views of treatment, prior research literature has focused on identifying the treatment preferences of help seekers.

This literature is reviewed here for its value in identifying the characteristics that help seekers find desirable when they are seeking treatment.

Treatment preferences may be related to the perception of the benefits of treatment. Research indicates that help seekers consider available information regarding quality of care in selecting providers (Sheeran, 2003). This suggests that help seekers have preferences for the treatment that they believe will be most helpful to them. An examination of treatment preferences may reveal information regarding the perceived benefits of treatment. This study extends previous research by examining the benefits that victims derive from treatment.

In a study of 271 women in public gynecology settings, 48 % indicated currently experiencing emotional or psychological distress and were asked about their mental health treatment preferences. The majority of women experiencing psychological distress were interested in receiving mental health care, with the greatest interest being in individual therapy and psycho education and the least interest in group therapy and medication (Alvidrez & Azocar, 1999). Although the issue of benefits was not specifically examined in the study, the expressed preference regarding treatment modality suggests that the women perceive differential benefits from different treatment types. An examination of the perceived benefits of these different types of treatment would contribute to understanding in this area.

In interviews conducted with twenty-one women with prior domestic violence experience recruited from a domestic violence shelter, hospital, and health care setting, Chang et al. (2005) identify treatment preferences related to addressing IPV in medical settings. Preferences included informational interventions and individual counseling. Specifically, women reported that when seeking treatment, they preferred not to be required to identify themselves as IPV victims, to be offered a variety of options, and to have their autonomy protected and respected.

Draucker (1999) reports on female survivors of sexual assault recruited through newspaper advertisements and sexual assault service providers who reported having ever experienced abuse or assault by an intimate partner. Some of the women had received mental health services and some had not. All of the women were asked what advice they would give nurses or mental health professionals who work with sexual assault victims. Findings from this study identify the therapeutic relationship as the most important factor in services. Sexual assault survivors indicate a desire for a therapist who is patient, helps build self-esteem, does not blame the victim or give advice, but instead allows women to make their own decisions and supports the women's abilities to contribute to their recovery.

The type, severity, and frequency of victimization as well as one's personal characteristics and social environment may influence one's progress through the recovery process (Bard & Sangrey, 1986). In recovery from trauma, reassurance and restoration of a sense of trust, safety, and control are important issues (McCann & Pearlman, 1990). These factors may be relevant to recovery from IPV victimization as well.

3.0 METHODOLOGY

3.1 RESEARCH DESIGN

This mixed-method study conducted at the Women's Center and Shelter of Greater Pittsburgh (WC&S) applies a health belief model approach to explore the mental health help-seeking experiences of female victims of IPV. The mixed-method design of this study utilizes a qualitative-descriptive methodology with overtones of grounded theory (Sandelowsky, 2000) and quasi-statistical analysis of data (Miller & Crabtree, 1992). The qualitative- descriptive approach allows for representation of data as a direct description of respondents experiences. Both the manifest (descriptive statistical representation) and latent content of the data are addressed in this approach with the purpose of developing a descriptive summary of the content of the data organized within a framework that suits the data. Quasi-statistical analysis utilizes counts and descriptive statistics towards the purpose of identifying patterns and consistencies in data. Content analysis of the qualitative data is applied to describe, summarize, and categorize the qualitative data. Techniques associated with grounded theory include: labeling, memoing (Glasser,1999), and coding (Strauss & Corbin, 1998) of data in the process of identifying the meaning of responses, grouping similar responses into categories and placing them within the paradigm of the study's model, the Health Belief Model.

3.2 RESEARCH SETTING

This study took place at the Women's Center & Shelter of Greater Pittsburgh (WC&S). Research interviews were conducted in a private office provided at the agency. The WC&S is located in an urban area and serves more than 5,000 individuals each year. It was founded in 1974, with the goal of providing education, advocacy and services related to domestic violence. It is one of the first six shelters in the United States for battered women and has been at the forefront of the Battered Women's Movement, creating and implementing programming aimed at preventing domestic violence and providing services to domestic violence victims.

The Women's Center and Shelter of Greater Pittsburgh provides residential services in the form of temporary protective housing for women and their children for a maximum stay of 30 days. They also provide non-residential services such as educational groups and supportive group and individual empowerment counseling. This counseling consists of education to increase understanding and awareness of violence, allowing women to make their own decisions and choose their own goals regarding their abusive situations, and connecting women to resources in the community. Women who require mental health treatment to address issues of trauma or other psychological issues are usually referred to agencies or professionals outside of the shelter.

If needed, assistance is also provided in accessing medical, income, employment, and legal services. For residential clients, there is a requirement that the women attend weekly psycho educational support groups related to understanding IPV. These groups offer education regarding the etiology and process of IPV within a feminist framework that stresses mutual support and a recognition of the social and historical context of IPV.

3.3 SAMPLING

This study used a purposive sample of twenty-two women currently receiving domestic violence services at the Women's Center and Shelter of Greater Pittsburgh. The potential age range of the subjects was 18-65 years. This subject population voluntarily enrolled in this research study in response to either an advertisement (Appendix A) posted in the client waiting area at the Women's Center and Shelter of Greater Pittsburgh, or after being informed of the study by staff members, who referred subjects who had indicated that they had considered obtaining or had obtained mental health services related to intimate partner violence victimization. Interviews were arranged via a phone call from the interested subject to the researcher.

3.4 PROCEDURE

Women who were interested in participating in the study were asked to phone the researcher to arrange an interview. Interviews were conducted at the Women's Center and Shelter of Greater Pittsburgh. Prior to the start of the interview, participants signed a written consent form. First the participants were asked to complete a demographic questionnaire (Appendix D). Second, the standardized measures for depression (PHQ-9), IPV (CTS2S), PTSD, (PCL-C), and social support (SFO) were administered (Appendix C). Third, the qualitative interview was administered (Appendix B). The study session for each participant lasted approximately one hour.

3.5 MEASUREMENT

3.5.1 STANDARDIZED MEASURES

There were four standardized measures used in this test, the Conflict Tactics Scale Short Form (CTS2S) was used to measure the extent of intimate partner violence. The Patient Health Questionnaire (PHQ-9), the self-report version of the clinically administered PRIME-MD depression scale. The Post traumatic Stress Disorder Checklist- Civilian Version (PCL-C) scale measured PTSD. The Support from Others Scale (SFO) was used to assess social support. These measures are discussed in the following section.

3.5.2 CONFLICT TACTICS SCALE 2 SHORT FORM (CTS2-S)

The Conflict Tactics Scale 2 Short Form (Straus & Douglas, 2004) was used to measure IPV. This scale is derived from the CTS2 (Straus, Hamby, Boney-McCoy, & Sugarman, 1996), which is a revision of the original CTS developed by Straus in 1979. The Conflict Tactics Scales measure conflict techniques used to manage disputes. The test provides an introductory paragraph that provides a context for answering the questions. Respondents are asked to think about how conflicts with their partners are managed. A list of behaviors representing various conflict management techniques is then presented and respondents are asked to identify the frequency of the use of each of these behaviors in their relationship. Different test versions allow for use by both partners and children (regarding their parents' conflict behavior).

The original CTS contains 39 items. It utilizes three composite scales. One scale measures use of violence, another verbal aggression, and a third measures reasoning behaviors.

The conflict behaviors within each scale are categorized as either mild or severe. It is thus possible to report the degree of severity for each of the scales—violence, verbal aggression, and reasoning. Items on the test represent the different types of behavior associated with each scale and are arranged in an hierarchical order ranging from more socially acceptable approaches for managing conflict to less acceptable, more violent means. A response scale for each item identifies the frequency of the behaviors used in resolving conflict over the past year, or whether the behavior happened prior to the past year. In the context of their relationship, respondents are asked how often their partner used a particular behavior to handle a conflict situation in the past year. Scores may be summed and presented as prevalence (occurred at least once) of conflict management behaviors and chronicity (how often it occurred) of behaviors. Scores can also be reported as mild or severe for each of the three scales of behavior.

The CTS2 (Straus, Hamby, Boney-McCoy, & Sugarman, 1996) consists of 78 items. The additional items were chosen in order to capture a wider variety of conflict behaviors. The scales were revised to include: physical assault, psychological aggression, negotiation (revised from the original “reasoning” scale), injury, and sexual coercion. A revision to the language used in the questions asking about behavior was made from the use of “he/she” to “my partner.” The CTS2 also categorizes behavior as mild or severe. In response to a perceived incongruity in item order and to avoid set-order responses, the CTS2 randomizes the order of items as opposed to listing them in hierarchal order. The internal consistency reliability of the CTS2 scales ranges from .79 to .95 (Straus et al. 1996).

The CTS2-S scale (Straus & Douglass, 2004) consists of twenty items that measure the same five scales of conflict behavior as the CTS2 (physical assault, psychological aggression, negotiation, injury, and sexual coercion). Of the twenty items, ten refer to the respondent’s

behavior and 10 to the respondent's partner's behavior. The CTS2-S was constructed by selecting the two items from each of the five scales of the CTS2 that had the highest reliability with the overall scale category score. Items on the test represent the different types of behavior associated with each scale (physical assault, psychological aggression, negotiation, injury, and sexual coercion) and are arranged in hierarchical order, from more socially acceptable approaches for managing conflict to less acceptable, more violent means. For each tactic, there are two questions that represent behavior indicative of the tactic. One question represents a more severe form of the tactic and one represents a less severe form of the tactic. For example, in measuring psychological aggression, one question states, "my partner destroyed something belonging to me or threatened to hit me" (indicating severe psychological aggression) and the second item indicating less severe psychological aggression, states, "my partner insulted, swore, or yelled at me".

A response scale for each item identifies the frequency of the behaviors used over the past year, and whether the behavior happened prior to the past year. In the context of their relationship, respondents are asked how often their partner used a particular behavior to handle a conflict situation in the past year. Scores may be reported to indicate prevalence (the behavior occurred at least once) and chronicity (how many times the behavior occurred). This scale also categorizes behavior as none, minor only, or severe. A criticism of the earlier scale is that there is behavioral overlap between the two categories of mild/severe, as most people who display severe aggression also display mild aggression.

Since there are fewer items on this scale than the previous ones, a concern for capturing prevalence of IPV behavior was addressed by combining some behaviors into one question. For example, questions measuring severe physical assault such as beating, hitting, or kicking, were

combined into one question on the CTS2-S. Preliminary psychometric data for an “approximation” of the CTS2-S are available. Concurrent validity for this CTS2-S scale with the CTS2 ranges from correlations of 0.65 to 0.94. Construct validity, measured against the Personal Relationship and Profile Scale, which measures risk factor areas for partner violence, ranges from correlations of 0.66 to 0.83. Sensitivity of the CTS2-S in measuring the prevalence of abuse is less than for the CTS2, due to a fewer number of items, but a large number of cases are still identified (Straus & Douglass, 2004).

This study asks only about the conflict behaviors of the respondent’s partner, thus reducing the questionnaire to ten questions. The format of the test is similar to previous tests. An introductory paragraph identifies the context of the test. Respondents are asked to think about how conflicts with their partners are managed. A list of behaviors representing various conflict management techniques is then presented and each respondent is asked to identify the occurrence and frequency of each of these behaviors in their relationships. The response categories of the CTS2-S are: 1 (once in the past year), 2 (twice in the past year), 3 (3-5 times in the past year), 4 (6-10 times in the past year), 5 (11-20 times in the past year), 6 (more than 20 times in the past year), 7 (not in the past year, but did happen before), and 8 (this has never happened).

Scoring of the CTS2-S can be conducted to report prevalence rates (the number of participants who experienced the behavior at least once in the past year) and chronicity rates (the number of times the behavior occurred in the past year). There have been criticisms related to the context, content, and format of the CTS. These criticisms include: 1) the scale presents abusive behaviors in the context of conflict management tactics. Strauss (1990) defends this context as being more acceptable to respondents, 2) the limited-response checklist format of the scale may exclude other relevant behaviors related to abuse. Strauss indicates that in-depth interviewing of

respondents' supports the content of the scale and that more information may be collected using the checklist format as it reminds respondents of behaviors, 3) behaviors that differ in severity are treated equally. Strauss indicates that separate ratings can be given for different levels of severity, and 4) the scale does not recognize behavior initiated as self-defense. Strauss points out that a brief survey research tool has limits, such as difficulty in measuring the context of behavior in the same measure as the content of behavior and that the wide-use of the test and the quantity of information it provides lends support to the value of the CTS (Strauss, 1990).

3.5.3 THE PATIENT HEALTH QUESTIONNAIRE (PHQ)-9

The Patient Health Questionnaire (PHQ)-9 (Spitzer, Kroenke, & Williams, 1999) is the self-report version of the clinically administered PRIME-MD depression scale. The PHQ-9 lists nine symptoms of depression and asks respondents to rate the frequency of the occurrence over the past two weeks. The possible responses for each of the 9 symptom items are 0 (not at all), 2 (more than half the days), and 3 (nearly every day). The symptoms correspond to the DSM-V criteria for depression. Scores may be evaluated in either of the following ways: 1) if 5 or more symptoms are rated as response number 2 (occurring more than half the days in the past two weeks) and one of those symptoms is feeling depressed or having little interest or pleasure in doing things, then major depression is diagnosed or 2) a summative score can be used. Possible total scores range from 0 (no symptoms) to 27 (all symptoms occurring daily). A summative score of 5 represents mild depression; a score of 6-10 indicates moderate depression; 11-15 represents moderately severe depression and 16 and above indicates severe depression. Respondents are asked in a final question to rate how difficult the problems in items 1-9 have

made it for them to do their work, take care of things at home, or get along with other people. Possible responses to this final question range from 0 (not applicable) to 4 (extremely difficult).

In assessing validity and reliability of the PHQ-9, Kroenke, Spitzer, and Williams (2001) report construct and criterion validity and internal reliability in a study of medical health care patients in a primary care and ob-gyn setting. Construct validity was found using the short-form general health survey and patients' self-reported number of disability days, health care clinic visits and level of difficulty due to symptoms. Mental health professionals established criterion validity using structured assessments. Correlation between the assessment by mental health professionals and clinic patients was 0.84. For the two samples, Cronbach's alpha was 0.89 and 0.86. In a test of discriminant validity, Williams, Brizendine, Plue, Bakas, Tu, Hendrie et al., (2005) compared depression diagnosis for a sample of 316 post stroke subjects, where 145 subjects met the Structured Clinical Interview for DSM-III-R (SCID) criteria for major or other depressive disorder and 171 did not meet SCID depression criteria. For this primary care sample, a PHQ-9 score of ≥ 10 had 91% sensitivity and 89% specificity for major depression, and 78% sensitivity and 96% specificity for any depression diagnosis.

3.5.4 POST-TRAUMATIC STRESS DISORDER CHECKLIST (PCL-C)

The Posttraumatic Stress Disorder Checklist (PCL-C) was developed at the National Center for PTSD by Weathers, Litz, Herman, Huska, & Kean in 1994 (Blanchard, Jones-Alexander, Buckley, & Forneris, 1996). The PCL-C is a 17-item measure of symptoms corresponding to the DSM-IV criteria for PTSD. An introductory question asks respondents to identify a particularly stressful experience in the past. This is followed by a list of 17 symptoms related to PTSD. A 5-point scale asks respondents to identify the degree to which the symptoms have bothered them

over the past month. For example, in the past month, how often have you been bothered by repeated, disturbing dreams of a stressful experience from the past? Possible responses range from 1(not at all) to 5 (extremely). The test authors report a test-retest reliability score of 0.96, a kappa of 0.64 in comparison to PTSD diagnosis from the SCID, and alpha coefficients of 0.89 to 0.92 for internal reliability (Blanchard, Jones-Alexander, Buckley, & Forneris, 1996). Using the Clinician Administered PTSD Scale (CAPS) for comparison in a sample that included female sexual assault victims, Blanchard, et al. found that a cutoff score of 44 on the PCL-C resulted in a diagnostic efficiency score of 0.90, a sensitivity score of 0.94, and a specificity of 0.86, with an internal consistency (Cronbach's alpha) score of 0.94. Scores are summed using a summative total score of 44 as a cutoff for indicating the presence or absence of PTSD.

3.5.5 SUPPORT FROM OTHERS (SFO)

The Support from Others Scale (Koeske & Koeske, 1989) asks respondents to identify the amount of emotional and practical support (financial, babysitting, etc.) that they receive from different categories of persons (spouse, children, other family/relatives, friends, co-workers). For the purpose of this study, three categories of persons were added to the measure. These additional categories were: Partners, Women's Center & Shelter staff, and Women's Center & Shelter residents. Ratings were made on a 5-point Likert scale, ranging from 1(not at all) to 5 (a great deal). The original scale has shown adequate test-retest reliability of .70 over an 8-week interval, and construct validity has been established in previous research (Koeske & Koeske, 1989).

3.6 QUALITATIVE MEASUREMENT

The interview protocol was developed with the input of the dissertation committee and staff of the Women's Center and Shelter of Greater Pittsburgh. Several staff members with extensive knowledge and professional experience in IPV and mental health volunteered to participate in pilot interviews. These interviews served as a check on the validity of the interview protocol. The staff participants provided feedback to the researcher on the nature of the interview questions and the interview experience. This feedback was discussed with the dissertation committee chair, Catherine Greeno, Ph.D. and the Director of Counseling at the Women's Center and Shelter of Greater Pittsburgh, Lynn Hawker, Ph.D., who is also a dissertation committee member. The feedback was integrated into the development of the interview protocol prior to beginning data collection. On-going assessment of the interview protocol was also conducted throughout the research process and adapted based on the interview experiences.

Dimension1. Perceived need

Questions:

- a) Thinking back to the time that you thought about seeing a mental health professional, can you describe how you knew that you might need to see someone?
- b) How did you see your concern as being related to your domestic violence experience?

Dimension 2. Barriers

Questions:

- a) Was there anything that was easy or difficult for you about the process of deciding to get help or finding help?
- b) Once you found help, was there anything about your experience in treatment that made it easy or difficult for you to continue in treatment?

Dimension 3. Benefits

Questions:

- a) In what ways was your treatment helpful or unhelpful to you?
- b) What do you think made your experience a good or bad one?

3.7 QUALITATIVE METHODOLOGY

This study utilizes a qualitative descriptive-exploratory (Rizzo-Parse, 2001) approach in the interactive interview portion of the study in order to examine the mental health help-seeking experiences of female victims of intimate partner violence (IPV). The selection of this approach was guided by the nature and purpose of the research study. A qualitative descriptive-exploratory approach allows for an intensive investigation of the meaning of a life event for those experiencing the event. This study attempts to describe the mental health help-seeking experience of female victims of IPV. Guided by the specific research questions in this study, the intent is to identify themes and patterns inherent in the participants' experiences of the event and to compare the outcomes of the qualitative analysis with those of the quantitative data. The health Belief Model (HBM) is used as the framework to guide the qualitative data collection. The HBM identifies three dimensions of help-seeking behavior: perceived need, barriers, and benefits. Participants are asked to discuss their experience of the mental health help-seeking process in terms of how they perceived their need for treatment, barriers that they encountered in accessing treatment, and the characteristics of treatment that they felt were beneficial to them. The identification of themes and patterns among the interview responses provides a description of the issues relevant to the mental health help-seeking process of female victims of IPV.

A systematic procedure for the data analysis-synthesis phase of this study was implemented in accordance with the scientific process associated with the descriptive-exploratory methodological approach (Rizzo-Parse, 2001). First, repeated readings of the transcripts were conducted and major themes were identified by the objectives of the study and in the language of the participants. These themes were then synthesized in the language of the researcher and the findings, the answers to the research questions, were interpreted within the frame of reference of the Health Belief Model and placed in the context of the research literature on intimate partner violence and mental health help-seeking.

Throughout the data analysis process, procedures were incorporated to enhance validity and reliability. Three researchers participated in the overall data analysis process (Appendix E). First, two researchers independently undertook content analysis of a sample of the transcripts that included the first, second, third, seventh, tenth, and twentieth interview. The content analysis (Patton, 2002) was the first step in qualitative data reduction. It consisted of identifying and highlighting respondents' answers in the interview text. The answers identified, in the language of the participants, were then labeled in the language of the researcher as to its meaning in relation to the research objectives (Rizzo-Parse, 2001). After completing the first content analysis, the two researchers compared notes and discussed any differences in interpretation until 100% agreement was reached regarding the intent of the participant's response and the appropriate labeling of the response. For the second and third interviews, the two researchers met again to compare notes and to reach agreement on the content analysis. A third reader was introduced at this time to review the first three interviews as a check on the decision reached by the first two readers. All three readers then met to discuss and reach agreement on the content analysis of the first three interviews. Once analysis of these first three interviews was complete,

and the work of the first two readers had been validated by a third, the first two readers arranged to meet again to discuss content analysis for selected interviews throughout the data analysis process. The seventh, tenth, and final interviews were selected to establish a schedule of periodic review that allowed for monitoring the data analysis process and maintaining consistency in analysis. The remaining sixteen interviews were coded independently by the primary researcher.

During the content analysis the researchers utilized the qualitative technique of memoing (Glasser, 1999). Memoing consists of written notations in the transcriptions that characterize the nature of the subjects' responses in the context of the study. For example, if a participant described an event such as "the violence was affecting my daughter, she was regressing, she was potty-trained and now she was back in diapers" in response to the interview question what was happening in your life that made you consider getting mental health help? The researcher would note this response with the label "IPV impact on child" in the margins of the relevant interview passage, next to the participant's comment. These labels were then discussed between the researchers in order to determine their meaning in relation to the research objectives.

Patterns or themes in the responses began to emerge as the researchers identified and discussed participant's responses. A theme is a response pattern derived from the data that functions as a descriptive and organizing tool in identifying concepts (Boyatzis, 1998). The process of theme development was also conducted with established procedures for checks on validity. Theme development was an ongoing process during data collection and was discussed, first between the two readers when they met to compare content analysis, and again after themes had been identified for all of the interviews. A third researcher, with extensive qualitative experience was consulted on the final themes.

As the individual interviews were analyzed and the content labeled in terms of its meaning in response to the research questions, discussions were held between the two readers on an on-going basis regarding assignment of appropriate themes to characterize the identified content. When all of the interviews had been read and coded for content, the primary researcher identified themes that had been discussed throughout the coding process and organized the themes within the categories of the help-seeking model along with the relevant excerpts from the interview text. A summative count was conducted on the coded data in order to identify the frequency of responses related to the themes. Numerical frequencies and illustrative excerpts from the transcripts related to the research objectives of the study will be presented, along with the identified themes, in the results of the study.

3.8 MIXED-METHODOLOGY

A mixed-method design is utilized for the purpose of expanding the breadth and depth of the information yielded from this study. The research objectives aim to describe the mental health help-seeking experience of female victims of IPV within the context of the dimensions of the Health Belief Model (HBM). The dimensions of the HBM include perceived need, barriers, and benefits of treatment. Perceived need is examined utilizing both quantitative and qualitative methods. Quantitative tests are conducted to identify a diagnosis of depression, the frequency and severity of intimate partner violence, and a diagnosis of post- traumatic stress disorder. These tests establish a quantitative measure of need. Perceived need is also assessed in a qualitative interview. Participants are asked about how they identified and experienced the need for mental health care.

Themes are identified related to perceived need and this information is compared with the quantitative measures of need. Using a t-test, the scores on each of the standardized tests assessing depression, domestic violence, and PTSD are compared with the qualitative data collected on the dimensions of need, barriers, and benefits associated with treatment. The qualitative data on need, barriers, and benefits is first organized by theme and then categorized as a dichotomous variable for the purposes of comparing the data with the quantitative scores. Need, barriers, and benefits are categorized as yes or no variables according to how the participants responding to these questions in the interview. Additionally, a Pearson correlation analysis conducted to determine if there is a relationship between depression, PTSD, IPV, and social support.

This research strategy, the integration of the features of a qualitative approach (focusing on the meaning participants ascribe to the dimensions of need, barrier, and benefits in their mental health help-seeking experiences) with the features of a quantitative approach (that produces a precise numerical outcome identifying mental health diagnosis) allows for the potential identification of relationships between diagnostic need as established by a standardized measure and need as viewed by the individual experiencing it. The use of alternative design methods pursuing different perspectives can contribute to a more complete picture of the mental health help-seeking experience for female IPV victims and serve as a source of measurement validation.

4.0 RESULTS

Data were collected on the sample utilizing a demographic survey, quantitative tests, and a qualitative interview. In the organization of this chapter, summary data on the demographic characteristics of the sample and treatment history are provided followed by the results of the quantitative measures assessing intimate partner violence (CTS2S), post-traumatic stress disorder (PCL-C), depression (PHQ-9), and social support (SFO). A correlation analysis among the main quantitative variables is presented followed by the t-tests examining the relationship between quantitative and qualitative variables. Next, the analysis of the qualitative research questions is reported.

4.1 DESCRIPTIVE RESULTS

4.1.1 DEMOGRAPHIC DESCRIPTION OF PARTICIPANTS

Twenty-two women participated in this study. Demographic characteristics are provided in Table 1. The participants ranged in age from 19-51, with a mean age of 39. According to the Bureau of Justice Statistics (BJS, 2003), females aged 20-34 have the highest rate of non-fatal IPV victimization. It has also been reported, however, that women experience an average of five years of abuse before seeking shelter services (Okun, 1986). The average age of 39 in this

sample of women currently receiving domestic violence services may reflect this tendency to seek help after several years of experiencing abuse. Sixty- eight percent of the women in this study identified themselves as Caucasian (n=13), 38% identified themselves as African-American (n=8) and one person did not respond to this item. The racial background in this sample may reflect community demographics. In its yearly demographic data, the Women's Center and Shelter of Greater Pittsburgh reports the racial composition of women seeking services and this study's racial demographics are reflective of the total population receiving services at the Women's Center and Shelter (Women's Center and Shelter, 2007).

Of the 21 women responding to the question assessing marital status, 52% (n=11) of the women in the sample identified themselves as currently single, 24% (n=5) identified themselves as divorced, 19% (n=4) as separated, and 5% (n=1) as married. In national data, separated or divorced women report the highest rates of IPV, followed by women who never married. Married women report the lowest rates of IPV (BJS, 2003).

Thirty-six percent (n=8) of the women interviewed in this study were high school graduates. Thirty-two percent (n=6) were college graduates. Eighteen percent (n=4) had less than a high school education, 14% (n=3) had some college, and one women had post-graduate education. Nationally, the highest rates of IPV are reported by women with a high school education or some college, followed by women with some high school education. Female college graduates report the lowest rates of IPV.

Thirty –three percent (n=7) of women in this study reported no current income and thirty-three percent (n=7) reported a yearly income of \$2,500-\$5,000. Twenty-four percent (n=5) of women reported a yearly income of \$6,000-\$8,000 and 14% (n=3) reported an annual income of \$25,000-\$38,000. In national data, women with lower annual incomes (less than \$7,500) report

the highest rates of IPV. The lowest rates of IPV are reported by women with annual incomes of \$50,000 or higher (BJS, 2003). The mean income among women in this study was \$7,000 year.

Thirty-six percent (n=8) of the women reported having no children under age 18. Thirty-two percent (n=7) reported one child. Fourteen percent (n=3) reported four children. Nine percent (n=2) reported having three children and nine percent (n=2) had two children. The mean age of this sample was 39 years, so women may have had children over age 18, not included in this study.

Table 1 Demographic Characteristics of Participants

Variable	n, % or Mean
Age:	
Range 19-51	<i>M</i> = 39, <i>SD</i> = 9.4
Marital Status:	
Single	11 (52%)
Divorced	5 (24%)
Separated	4 (19%)
Married	1 (5%)
Race/Ethnicity:	
Caucasian	13 (68%)
African-American	8 (38%)
Education:	
High school graduate	8 (36%)
College graduate	6 (32%)
Some high school	4 (18%)
Some college	3 (14%)
Beyond undergraduate	1 (5%)
Children under 18:	
None	8 (36%)
One	7 (32%)
Four	3 (14%)
Three	2 (9%)
Two	2 (9%)
Yearly Income:	
None	7 (33%)
2,500-5,000	7 (33%)
6,000-8,000	5 (24%)
25,000-38,000	3 (14%)

4.1.2 TREATMENT HISTORY

Treatment history was assessed for this sample population. In the demographic questionnaire, the women were asked to identify any prior mental health treatment that they had received and to identify the type of service provider from whom they received treatment. The first question asked “Have you ever received any mental health services in the past? Please check any that apply. A checklist was provided to indentify the type of treatment such as counseling, medication, hospitalization, or other. The second question measuring treatment history was, “If you did receive treatment, who did you see for mental health services?” A checklist was provided to identify the type of provider such as, a minister, social worker, psychiatrist, psychologist, medical doctor, nurse, don’t know, or other. Table 2 presents the type of treatment and the number of women who received the treatment.

Of the twenty-two respondents, 14 (64%) reported prior individual therapy. Six had prior involuntary hospitalizations, and 6 had prior voluntary hospitalizations. Five reported prior drug and alcohol services, and 5 had prior group counseling. Two of the 21 participants reported having obtained spiritual/religious counseling. One respondent had attended couples counseling, 1 worked with a resources coordinator, 1 received service from an after care nurse who provided follow- up care after psychiatric hospitalization. One respondent received wraparound in-home therapy services that addressed family violence issues. Twelve (55%) of the respondents indicated that they had received only one type of mental health treatment in the past, while 10 (45%) indicated that they had obtained more than one type of mental health treatment in the past.

Table 2 Treatment History of Participants

Treatment Type	N, %
Individual Counseling	14 (64%)
Voluntary Hospitalization	6 (27%)
Involuntary Hospitalization	6 (27%)
Group Counseling	5 (23%)
Alcohol/Drug Counseling	5 (23%)
Spiritual Counseling	2 (8%)
Couples Therapy	1 (2%)
Wrap-around Family	1 (2%)
Resource Coordinator	1 (2%)
After care Nurse	1 (2%)
One type	12 (55%)
More than one type	10 (45%)

4.2 STANDARDIZED MEASURES

4.2.1 CONFLICT TACTICS SCALE 2 SHORT FORM (CTS2S)

The Conflict Tactic Scale Short Form (CTS2S) was used to measure IPV. The ten-item scale asks respondents about their partner's use of five types of conflict tactics (psychological aggression, physical assault, injury, sexual coercion, and negotiation). Each tactic is represented by two items on the scale. For the items representing psychological aggression, physical assault, injury, and sexual coercion, one item indicates a less severe form of behavior and one indicates a more severe form of behavior. For the negotiation item, the two items represent different types of negotiation behavior.

The test asked respondents to identify the use and frequency of conflict tactics in their relationship. The response categories of the CTS2S are: 1 (once in the past year), 2 (twice in the past year), 3 (3-5 times in the past year), 4 (6-10 times in the past year), 5 (11-20 times in the past year), 6 (more than 20 times in the past year), 7 (not in the past year, but did happen before), and 8 (this has never happened). Of the twenty-two women participating in this study, one declined to complete this scale due to the discomfort associated with answering the questionnaire. However, this participant did indicate instances of physical and psychological abuse by a partner in the qualitative interview portion of the study. Reported scores indicate prevalence (the behavior occurred at least once) and chronicity (how many times the behavior occurred) in the past year.

Table 3 presents the prevalence and chronicity of conflict tactics experienced by the respondents in the past year. Ninety-five percent (n=21) of the women experienced psychological aggression at least once in the past year. The mean score for chronicity of

psychological aggression was 4.6, indicating 6-10 occurrences in the past year. Eighty-two percent (n=18) reported physical assault at least once in the past year. The mean score for physical assault was 3.2 indicating 3-5 incidents of physical assault in the past year. Eighty-two percent (n=18) of the women reported injury at the hands of their partner in the past year. The chronicity mean score was 3.7, indicating 3-5 incidences of injury in the past year.

Sexual coercion was the least reported of the items representing IPV. Sexual coercion was reported by 64% (n=14), with a chronicity mean score of 3.6, indicating 3-5 incidents of sexual coercion in the past year. Finally, sixty-four percent (n=14) of the women the use of negotiation tactics in the past year, with a chronicity mean score of 3.8, indicating 3-5 incidence in the past year.

Table 3 Occurrence and Frequency of Conflict Tactics in Past Year (CTS2S), n=21

Technique	Prevalence	Chronicity
	N (%)	Mean (SD)
Psychological Aggression	21(95%)	4.6 (1.5)
Physical Assault	18 (82%)	3.2 (2.6)
Injury	18 (82%)	3.7 (1.5)
Sexual Coercion	14 (64%)	3.6 (2.0)
Negotiation	14 (64%)	3.8 (2.3)

Prior research on intimate partner violence tends to either focus primarily on physical abuse or considers psychological abuse and physical abuse jointly. Few studies focus solely on the effects of psychological violence apart from physical violence. The finding of a high rate of psychological aggression (95%) in this study indicates that the occurrence and impact of psychological abuse among IPV victims could be explored in future research. Findings indicate that psychological abuse often accompanies physical violence (Tjaden & Thoennes, 2000) and may precede it (Coker et al, 2007). Pico-Alfonso (2005) found that psychological abuse strongly predicted both PTSD and fear of further abuse. Fear of further abuse was identified as both a chronic stressor in the lives of abused women and as a contributor to psychological impairment. Follingstad et al., (1990) found that 72% of women who had experienced both physical and emotional abuse reported a more severe impact of emotional abuse.

The category of physical violence roughly equates with legal definitions of simple and aggravated (serious harm, use of a weapon) assault. The high rates of physical assault (96%, 71%) reflect national data. Simple assault is the most frequently reported type of IPV experienced by women, followed by aggravated assault, and sexual abuse/rape (BJS, 2003).

4.2.2 POST-TRAUMATIC STRESS DISORDER CHECKLIST (PCL-C)

The Post-traumatic Stress Checklist, Civilian version (PCL-C) was used to assess symptoms of posttraumatic stress disorder (PTSD). The 17 – item scale asks respondents to rate their experience of PTSD-related symptoms in the past month, on a scale of one (not at all) to five (extremely). For this sample, $M = 49$, $SD = 17$, skewness = .212. The criterion for diagnosis of PTSD is a score of 44.

Sixty-two percent (n=13) of respondents met the criteria for PTSD. The mean score among those who met the criteria for PTSD was 60. Thirty-eight percent (n=8) women did not meet the criteria for PTSD. The mean score of this group was 32.

Table 4 Treatment History of Participants

	Met criteria for PTSD for PTSD (≥ 44)	Didn't meet criteria for PTSD (< 44)	Total Sample
Number	N= 13	N = 8	N = 21
Mean (SD)	60 (12)	32 (7.5)	49 (17)
Range	45-83	23-43	23-83

The findings of a high rate of PTSD (62%), psychological abuse, and physical abuse in this study offers support to prior research indicating a relationship between IPV and PTSD. A high prevalence of PTSD has been associated with high levels of IPV (Dutton et al, 2005) and symptoms of PTSD may continue after women leave abusive relationships (Woods, 2000). Research and treatment regarding IPV victims requires further consideration of the nature of this relationship.

4.2.3 PATIENT HEALTH QUESTIONNAIRE (PHQ)-9

The PHQ- 9 is the depression subscale of the Patient Health Questionnaire (PHQ), a self-administered version of the PRIME-MD diagnostic instrument for common mental disorders. The PHQ-9 lists nine symptoms of depression based on DSM-IV criteria and asks respondents to rate the frequency of the experience of each of these symptoms on a scale of 0 (not at all) to 5 (nearly every day) over the past two weeks. The total possible score is 45. A score of ten or higher indicates depression. For the total sample, $M = 12$, $SD = 7$, skewness = .49. Fifty-five percent ($n=11$) of the sample met the criteria of moderate to severe depression (a score of 10 or higher). For those meeting the criteria for depression, $M=17$, Range 10-28. Thirty-five percent ($n=9$) of the women did not meet the criteria for depression. For this group, $M= 6$, Range 3-9.

Table 5 Patient Health Questionnaire (PHQ)-9

	Met criteria for Depression	Didn't meet criteria for Depression	Total Sample
<u>Number</u>	<u>N = 11</u>	<u>N = 9</u>	<u>N = 20</u>
<u>Mean (SD)</u>	<u>16 (4.7)</u>	<u>6 (2.0)</u>	<u>12 (7)</u>
<u>Range</u>	<u>10-25</u>	<u>3-9</u>	<u>3-25</u>

This finding of a high rate of depression (50%) is consistent with previous studies indicating a high incidence and severity of depression among female IPV victims (Pico-Alfonso et al, 2006) and high rates of depression among shelter samples of IPV victims (Golding, 1999).

As depression and PTSD are found to co-occur among IPV victims and severity of abuse may be associated with severity of psychological symptoms, scores on all three of the quantitative scales, the PHQ-9, PCL-C, and the CTS2S were examined for their correlation with each other.

4.2.4 SOCIAL SUPPORT FROM OTHERS (SFO)

The Support from Others Scale (SFO) (Koeske & Koeske, 1989) was modified to include three additional categories: Partner, Women's Center & Shelter staff and Women's Center & Shelter residents. Respondents were asked to indicate on a scale of 1 (none at all) to 5 (a great deal) the amount of both emotional support and practical support (financial, babysitting, etc.) that they received from each of the relationships listed in the questionnaire. The data in Table 6 represent a composite score derived from the two scores of emotional support and practical support. The composite scores were coded into two categories: 1(low support) and 2 (high support). The scores presented here represent the number and percentage of women who reported high support from each category of persons. The descriptive statistics representing the full range (1-5) of responses (before coding the responses as high or low) were $M = 3.1$, $SD = 1.0$, skewness .243. Twenty-three percent ($n=5$) of the women indicated no support from any category listed on the scale.

Table 6 Post-Traumatic Stress Disorder

Support from Others

Variable	n, %
WC&S Resident	12(55%)
WC&S Staff	10(45%)
Other family	8(36%)
Children	7(32%)
Partner	6(27%)
Co-Workers	4(18%)
Friends	3(14%)
Spouse	0

Fifty-five percent (n=12) of the women reported receiving support from other residents at the Women's Center and Shelter of Greater Pittsburgh(WC&S) and 45% (n=10) of the respondents reported receiving support from the staff at WC&S. None of the women reported receiving support from their spouses.

4.3 CORRELATIONS: DEPRESSION, PTSD, CT2S, SFO

Table 5 reports on the significant correlations among depression (PHQ-9), PTSD (PCL-C), and intimate partner violence (CTS2S). A significant relationship was found for depression and PTSD as well as for depression and intimate partner violence. Women's scores on the depression scale were significantly correlated with their scores on the PTSD scale and the CTS. The mean score on the depression scale for this sample was twelve, two points above the cut-off score indicating depression, ten. The mean score for PTSD was 49, five points above the criterion for diagnosis of PTSD, a score of forty-four.

The mean score on the CTS was 3.7, indicating the occurrence of 3-5 incidents of intimate partner violence in the past year. Social Support showed a negative correlation with each of the three variables, Depression, PTSD, and CTS.

Table 7 Bivariate Correlations and Means, SDs, and Skewness of Variables

<i>Variables</i>	1	2	3	4
1. PTSD				
2. Depression	.51 [*]			
3. CTS	.19	.50 [*]		
4. Social Support	-.04	-.06	-.16	
Mean	49	12	3.7	3.1
SD	17	7	1.6	1.2
Skewness	.22	.49	-.71	.24

^{*}p < .05

Selected demographic variables, education, income, and race were examined for relationships with depression and PTSD. No significant relationships were found for education or income on depression, PTSD, and IPV. For income, there was little As prior research suggests that there may be differences in rates of depression and PTSD among different racial and ethnic groups in society. The following analysis examines the relationship of race with the quantitative measures of depression and PTSD, and intimate partner violence.

4.4 T-TEST FOR RACE

4.4.1 RACE AND PTSD

A t-test was conducted to explore the relationship of the race of respondents (Caucasian and African American) and symptoms of PTSD. The measurement of PTSD, the PCL-C, is a 17-item list of PTSD symptoms asking respondents to identify the degree to which they have been bothered by these symptoms in the past month. Possible responses range from 1(not at all) to 5 (extremely). The mean scores and standard deviations, based on the mean scale score, are reported here. A significant relationship was found for the relationship of PTSD with Caucasian respondents. For this sample, being Caucasian identified higher PTSD symptoms. For African – Americans ($M = 2.5$, $SD = .88$), a mean score of 2.5 out of five. For Caucasians ($M = 3.3$, $SD = 1.0$) $t(17) = 1.9$, $p = .073$, a mean score of 3.3 out of five is viewed as significant due to the small sample size, although it is slightly above the $p = .05$ level.

4.4.2 RACE AND DEPRESSION

For race and depression, there was no significant relationship found. For African-American ($M = 2.7$, $SD = 3.2$) and for Caucasians ($M = 1.3$, $SD = .8$) $t(5.3) = 1.2$, $p = .34$.

4.4.3 RACE AND IPV

No significant relationship was found for race and intimate partner violence. For African-Americans ($M = 5.5$, $SD = 1.0$) and Caucasians ($M = 1.3$, $SD = 1.3$) $t(17) = .32$, $p = .76$

4.5 QUALITATIVE RESULTS

This section presents the analysis of the qualitative data collected in the interview portion of the study. The qualitative interview portion of this study was guided by the three dimensions (need, barriers, and benefits) of the HBM. The interview explored the following research questions: 1) How do female IPV victims identify their need for mental health care? 2) What are the perceived barriers to mental health treatment for female IPV victims? and 3) What are the perceived benefits of mental health treatment for IPV victims?

A semi-structured interview, structured according to the three dimensions of the health belief model approach, guided the interview. Based on the interview responses, themes were developed that represented the responses to each research question. Following is an introduction to the format of the qualitative interview, organized by research question, along with a presentation of the findings for each question and selected interview excerpts to support the findings.

4.5.1 PERCEIVED NEED

Research Question 1. How do female IPV victims identify the need for mental health care?

The following questions were utilized to explore the question of how the participants identified the need for mental health treatment in relation to the domestic violence experience.

- a) Thinking back to the time that you thought about seeing a mental health professional, can you describe how you knew that you might need to see someone?
- b) How did you see your concern as being related to your domestic violence experience?

Four themes were identified to represent the responses given by study participants during the discussion of the perceived need for mental health treatment. These four themes, depression, fear, worry about children, and isolation are presented in Table 8, along with excerpts from the interviews that support the themes.

Table 8 Perceived Need

<u>Need</u>	<u>N, %</u>	<u>Sample Comments</u>
Depression	10 (45%)	“sad, tired, struggling” “ my thoughts went way down”
Children	6 (27%)	“I didn’t want harm to come to my kids” “ I didn’t want to sacrifice being a parent”
Fear and Anxiety	5 (23%)	“ terrified of the world” “shaking like a crack head”
Isolation	4 (18%)	“ someone to talk to”

Of the twenty-two respondents, six identified more than one need in discussing mental health help-seeking. Ten (45%) discussed symptoms associated with depression, such as sadness, low energy, emotional pain, and apathy as motivations for the decision to seek help. Concerns regarding the consequences of violence in the home on their children were cited by six of the women (27%) as the reason for feeling the need to seek mental health help. The mothers were concerned about the immediate impact of violence in their children’s lives as well as consequences in the future. Feelings of fear, anxiety, and stress-related symptoms were cited by five (23%) of the women as reasons for seeking help. Four (18%) of the women mentioned that

they sought therapy in order to have someone to talk to. Three (14%) of the women who indicated concern for children in their response also indicated one psychological/emotional symptom.

Discussion of Findings on Perceived Need

The Health Belief Model identifies perceived need as a belief in the susceptibility and severity of the problem. The women's comments indicate that they did recognize both of these elements. In the recognition of need, the women were responding to feelings or experiences that exceeded their ability to cope. The descriptions of the severity of the situations that prompted them to seek help acknowledge the susceptibility to the consequences of abuse in their lives and the lives of their children. The identified these issues as warranting help.

The decision to seek mental health services reflects the concern that without help they or their children would succumb to these consequences as well as the belief that services would be helpful in addressing the concerns. Perceived need for some of the women was identified in terms of the needs of their children, rather than directly for themselves. As mothers witness the impact of abuse on their children, they may be motivated to seek help initially for their children rather than themselves. This may allow women to maintain appropriate role functioning and control by attending to their children's needs. By seeking counseling, the women hoped to restore a sense of perspective regarding themselves and their life situation, as well as the ability to provide security for their children. As the women perceived the need for help in terms of personal crisis and concerns about their children, they were acknowledging the severity of and susceptibility to negative consequences of the domestic violence experience.

The women's comments regarding perceived need revealed that the domestic violence experience had affected their overall perspective and self-confidence. They were often fearful

and unsure of themselves and concerned about protecting their children. The experience of abuse challenged the well-being, safety and security of themselves and their families. They recognized a negative change in their beliefs and behaviors due to the domestic violence experience. Self-doubt, fear, sadness, and apathy affected their ability to function in desired ways.

The women's comments related to the nature of the experience of need, such as challenges to self-perception, impaired functioning, concern for children and isolation support previous findings. Mojtabai, Olfson, and Mechanic (2002) report that a decline in role functioning is an important factor in perceived need for help. As the women came to see a decline in their ability to carry out behaviors that they had previously engaged in and that had helped define who they were, they began to identify a need for help. As indicated by one respondent,

"I wasn't myself anymore; I used to be confident, independent, now I was afraid of the world"

This fear and change in one's confidence and functioning may reflect Bard and Sangrey's, (1986) identification of the disorganization of self that accompanies traumatic experience. McCann (1988) also reports that the consequences of violence victimization can include a change in one's sense of self-worth, safety, and meaning. Laughan (2007) also identified feelings of being tired, depressed, and isolated as motivating factors in help-seeking among African-American women with current or recent experience of intimate partner violence. In summary, identified perceived need for mental health treatment related to IPV represented threats to self-esteem, confidence, cognitive evaluative abilities, and concern for children. Once the women had perceived a need for mental health help, they faced the decision of whether or not to pursue treatment and of what type of treatment to obtain. The second variable in the

study model, barriers, is discussed in the following section. Identifying and categorizing barriers followed the same procedure as that of perceived need

4.5.2 BARRIERS TO TREATMENT

Research Question 2. What are the perceived barriers to mental health treatment for female IPV victims?

The Health Belief Model (HBM) conceives of barriers as the negative costs associated with obtaining help. These costs may include, fear, disappointment, or side-effects of treatment. The HBM suggests that one must perceive positive outcomes from treatment in order to pursue help. The model indicates that a risks/benefits analysis is conducted and that if the perceived benefits outweigh the risks, the individual will pursue help. Barriers to treatment represent obstacles to obtaining desired outcomes.

The examination of barriers in this study is primarily retrospective. The women discuss previous or current experiences with mental health help-seeking. Therefore, they are discussing barriers that they have encountered in their previous or current help-seeking experiences. The following questions were utilized in the interview discussion of perceived barriers to mental health treatment.

- a) Was there anything that was easy or difficult for you about the process of deciding to get help or finding help?
- b) Once you found help, was there anything about your experience in treatment that made it easy or difficult for you to continue in treatment?

The costs identified in this study were categorized into three groups. These groups were: Provider characteristics, Treatment Modality, Institutional Barriers. Themes were identified

within each category that represented the participants' responses. The distributions of responses, along with sample comments are presented in Table 9.

Table 9 Perceived Barriers to Treatment

<u>Barriers</u>	<u>N, %</u>	<u>Sample Comments</u>
<u>Provider</u>		
Lack of Attention	6 (27%)	"he (therapist) nodded off"
Lack of Connection	6 (27%)	"she (therapist) never had hardship"
Lack of Autonomy	3 (14%)	"he (therapist) just told me to leave"
Blaming	3 (14%)	"said it was my fault"
<u>Treatment</u>		
Lack of Practical Focus	4 (18%)	"she wanted to talk about my childhood"
Lack of Belonging	4 (18%)	"no one talked about it (IPV)"
Lack of Safety	3 (14%)	"what I said would get back to him"
<u>Institutional</u>		
Lack of Provider Options	4 (18%)	"Public welfare...they're no good"
Fragmented Care System	4 (18%)	"We didn't discuss violence there"

Discussion of Findings Related to Barriers

For barriers, 41% (n = 9) of respondents mentioned at least one barrier to treatment and 45% (n = 10) mentioned more than one barrier, M=1.7, range 0-5. Since the participants were discussing obstacles or difficulties associated with accessing mental health treatment retrospectively, the obstacles mentioned tended to refer more to difficulties that led to dissatisfaction with treatment or the decision to quit therapy, rather than obstacles to obtaining initial treatment. However, the barriers did appear to influence the decision to not return to the same provider or type of treatment. The identified barriers are organized here by the following three categories: provider characteristics (interpersonal barriers), treatment modality (type of treatment), and institutional barriers (structure of service delivery system). The following is a presentation of the barriers expressed by the participants based on their prior experiences with treatment.

Provider Characteristics

The comments included in this category relate primarily to difficulties that the women had in trusting mental health providers. The women questioned the therapist's knowledge regarding IPV, the therapist's ability to understand the women's experiences (related to IPV), and the therapist's responsiveness. Twenty-seven percent (n = 6) of the respondents discussed feelings of a lack of attentiveness and lack of connection with their therapist. Comments related to the therapist being too young and inexperienced or having not experienced the same life "hardships" as the respondent. The women believed that only someone who had experienced IPV could understand the experience. This perception of lack of experience interfered with the women's ability to trust or establish a connection with the therapist.

The concerns regarding trust and provider-authenticity may reflect the consequences of the respondents' IPV experiences. In discussing their abuse, the women identified feelings of shame, guilt, and vulnerability. One of the women remarked how embarrassing it was to talk about her experience of IPV and that it would be easier if she felt a sense of shared experience with the therapist. This expectation of shared experience may derive from the women's experience of service provision within the WC&S where other women and advocates have experienced IPV victimization. The sense of connection, understanding, and support that they received in this environment may contribute to the belief that only victims can understand other victims and to the perception of disappointment with mental health providers outside of the setting of the WC&S, who may not have had personal experience as IPV victims. Also, in the administration of the support from others measure (SFO), the women identified the WC&S staff and residents as the strongest sources of support in their lives at the time of this study, this experience may have also contributed to a heightened feeling of a lack of acknowledgment or understanding from mental health professionals outside of the WC&S.

Fourteen percent ($n = 3$) of the women identified that they had been told by a therapist to "just leave" the abusive relationship. This experience was perceived as an indication that the therapist didn't not understand the complexity of the situation or make an effort to really understand the respondent's perspective or need for autonomy in decision-making. As one woman stated:

"If I want to go back (to the abuser) 50 times, that's my business"

One respondent explained that once she believed that her therapist thought that she should leave her abuser, she felt that she was "letting him down" so she didn't discuss the abuse in therapy

anymore. Finally, 14% (n=3) of the respondents reported feeling “blamed” for their IPV victimization. This was difficult to hear as explained by one respondent:

“When you already have mental health problems, then being told that it’s your fault, doesn’t help”

The respondents in this study were often sensitive to the subtle cues and overt statements of therapists that indicated a lack of understanding or attention to their situation. The consequences of this experience may include a re-experiencing of negative views of self, a reluctance to further discuss the violence, and in some cases, termination of therapy by the women. In the course of the interview, the women also mentioned positive past or current experiences with therapists. The comments related to appreciating the therapist’s calling them when an appointment had to be rescheduled, returning phone calls, and providing support over the phone in a crisis. Those women who felt comfortable with their therapists also discussed enjoying that the therapist made jokes, was friendly, and shared some of their own experiences with the women.

Treatment Modality

This category relates to barriers or obstacles to treatment due to the type or setting of the treatment. Within this category, 18% (n =4) of the women discussed their disaffection with the focus of their therapy. The women preferred a more practical, problem-solving approach that focused on understanding the current relationship dynamics. As described by two respondents:

“It was too Freudian, not useful, I went in thinking,” I’ll talk about my relationship, that’s why I was there, not to talk about my mother, my parents were like Ozzie and Harriet”.

“Help me understand the triggers, what happened, so that I know next time”

Another barrier identified by 18% (n = 4) of the respondents related to a feeling of not “belonging” in treatment. This feeling was expressed regarding group treatment, As stated by one respondent:

“It was like mainstreaming special ed kids, I didn’t belong there. The other people there were pulling lice from their head, examining their armpits, shaking from drinking”

Group treatment that didn’t focus on IPV was problematic as well.

“No one brought it up, they didn’t talk about it, so I didn’t bring it up”

Finally, 14% (n = 3) of the women discussed difficulty with the community setting of their group treatment. One woman reported a concern that if she said anything about the abuse the information would get back to her abuser, as people in the group knew him and would tell him. There was a lack of trust with other group members and the feeling that since they would be disclosing sensitive information, it would be more comfortable to share in private.

The final category of barriers is institutional barriers. These are barriers related to the nature and structure of the mental health service delivery system. These barriers are discussed next.

Institutional Barriers

This theme related to institutional concerns regarding the limited availability of preferred therapists and the lack of a comprehensive approach to treatment. Eighteen percent (n = 4) of the respondents reported difficulty locating a therapist that they felt was appropriate for them. This was due to limited choices within their insurance plan and having to go through a “trial and error” process to find a therapist that they felt could help them.

For 18% (n = 4) of the women a barrier to treatment related to the lack of a comprehensive approach in therapy. If the women had multiple issues to address, such as

substance abuse and mental illness, there was a complaint that one provider did not address both of these issues. Rather, there was separate treatment for drug and alcohol and mental health issues and this limited the success of their treatment. For example, unaddressed substance abuse issues in mental health treatment interfered with the women's ability to maintain mental health treatment and untreated mental health issues interfered with maintain drug and alcohol treatment.

Overall, barriers relate to perceived effectiveness of providers and treatment. This supports the notion of consumer interest in the availability of quality, appropriate care as part of the help-seeking process. The female IPV victims in this sample experienced difficulties with trust, security, control, and choice in help-seeking. These issues may relate to the consequences of IPV victimization. The perception of need that generated help-seeking for some of the women was based in their feelings of a loss of control, security, and trust in themselves and their lives. Re-experiencing these feelings in help-seeking may increase the difficulty in accessing and maintaining mental health treatment. As the women's experience of barriers hindered access to treatment and development of a therapeutic relationship, increased awareness of and responsiveness to these vulnerabilities is warranted.

The following discussion presents the data collected on perceived benefits of treatment. In response to this inquiry, the women identified what they found to be beneficial and helpful about therapy. As the responses are retrospective in nature, the identified benefits relate to assessments made about the value of treatment after they began therapy. In assessing expected benefits of therapy prior to accessing help, the women referred primarily to wanting help addressing their reasons for entering therapy. When these goals were met, the therapy was evaluated as helpful or beneficial. If goals were not met, the therapy was not viewed as having been beneficial.

For most of the women, as illustrated in the comments regarding perceived need, their goals for treatment related to wanting to feel better or have more control in their lives and their children's lives in order to increase the overall quality of their lives. They often did not express any particular sense of expected benefits prior to treatment other than to have these needs met. Presumably, the women initially believed that mental health treatment would be helpful in achieving their goals. However, the results of their treatment experience did not always meet these expectations of benefits.

4.5.3 BENEFITS OF TREATMENT

Research Question 3. How do female victims of IPV perceive benefits of mental health treatment?

The women's reports of the perceived benefits of treatment related to having the opportunity to talk and have someone listen and validate their sense of themselves and their view of reality. The comments share some underlying issues, expressed or focused on a different aspect, perhaps, of the same theme. In regards to themes on benefits, both themes recognize a similar need, but represent a different focus, one emphasizing the interpersonal support of the therapist that led to an increased feeling of self-esteem and the other identifying the outcome related to a change in external perception of reality. Table 10 identifies the perceived benefits of mental health treatment.

Table 10 Benefits of Treatment

<u>Benefits</u>	<u>N, %</u>	<u>Sample Comments</u>
Reality Testing	5 (23%)	“A place to reconstruct my reality”
Validation	5 (23%)	“She looks at me, I feel important”

Forty –five percent (n=10) of the women identified benefits of treatment. Twenty-three percent (n=5) cited the opportunity to have the time and space to understand what had happened in their live and come to terms with their current reality as a benefit of therapy. Twenty-three percent (n=5) of the women discussed the validation that they felt in therapy. The feelings of validation were associated with the attentiveness and helpfulness of their therapist. Comments such as the following illustrate this finding.

“She (therapist) gave me the chance to reflect on things, see how they really were”

The identification of the benefits of treatment adds specification and lends support to previous research related to preferences for treatment. McCann and Pearlman (1990) identify reassurance and restoration of a sense of trust, safety, and control as necessary to recovery from traumatic victimization. McCauley et al (1998) report that victims need a caring, protective clinician who is easy to talk to and offers continued treatment. In this study, the women report a need for respect and attentiveness from mental health care providers as well as a need for security and trust. Nehls & Sallmann (2005) found that victims want to be listened to without preconceived notions. A provider response that supports these expressed benefits of treatment may facilitate victims healing process.

This study's findings related to benefits of treatment support the prior findings of Kearney (2002) in her study of women's experience of domestic violence. Kearney cites a process of changing perception that takes place as women move from within to beyond an abusive relationship. This process coincides with the feelings of futility and being overwhelmed that may prompt help-seeking and the re-definition of self that takes place as women restructure a new, safe environment for themselves and their children.

Fifty-five percent (n=12) of the women did not identify any benefits of treatment. This suggests an inconsistency between the mental health help-seeking needs of victims and the reality of their help-seeking experience. Rather than receiving help, the women experienced barriers that outweighed benefits or prevented them from obtaining potential benefits from treatment.

These findings provide insight into understanding the influence of IPV on the mental health help-seeking process of female victims of IPV. As victims consider obtaining mental health treatment they evaluate and respond to the consequences of abuse in their lives, they may identify the need for help in terms of threats to their sense of self or functioning or recognize need based on their concern for their children. Barriers that hinder access and maintenance of treatment relate to perceived competence, respect, and helpfulness of providers, appropriateness of available treatment, and access to appropriate treatment. Psychological symptomology may influence the perception of barriers. Benefits of treatment relate to the opportunity for recovery within in a supportive environment. The experience of IPV may impact on one's evaluation of need, perception of barriers, and benefits of treatment.

The following section presents the results of the mixed-method analyses that examined relationships between the quantitative variables and the qualitative variables. These analyses were conducted for the purpose of validation of the measures. The three qualitative variables, need, barriers, and benefits were examined for their relationship to the quantitative variables measuring PTSD, depression, and CTS.

4.6 MIXED-METHOD ANALYSIS

4.6.1 INTRODUCTION

Analyses were conducted to examine the relationship between selected quantitative and qualitative variables. The qualitative interview measured the three dimensions (need, barriers, and benefits) of help-seeking identified by the HBM. The quantitative measures examined rates of depression (PHQ-9), PTSD (PCL-C), and intimate partner violence (CTS2S). These analyses were conducted for the purpose of validation of the measures and in order to assess and compare the relationship of the qualitative measures of need and barriers to the quantitative measures for depression and PTSD.

Perceived need, the first dimension of the HBM, was assessed by a question in the qualitative interview asking the women to identify what led them to believe that they needed mental health services. The responses to this question were coded either 1 (recognition of psychological symptoms) or 2 (no identification of psychological symptoms). A t-test was conducted in order to determine if there was a significant relationship between the qualitative

measure indicating psychological symptoms and the quantitative measures of PTSD and depression. The results of this analysis are provided here.

4.6.2 PERCEIVED NEED AND PTSD

Perceived need as psychological symptoms (depression, fear/anxiety, and isolation) was coded as 1 (yes) for need and those indicating no perceived need based on psychological symptoms was coded as 2 (no) need. For yes need ($M=3.3$, $SD\ 1.0$) and no need ($M=2.4$, $SD\ .81$) $t(19) = 1.9$, $p = .072$. This is approaching significance at $p = .05$ level and given the small sample size, is an important finding. Findings indicate that there is a relationship between the qualitative measure of need and the quantitative measure of PTSD.

4.6.3 PERCEIVED NEED AND DEPRESSION

The analysis of the relation between the qualitative measure of need and depression was also examined using a t-test. For the t-test comparing the results of the qualitative measure of perceived need with the results of the depression measure, the PCL-C, psychological symptoms ($M=1.6$, $SD\ .68$) and no psychological symptoms ($M=.89$, $SD\ .47$) $t(18) = 2.7$, $p = .01$. This finding identifies a relationship between the quantitative measure of depression, PCL-C and the qualitative measure of need. The finding of significance in this relationship is probably related to the prevalence of indicated symptoms of depression in the qualitative interviews. Depression symptoms may be more recognizable than PTSD symptoms and thus more likely to be identified and discussed by the women in the interviews. Depression symptoms were mentioned by 45% ($n=10$) of the women in the qualitative interviews as reasons for seeking help.

4.6.4 BARRIERS TO TREATMENT

The second dimension of the HBM explored in the qualitative interview was the concept of barriers to treatment. This concept is examined in relation to scores on the quantitative scales for depression and PTSD. The results of this analysis are presented below.

4.6.5 BARRIERS AND PTSD

Respondents' answers to the qualitative question regarding barriers to treatment were categorized into three areas; provider barriers, treatment modality barriers, and institutional barriers. Then, the barrier variable was coded as a dichotomous variable (yes, no) where respondents who identified at least one barrier were coded as 1 (yes), and respondents indicating no barriers were code as 2 (no). There was a significant difference in scores for barriers ($M=53.2$, $SD\ 16.6$) and no barriers group ($M=32$, $SD\ 10.0$) $t(20) = 2.1$, $p=.05$. Higher PTSD scores were more likely to identify perceived barriers to help-seeking. This finding suggests that IPV victims experiencing PTSD may have more difficulty or obstacles in the mental health help-seeking process.

4.6.6 BARRIERS AND DEPRESSION

The perception of barriers to treatment among female IPV victims was also analyzed in relation to scores on the quantitative measure of depression, the PHQ-9. Responses of victims to the qualitative question asking about difficulties in help-seeking were categorized into two groups, perceived barriers and no perceived barriers. There was a significant difference in the scores of

the barriers group ($M=13.7$, $SD= 7.1$) and the no barriers group ($M=8.3$, $SD= .58$) $t(20) = 3.3$, $p=.01$ on the depression scale. Higher depression scores were more likely to identify perceived barriers to help-seeking. This suggests that victims experiencing depression may have more obstacles in the mental health help-seeking process.

4.6.7 BENEFITS AND PTSD

The relationship of perception of benefits and PTSD was examined. The responses of the participants who perceived benefits to treatment were coded as 1(yes) and the responses of those participants who did not perceive benefits were coded as 2 (no). There was a significant difference in the scores of those who perceived benefits ($M=38$, $SD=10.3$) and those who did not perceive benefits ($M=55$, $SD=23$), $t(20) = -2.0$, $p=.06$ on the PTSD scale. A higher PTSD score was more likely to identify not having perceived benefits of treatment.

4.6.8 BENEFITS AND DEPRESSION

The relationship of perceived benefits and depression was also examined. There was a not a significant relationship for benefits and depression, although the mean score on the depression scale was slightly higher for those who perceived no benefits than for those who perceived benefits. For those who did perceive benefits, ($M=11$, $SD=5.8$), and for those who did not perceive benefits, ($M=15$, $SD=8.5$), $t(19) = -1.3$, $p=.22$.

5.0 DISCUSSION AND CONCLUSION

This study examined the mental health help seeking experience of female victims of IPV. The participants in this study were 22 women who had received domestic violence services at the Women's Center and Shelter of Greater Pittsburgh (WC&S). Quantitative measures, PCL-C, PTSD, CTS, and SFO were administered to the participants as well as a qualitative interview assessing help-seeking based on the framework of the HBM. The HBM identifies three dimensions of help-seeking: need (susceptibility and severity), barriers, and benefits. The mixed-methodology approach compared the results of the quantitative and qualitative data. Following is a discussion of the findings, grouped by the help-seeking dimensions of the HBM, and concluding remarks.

5.1 PERCEIVED NEED

For the first dimension of help seeking that was assessed, perceived need, the HBM provided a guideline that characterized need as based on severity and susceptibility. This concept appeared to have some relevance for the study participant's perception of the need for mental health care. However, the need for mental health care for 27% (n=6) of the participants related a concern for their children's well-being. This suggests the need for a broader conceptualization of the need for

help among female IPV victims. This recognition is significant as it identifies an area of potential outreach as well as a component of mental health treatment that IPV victims may require.

In this study, the women with higher indications of PTSD and depression experienced a higher level of need. This need, motivated by psychological distress may reflect the experience of the traumatic victimization of IPV. As the experience of trauma often threatens one's sense of safety in the world and relationships, the depression, fear, anxiety, and isolation associated with IPV may be a consequence of experiencing trauma. The nature of the relationship between trauma and IPV and the appropriate treatment response to trauma for IPV victims could be explored further.

The next dimension of help-seeking of the HBM that was studied in order to assess the influence of IPV on mental health help-seeking was the concept of barriers. While the experience and perception of need may be a prerequisite to help-seeking, the identification of barriers to treatment is also an important factor in the decision of whether or not to seek or continue with mental health treatment. A discussion of the findings related to barriers follows.

5.2 BARRIERS

Barriers emerge as obstacles in the path to meeting the needs of victims for mental health help. Providers, treatment modality, and institutional factors all present potential areas of difficulty for victims as they make the effort to meet their needs. A provider or service response to victims' needs for self-validation, realistic cognitive appraisals, and a sense of security and interpersonal connection appears to be an important factor in facilitating a therapeutic relationship and engaging clients in treatment. The identification of these barriers is a reflection

of the therapeutic needs of the women. This study's finding that women with higher levels of depression and PTSD perceive more barriers to treatment indicates that this population may be more difficult to engage in treatment or require an alternative approaches to treatment. The study participants' perceptions of barriers in mental health treatment may also reflect their experience within the environment of the Women's Center and Shelter (WC&S) of Greater Pittsburgh, the setting of this study. The following comments relate to the different experience of the WC&S and mental health treatment obtained outside of the shelter.

“Well, what I like about this place is that I feel safe. I like the posters about helping hands; it's geared for women. Sometimes in my mental health trail, I'd think that people weren't really that interested, like I was just filling their spaces. I detected that”

“There are a lot of issues that bring us to mental health. They (mental health provider) couldn't really help me with the domestic violence issues except to say, ” you need to leave.” Here, they understand why I couldn't leave. I have to fix the things that make me depressed. The medicine can help me a little bit, but the issues are still there.

Respondents also identified lack of security, particularly in community-based group treatment settings, due to concerns that their abuser would access information regarding their group attendance and involvement. These concerns reflect the IPV experience and may need to be addressed within the mental health service delivery system. Despite the identified barriers to treatment, the majority of the women indicated that they intended to seek mental health services in the future. The two women who did not plan to utilize further services included: the young women referred to marital counseling by her mother-in-law, who perceived no help from previous service and no expectation of help from future mental health service; and one women who preferred spiritual/religious help, based on her personal beliefs. Thus, while barriers may have contributed to the women having a negative experience with or terminating treatment, the

past experience of barriers did not prohibit the continuing belief that, under the right circumstances, the women expected to have a positive experience with treatment in the future. These expectations offer the opportunity to continue to refine and develop appropriate outreach and treatment response for female victims of IPV. On a systems level, limited treatment choices, the perception that quality of care is better in private care rather than public service settings, and the “trial and error” process that women identified in their efforts to locate appropriate mental health treatment, suggest areas for improvement in providing mental health services to female victims of IPV illustrate broader social concerns of a two-tier system of care, one for those with resources and one for those without.

The barriers to treatment identified by the women influence the likelihood of their obtaining and maintaining treatment. The extent to which these barriers can be minimized or removed in the help-seeking process will assist women in progressing through the process of reclaiming their lives. The perception of barriers also influences the women’s beliefs about the helpfulness and overall quality of their treatment experience. The perceived benefits or positive outcomes of treatment identified by the respondents are discussed next.

5.3 BENEFITS

Those who identified benefits of treatment cited validation of themselves and their experience as important benefits of mental health treatment. The opportunity to have the time and space to regain perspective on what was happening in their lives and develop a more realistic view of their situation was a transformational experience. A treatment approach that does not engage victims in this experience inhibits the realization of these benefits.

Assisting female victims of IPV in obtaining the desired benefits of mental health treatment may require a multifaceted intervention. Social workers can play a role in implementing this strategy. Social workers often act as both direct mental health service providers as well as coordinators of care for women in the social service system. In these roles, they can increase their awareness and understanding of IPV and facilitate diffusion of this knowledge. This knowledge can also be used to empower IPV victims in their help-seeking process and in making appropriate referrals to treatment. As systems of care become more specialized and differentiated, this ability to assist in coordinating services to a vulnerable population becomes more important.

Trends within the mental health system may also explain the difficulty that some of the women experienced in obtaining appropriate treatment. The movement towards short-term treatment may not allow for the focus on and benefits that can be derived from a relational approach to meeting trauma needs in therapy. Current predominant understandings regarding treatment determine the available treatment options and may not provide the flexibility that vulnerable and marginalized populations with complex issues require. A lack of integration of services due to the trend towards specialization and professionalization within each field of treatment also impacts the treatment experience. Women with multiple needs such as combined IPV, drug and alcohol, mental health, and perhaps childhood abuse and trauma issues may find it difficult to have their needs met in one treatment setting.

5.4 STUDY LIMITATIONS, STRENGTHS, AND SUGGESTIONS FOR FUTURE RESEARCH

Limitations of this study include a small sample necessitated by practicality and the nature of the issue being explored. The sample of twenty-two women allowed for a richer, in-depth analysis of the help-seeking experience. A larger, more diverse sample would improve the ability to generalize to a wider population. The sample had limited diversity. It was primarily Caucasian and lower-income, although the sample did represent the demographics of the community served in the shelter. The sample did identify a saturation of responses in the qualitative interviews, as well. Similar responses were consistently noted within the twenty-two interviews.

The strengths of this study include the richness of data collected from the qualitative interview, the extension of the health belief model to an examination of the experience of mental health help-seeking among intimate partner violence victims, and the mixed-method approach used to examine both the relationship between quantitative and qualitative measures and to explore help-seeking from multiple perspectives. The finding of high rates of psychological abuse calls attention to this form of abuse as a both precursor and accompaniment to physical violence. Psychological abuse may play a unique role in the relationship between psychological symptoms and IPV that has yet to be explored.

The finding of a relationship between the qualitative variables of need and barriers and the psychological symptoms measured in the quantitative tests identifies a potential area of focus for improving outreach and service delivery to victims of IPV. In particular, the incorporation of trauma and feminist-informed therapy may facilitate congruence in the treatment response to IPV. The extent to which victims' view treatment as appropriate and helpful will impact the likelihood that they will obtain and benefit from mental health treatment.

In the framework of prior research in this area, this study expands on previously knowledge regarding the relationship of mental health and IPV. The experience of IPV victimization appears to influence the mental health help-seeking process of victims through its impact on the evaluation of the need for treatment, perceived barriers in accessing treatment, and the perceived benefits of treatment. Meeting the mental health needs of female IPV victims presents a challenge to providers and the mental health system. Future research is suggested in increasing understanding of the role of psychological abuse in the mental health needs of IPV victims, the relationship of trauma to IPV, and the appropriate therapeutic response to IPV within the mental health sector. Education and training regarding the IPV victimization experience can assist in this process. Social understandings that influence services need to be flexible in order to respond to the diverse needs of a marginalized group. Increased integration of multi-faceted services that address issues of IPV victims, such as substance abuse, housing, and employment may be relevant to enhancing and maintain mental health. Recognition of the importance of these issues as influences on successful functioning and well being is necessary.

Systematic change may be difficult as social understandings and attitudes as well as economic preferences and concerns often underlie service response. As the trends towards privatization, specialization, and professionalization in service provision continue, perhaps there is room for recognition of and negotiation and advocacy for the needs of unique populations. This is the mandate of social work and social workers.

APPENDIX A

RECRUITMENT FLYER

RESEARCH STUDY

Some women who experience domestic violence also think about receiving counseling or other mental health services. Sometimes they find mental health services helpful and other times they don't. If you have ever received mental health services, I'd like to hear your story and learn from you about your experiences. Your first-hand knowledge and experience will benefit other women in a similar situation and help providers better understand domestic violence concerns. This study is part of my dissertation for my Ph.D. in social work at Pitt. I want to learn more about women's experience with domestic violence and mental health services.

This study will ask about your domestic violence experience and mental health issues and experiences.

You don't have to give your name and no information identifying you will be shared with the Women's Center or anyone else.

- Interviews will be private and confidential
- Interviews will last about 1 hour.
- Interviews will be held at the Women's Center at a time convenient for you.
- Your knowledge and experience is necessary and important
- Your participation is voluntary
- You will be paid \$20.00 for your time

For more information, please contact:

APPENDIX B

INTERVIEW PROTOCOL

Introduction

I'm interested in hearing from you about your knowledge and experiences with seeking mental health services for domestic violence related concerns. If you want to start by just talking about your experience, that's fine, or I could begin by asking you some questions.

(ID the Problem- susceptibility/seriousness)

1. I'd like to hear about your experiences with mental health services related to your domestic violence experience.

2. When you thought about seeing a mental health professional for help with your concerns, can you describe how you knew that you might need to see someone?

Probe: what you were experiencing at the time? What was going on, what did the concern feel like for you?

3. How did you see this concern as related to your experience with domestic violence?

(Barriers/Facilitators: Environmental Influences/Attitudes)

1. When you were making this decision, was there anyone who helped you to decide to see someone for help?

2. What did you think others might think about your getting services? What do you think about people who get mental health help? How did you feel about yourself, seeing a mental health professional?

3. How do you think your experience with domestic violence may have affected your decision to seek help?

Probe: Do you think your domestic violence experience made you more or less willing to seek help from a mental health professional? Why?

4. Was there anything that made it easy or hard for you to make the decision to get help, to make an appointment, keep the appointment, to continue to go back?
5. Do you have any suggestions about what could have made any part of the process of getting help easier or better?

Probe: Anything that would have helped in your decision to get services, finding a provider, getting/making appointments, made treatment more helpful for women in a similar situation

(Benefits)

1. In what way was your treatment experience helpful or unhelpful?

Probe: Was there anything about obtaining service or the actual treatment itself that you found helpful or not helpful?

2. Did you feel that your experiences/issues with domestic violence were adequately addressed by your provider? Can you describe why or why not?
3. What suggestions or advice do you have for mental health providers about how they could better help women with domestic violence experience?
4. Is there anything else that you want to say about your experience of receiving mental health services for domestic violence related issues?

APPENDIX C

STANDARDIZED MEASURES

Patient Health Questionnaire (PHQ) -9

Interview Date _____

Number _____

These questions ask about feelings that you may have had over the past two weeks. Your answers will help us to understand the feelings you may be having. Please circle the answer that best describes how often you have experienced the feeling in the past two weeks.

1. Over the <u>last 2 weeks</u>, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	N early every day
a. Little interest or pleasure in doing things	0	1	2	3
b. Feeling down, depressed, or hopeless	0	1	2	3
c. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
d. Feeling tired or having little energy	0	1	2	3
e. Poor appetite or overeating	0	1	2	3

f. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
g. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
h. Moving or speaking so slowly that other people could have noticed? Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
i. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

How difficult have these problems (questions 1 - 9) made it for you to do your work, take care of things at home, or get along with other people?

NA				
Did not answer yes to any question 1-9	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>

PTSD CHECKLIST FOR STRESSFUL EVENTS (PCL-C)

Interview Date _____

Number _____

Have you ever had something happen to you that was extremely upsetting? I mean something really bad, like being in a life-threatening situation of some kind?

☐ 0 No. Continue to checklist.

☐ 1 Yes ↓

Below is a list of problems and complaints that people sometimes have in response to stressful life experiences like these. Please indicate how much you have been bothered by each of the following problem in the past month.

In the <u>past month</u>, how often have you been bothered by...	Not at all	A little bit	Moderat ely	Quite a bit	Extreme ly
1. Repeated, disturbing memories, thoughts, or images of a stressful experience from the past?	1	2	3	4	5
2. Repeated, disturbing dreams of a stressful experience from the past?	1	2	3	4	5
3. Suddenly acting or feeling as if a stressful experience were happening again (as if you were reliving it)?	1	2	3	4	5
4. Feeling very upset when something reminded you of a stressful experience from the past?	1	2	3	4	5
5. Having physical reactions (e.g., heart pounding, trouble breathing, sweating) when something reminded you of a stressful experience from the past?	1	2	3	4	5
6. Avoiding thinking or talking about a stressful experience from the past or avoiding having feelings related to it?	1	2	3	4	5
7. Avoiding activities or situations because they remind you of a stressful experience		2	3	4	5

In the <u>past month</u>, how often have you been bothered by...	Not at all	A little bit	Moderat ely	Quite a bit	Extreme ly
8. Trouble remembering important parts of a stressful experience from the past?	1	2	3	4	5
9. Loss of interest in activities that you used to enjoy?	1	2	3	4	5
10. Feeling distant or cut off from other people?	1	2	3	4	5
11. Feeling emotionally numb or being unable to have loving feelings for those close to you?	1	2	3	4	5
12. Feeling as if your future will somehow be cut short?	1	2	3	4	5
13. Trouble falling or staying asleep?	1	2	3	4	5
14. Feeling irritable or having angry outbursts?	1	2	3	4	5
15. Having difficulty concentrating?	1	2	3	4	5
16. Being "super-alert" or watchful or on guard?	1	2	3	4	5
17. Feeling jumpy or easily startled?	1	2	3	4	5

CONFLICT TACTICS SCALE 2 SHORT FORM (CTS2S)

Interview Date _____

Number _____

No matter how well a couple gets along, there are times when they disagree, get annoyed with the other person, want different things from each other, or just have spats or fights because they are in a bad mood, or tired, or for some other reason. Couples also have many different ways of trying to settle their differences. This is a list of some things that might happen when you have differences. Please read the list and then circle one number for each item to indicate how often your husband/partner might have done this in the last year. If your partner did not do one of these things in the past year, but it did happen before that, circle the “7” for that question. If it never happened, circle the “8”.

How often did this happen?	In the past year...						Not in past year but It did happen before	This has never happened
	Once	Twice	3-5 times	6-10 times	11-20 times	More than 20 times		
1. My partner explained their side or suggested a compromise for a disagreement with them.	1	2	3	4	5	6	7	8
2. My partner insulted or swore or shouted or yelled at me.	1	2	3	4	5	6	7	8
3. I had a sprain, bruise, or small cut, or felt pain the	1	2	3	4	5	6	7	8

next day because of a fight with my partner.								
4. My partner showed respect for or showed that they cared about my feeling about an issue we disagreed on.	1	2	3	4	5	6	7	8
5. My partner pushed, shoved, or slapped me.	1	2	3	4	5	6	7	8
6. My partner punched, or kicked, or beat me up	1	2	3	4	5	6	7	8
7. My partner destroyed something belonging to me or threatened to hit me.	1	2	3	4	5	6	7	8
8. I went to see a doctor (MD) or needed to see a doctor because of a fight with my partner.	1	2	3	4	5	6	7	8
9. My partner used force like hitting, holding down, or using a weapon to make me have sex.	1	2	3	4	5	6	7	8

10. My partner insisted on sex when I did not want to or insisted on sex without a condom but did not use physical force.	1	2	3	4	5	6	7	8
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Straus, M.A., & Douglas, E.M. (2004). A short form of the revised conflict tactics scales, and typographies for severity and mutuality. *Violence and Victims*, 19(5), 507-520.

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SUPPORT FROM OTHERS

Instructions: For each of the categories of persons listed below, *rate the amount on support* that is provided to you from 1 (None At All) to 5 (A Great Deal). Please rate the amount of support in both columns A and B. Under A, rate the amount of EMOTIONAL SUPPORT, under B, rate the amount of PRACTICAL SUPPORT (such as help with finances, transportation, and babysitting) provided. In other words, *make two ratings* for each category of person. Circle a number from 1 to 5, or NA if the rating is not applicable for you. Refer to this scale.

None	A	A Fair	Quite	A Great
At All	Little	Amount	A Bit	Deal
1	2	3	4	5

Person(s)	A	B
	EMOTIONAL SUPPORT	PRACTICAL SUPPORT
Spouse	1 2 3 4 5 NA	1 2 3 4 5 NA
Partner	1 2 3 4 5 NA	1 2 3 4 5 NA
Children	1 2 3 4 5 NA	1 2 3 4 5 NA
Other family/relatives	1 2 3 4 5 NA	1 2 3 4 5 NA
Friends	1 2 3 4 5 NA	1 2 3 4 5 NA
Co-Workers	1 2 3 4 5 NA	1 2 3 4 5 NA
Women's Center Staff	1 2 3 4 5 NA	1 2 3 4 5 NA
Women's Center Resident	1 2 3 4 5 NA	1 2 3 4 5 NA
Other _____	1 2 3 4 5 NA	1 2 3 4 5 NA

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APPENDIX D

DEMOGRAPHIC QUESTIONNAIRE

1. Age: _____

2. Race/Ethnicity: Select the category that best fits your racial or ethnic group

Black or African –American _____
Non- Hispanic White _____
Asian _____
Hispanic _____
Native Hawaiian/Pacific Islander _____
American Indian/Alaska Native _____
Other _____

3. Education level:

some high school _____ high school graduate/GED _____ some college _____
college graduate _____ beyond undergraduate _____

4. Marital status: single _____ married _____ divorced _____ separated _____

4. Approximate yearly income _____

5. Number of children under age 18 _____

6. Have you received domestic violence services in the past? Yes _____ No _____

7. If yes, what types of services have you received in the past? Check all that apply.

Telephone support _____
Residential _____
Advocacy _____
Education _____
Support Group _____
Other (please identify) _____

8. Have you ever received any mental health services in the past? Please check any that apply. counseling _____ medication _____ hospitalization _____
other (please identify) _____

9. If so, who did you see for mental health services? Minister _____
social worker _____ psychiatrist _____ psychologist _____
medical doctor _____ nurse _____ don't know _____
other (please identify) _____

10. Did you have medical insurance coverage for any mental health treatment that you received in the past? Yes _____ No _____

11. If you had insurance for your past treatment, in whose name was this coverage?
My name _____ My husband/partner's _____ My parent's _____

12. Do you currently have health insurance coverage? Yes _____ No _____

13. In whose name is your current insurance? My name _____
My husband/partner's _____ My parent's _____

12. Do you identify yourself with a particular religion? Yes _____
No _____

13. If so, which one? _____

14. How would you describe yourself? Check the answer that best applies to you.

	Not at all	Somewhat	Moderately	Strongly
1. Religious	_____	_____	_____	_____
2. Spiritual	_____	_____	_____	_____

APPENDIX E

[RESEARCHER QUALIFICATIONS]

Qualifications of Investigators

Principle Investigator: Karen Woodcock, MSW, Ph.D., has a B.S. degree in Psychology, Cum Laude, from the University of Pittsburgh, and an MSW and Ph.D. from the University of Pittsburgh, School of Social Work. In her studies, she has conducted independent research and taken courses on research design, mental health, and inferential and multivariate statistics. The current research is her doctoral dissertation. The researcher has worked in the community mental health field providing direct services to adults with mental illness, for 6 years. She completed a 60 hour PA state mandated volunteer training course on domestic violence at the Women's Center and Shelter of Greater Pittsburgh. Her doctoral committee consists of Chair, Catherine Greeno, Ph.D., Associate Professor, School of Social Work; Patricia Cluss, MD, Ph.D. University of Pittsburgh Physicians faculty and UPMC affiliate, Dept. of Psychiatry; Esther Sales, Ph.D, Faculty Emeritus, School of Social Work; Lambert Maguire, Ph.D. Professor and Associate Dean, School of Social Work; and Lynn Hawker, Ph.D. Clinical Director, Retired, Women's Center and Shelter of Greater Pittsburgh. The committee oversaw this research study.

Committee Chair: Catherine Greeno, Ph.D., Associate Professor, School of Social Work. Dr. Greeno conducts research on efficacy-based treatments relevant for community mental health providers, and consumers' treatment-seeking decisions. She is affiliated with the Women's Center and Shelter of Greater Pittsburgh and WPIC: Intimate Partner Violence Taskforce. She teaches research courses at the School of Social Work and has published articles on community mental health and research issues. Dr. Greeno is currently PI for the Caring for Moms Study being conducted in affiliation with the Treatment Effectiveness Studies for Women Project, associated with the Mental Health Clinical Research Center under the leadership of Dr. David Kupfer.

Qualitative Research Assistant/Consultant: Joni Vander Bilt, MPH, has fifteen years of research experience, with a focus on mental health, epidemiology, and women's health. Her qualitative experience began at the Yale University Consultation Center working on an evaluation of the Rhode Island mental health system for children. There, she conducted focus groups and helped analyze the qualitative data of the evaluation. More recently, she has worked on a qualitative paper with Carol Anderson, Ph.D. and Catherine Greeno, Ph.D., about the experience of low-income women with children with mental health problems.

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