HHS Public Access

Author manuscript

J Health Care Poor Underserved. Author manuscript; available in PMC 2016 April 01.

Published in final edited form as:

J Health Care Poor Underserved. 2015 November ; 26(4): 1286–1303. doi:10.1353/hpu.2015.0135.

Multiple Intimate Partner Violence Experiences: Knowledge, Access, Utilization and Barriers to Utilization of Resources by Women of the African Diaspora

Bushra Sabri, PhD, **Julia Huerta, MPH**, **Kamila A. Alexander, PhD**, **Noelle M. St.Vil, PhD**, **Jacquelyn C. Campbell, PhD**, and **Gloria B. Callwood, PhD**

is a Research Associate at the School of Nursing Johns Hopkins University. **MS. HUERTA** is a BSN Candidate at the School of Nursing Johns Hopkins University, Baltimore, MD. **DR. ALEXANDER** is a Post-doctoral Fellow at the School of Nursing Johns Hopkins University, Baltimore, MD. **DR. ST.VIL** is a Post-doctoral Fellow at the School of Nursing Johns Hopkins University, Baltimore, MD. **DR. CAMPBELL** is Professor at the School of Nursing, Baltimore, MD. **DR. CALLWOOD** is an Associate Professor and Director of the Caribbean Exploratory NIMHD Research Center of Excellence at the University of the Virgin Islands

Abstract

Objective—This study examined knowledge, access, utilization, and barriers to use of resources among Black women exposed to multiple types of intimate partner violence in Baltimore, Maryland and the U.S. Virgin Islands (USVI).

Methods—We analyzed quantitative survey data collected by 163 women recruited from primary care, prenatal or family planning clinics in Baltimore and the USVI. In addition we analyzed qualitative data from in-depth interviews with 11 women. Quantitative data were analyzed using descriptive statistics and qualitative data were analyzed using thematic analysis.

Results—A substantial proportion of Black women with multiple types of violence experiences lacked knowledge of, did not have access to, and did not use resources. Barriers to resource use were identified at the individual, relationship, and community levels.

Conclusion—There is need for programs to develop awareness, promote access and utilization of resources, and eliminate barriers to resource use among abused Black women.

Keywords

Barriers; knowledge; access; utilization; resources; multiple types of intimate partner violence; women from African diaspora; mixed methods

Intimate partner violence (IPV) is a pervasive public health problem that disproportionately affects Black women. In nationally representative studies, higher rates of IPV[1] and IPV-related crimes (e.g., murders) have been reported among Black women compared with their White counterparts.[2] Disadvantaged groups of Black women experience multiple types of violence.[3] Intimate partner violence has also been identified as a significant problem in the

Correspondence should be addressed to Bushra Sabri by bushrasabri@gmail.com or by phone: (319) 331-3732.

U.S. Virgin Islands (USVI),[4] with many women likely to experience multiple types of IPV. Women exposed to multiple types of IPV may experience worse health outcomes[5] than those with one type of IPV experience. However, the effects of IPV may be moderated by factors such as presence/absence of social support, community resources, and access to services.[6] This calls for a greater understanding of help-seeking among women exposed to multiple types of IPV and their barriers to seeking help.

Research shows that Black women in abusive relationships are less likely to seek help than White women in abusive relationships.[7, 8] Barriers to service utilization include individual (e.g., shame, fear, emphasis on self-reliance), relationship (e.g., abusive partner control tactics) and community barriers such as stigma or discrimination.[7–9] Additional barriers include poverty, inadequate assessment tools, stereotyping and labeling women who experience IPV, lack of cultural competence, and language differences. [10] Other barriers reported in the literature are prior experiences with formal and informal services, hearing about negative interactions with formal services, lack of services, and finances.[11] Further, Black women may feel shame and guilt about their abuse due to lack of knowledge about IPV in their communities.[10] In a predominantly Black sample of women, the reasons given for non-use of resources included barriers such as no money, insurance, or time; lack of knowledge of resources; partner preventing them from using resources; fear; confidentiality concerns; and tangible loss.[12] Thus, studies have identified various barriers to resource use among Black women and women from other racial/ethnic groups. However, the focus in previous studies has not been on differences within the Black population. This study addressed this gap by examining barriers to resource use among ethnically diverse groups of Black women with multiple types of IPV experiences.

Exposure to multiple types of IPV, in this study, is defined as experiences of physical, sexual, and psychological abuse by an intimate partner. Despite experiencing multiple types of IPV, Black women may not seek help, have access to resources or be aware of available resources in the community. Although specific types of IPV such as physical and psychological abuse frequently co-occur with other types of IPV such as sexual abuse, the majority of research on resource use among IPV victims assess IPV as a one-dimensional construct.[5] This study extends previous research by focusing on resource use among Black women exposed to multiple types of IPV and comparing Black women in Baltimore with Black women in the USVI. Specifically, this study a) examines knowledge, perceived access, and utilization of resources by women with multiple types of IPV experiences; and (b) identifies women's barriers to resource utilization.

An ecological framework[13–15] was used to study barriers to utilization of resources among Black women with multiple IPV experiences. The focus was on individual, microsystem (i.e., relationship), and exosystem (community) factors related to resource use. The ecological framework seeks to examine women's experiences in the more complex context of interacting systems such as family and community. Individual factors (e.g., depression) interact with the social environment (e.g., family, community and culture) and influence health outcomes of violence and women's ability to seek help. An examination of factors at multiple levels is useful for developing prevention and intervention strategies that address

not only individuals but systems that indirectly or directly support the violation of Black women with histories of violence.[15]

Methods

This cross-sectional mixed methods study is part of a large multisite comparative case-control research project that involves African American and African Caribbean women. Women were recruited from primary care, prenatal or family planning clinics in Baltimore, Maryland (in the mainland U.S.) and St. Croix and St. Thomas (in the USVI). Eligible women were English- and Spanish-speaking women of African descent, aged 18–55, who were in an intimate relationship within the past two years. Women who consented to participate in the study completed a 30-minute, audio computer-assisted structured self-interview (ACASI). A $20 gift card was provided as incentive for those who screened into the study and completed ACASI. Women who participated in the qualitative interviews were provided with additional $20 for participation. All study procedures were approved by the institutional review boards of Johns Hopkins University, the University of the Virgin Islands, and the National Center for Minority Health Disparities.

In the parent study, women who reported lifetime and past year two experiences of intimate partner physical and sexual abuse, with or without psychological abuse (n=543) were categorized as abused women. Twenty-nine abused women who consented to participate in the qualitative phase of the parent study completed semi-structured in-depth interviews (n=18 in Baltimore and n=11 in the USVI). The purposive sampling approach was used to select women for in-depth interviews to achieve variation based on factors such as age and severity of abuse. All in-depth interviews were conducted by two trained interviewers in Baltimore and four trained interviews in the USVI. The interviews focused on questions about major life events, childhood experiences, relationships including sexual partners, abuse disclosure to health care providers, and sexual health. All interviews were recorded using digital recorder and transcribed verbatim.

For quantitative portion of the present study, we selected 163 women who reported multiple types of IPV experiences (i.e., physical, psychological and sexual) in the quantitative survey (30.1%; n=49 in Baltimore and 69.9%; n=114 in the USVI). Of the 163 participants with multiple types of IPV experiences, 11 women consented to participate in the follow-up interviews. Therefore, for the qualitative portion of the study, we purposively selected 11 women (eight from Baltimore and three from the USVI) who participated in the in-depth interviews and also reported multiple types of IPV experiences in the quantitative survey. The remaining in-depth interview participants who reported only one or two types of violence (e.g., psychological and physical) in the survey were excluded (n=18). The qualitative data were used to identify barriers to use of resources among women exposed to multiple types of IPV.

Quantitative measures

Multiple types of intimate partner violence—The dichotomous multiple types of intimate partner violence variable was created using items from the Severity of Violence Against Women Scale[16] (SVAWS; 46 items; alpha=0.94)) for physical and sexual abuse and

the Women's Experiences of Battering (WEB; 10 items, alpha=1.00; range=0–71) for psychological abuse. In SVAWS, women were asked how often in the past 12 months they experienced the behavior from their abusive partners or if they never had an abusive partner about their current or most recent partner. The items were rated using a four-point scale ranging from 0 (never) to 4 (not in the last 12 months but it did happen before). The WEB captured psychological abuse using the following six domains: perceived threat, altered identity, managing, entrapment, yearning, and disempowerment.[17] Each item was rated using a six-point Likert scale ranging from 1 (Strongly disagree) to 6 (Strongly agree). A categorical variable was created to classify women into two categories: those with all three types of victimization (physical, sexual, and emotional), and those with a single type of victimization. Women who endorsed all three types of victimization by their intimate partners were classified as those with multiple types of IPV and assigned the value of 1 (multiple type of victimization=1, single type=0).

Resources—The respondent's relationship to possible resources to help cope with her situation was assessed in several domains. a) Utilization of resources to deal with an abusive partner was measured using health care, social, and religious resources (i.e., help from minister, church, or other religious support group) items under the following question: "There may or may not be resources in the community that can help women with problems in their relationships and with the abuse. Sometimes women use these resources and others do not. Which of the following services or people have you used to get help with an abusive partner? (0 = No, 1 = Yes). b) For perceived access to resources, a follow-up question was asked about availability of each resource (0 = No, 1 = Yes); c) For knowledge of each resource, women who responded "don't know" about the availability of a resource were categorized into the group who lacked knowledge of that resource, and those who responded yes or no were categorized in the knowledgeable group.

PTSD—Post-traumatic stress disorder (PTSD) was assessed using the Primary Care Post-traumatic Stress Disorder Screening (PC-PTSD).[18] The PC-PTSD (Past month; four items; alpha = 0.78) is a self-report screening tool designed to assess PTSD symptoms in the past month, with scores ranging from 0 to 4. A score of 3 or higher is the cutoff for clinically significant PTSD symptoms (Response options: 0 = No, 1 = Yes).

Depression—Depression was measured using the *Center for Epidemiologic Studies Depression* (CESD-10).[19] The CESD-10 (Past week, 10 items; alpha = 0.80) is a brief screening measure for assessing levels of past-week depressive symptoms (Range 0–29). A score of 10 or higher is the cutoff for clinically significant depressive symptoms. Each symptom item is rated according to its frequency of occurrence using a four-point scale ranging from 0 [rarely or none of the time; less often than one day per week] to 3 [All of the time; five to seven days per week]).

Risk for lethality—Risk for lethality was assessed using 20 dichotomous items from the *Danger Assessment* (DA) instrument (20 items; alpha = 0.83; Range = – 3–36). The DA is a clinical and research instrument developed to assist women in assessing their danger of being murdered or seriously injured by their intimate partners.[20] A weighted scoring system

identified women at the following levels of danger: variable danger (≤8), increased danger (8–13), severe danger (14–17), and extreme danger (18 and above).[20]

Qualitative measure

The semi-structured interview guide included open-ended questions with additional probes for deeper exploration of major life events, lifetime abuse experiences (during childhood and adult intimate partner relationships), abuse disclosure to health care providers, and overall health. The interview guide was developed by two members on the research team using existing literature and members' past experiences with research on abused women. The guide was further developed and revised based on feedback from expert members on the team. After the interview guide was made final, the interviews were conducted, audio-taped, and transcribed.

Data analysis

Quantitative data—Quantitative data were analyzed to determine whether Black women with multiple types of IPV experiences in Baltimore differed significantly from Black women with multiple types of IPV experiences in the USVI with respect to socio-demographic characteristics, mental health, risk for lethality and knowledge, perceived access, and utilization of resources (Tables 1 and 2). Bivariate analysis was conducted using t-test and chi-square procedures. Data were analyzed using the Statistical Package for Social Sciences version 21.0.[21] A p value of less than .05 was defined as statistically significant in the analysis.

Qualitative data—Data were analyzed using a theoretical thematic analysis procedure.[22] Four team members read the transcripts and independently identified initial codes about barriers to utilization of resources reported by participants (e.g., community-level barriers and relationship barriers) and searched for themes among codes. Common themes were identified across data, grouped according to emerging patterns and named accordingly. Any inconsistencies or differences in interpretation were reconciled between the four coders.

Results

Results of quantitative analysis

Characteristics of women with multiple types of IPV experiences—Table 1 displays the characteristics of women with multiple types of IPV experiences. A total of 163 women reported multiple IPV experiences (i.e., 49 in Baltimore and 114 in the USVI). The difference in exposure to multiple types of IPV among abused women in the two sites (i.e., 29.7% (n=114) of the abused women in the USVI and 30.8% (n=49) of the abused women in Baltimore) was not statistically significant. The average age of women with multiple types of victimization was 29.7 years. More than a third of the women in Baltimore and USVI (35.4%–44.9%) had at least a high school education. Most of them were unemployed (61.2% in Baltimore and 52% in the USVI). Out of 163 women with multiple types of IPV, 147 self-identified as African American or African Caribbean and 11 women in the USVI reported being from Spanish, Hispanic or Latino origin. Five women self-identified as being from other/mixed race/ethnicity (two from Baltimore and three from the USVI). More than

one half (60.1%) had clinically significant depressive symptoms and 35% had clinically significant PTSD problems. The average score on the danger assessment was 27.8, indicating that women exposed to multiple types of IPV in the sample, on average, were in extreme danger of lethality according to the Danger Assessment.

Knowledge of available resources among women exposed to multiple types of IPB—Although resources for dealing with abusive relationships are available in both sites, abused women may not be knowledgeable about available services. Nearly a quarter and more of the women exposed to multiple types of IPV (25.2%–43%) in Baltimore and the USVI did not know about available resources to help them with their abusive partners. Forty three percent of the women exposed to multiple types of IPV lacked knowledge about health care provider as a resource, one third (37.6%) lacked knowledge about emergency room services, 37% did not know about domestic violence services (i.e., domestic violence hotline/advocate or shelter) in the community, 24.1% lacked knowledge about police as a resource for assistance in dealing with intimate partner abuse, and 33.7% were unaware of the restraining order as a resource. Women exposed to multiple types of IPV in Baltimore did not significantly differ from women exposed to multiple types of IPV in the USVI on knowledge of resources (see Table 2).

Perceived access to resources among women exposed to multiple types of IPV—More than half of the women exposed to multiple types of IPV in Baltimore and USVI reported no access to community resources to deal with their abusive partners. Among health care resources, 71% did not have access to a health care provider, 66.3% did not have access to emergency medical services, and 82.8% did not have access to a mental health counselor or a therapist. Regarding social services, more than three-fourth (75.5%–77.9%) reported not having access to police or a restraining order, and 61% women reported unavailability of domestic violence hotline/advocate or a shelter in their area (see Table 2).

Utilization of resources by women exposed to multiple types of IPV—Overall resource utilization was low among women with multiple types of IPV experiences. Women exposed to multiple types of IPV in the USVI were less likely to use resources than those in Baltimore. A majority of women in Baltimore (59.2%) used police services, significantly more than in the USVI (43%) with a similar difference in restraining order use. More than 70% of women exposed to multiple types of IPV in Baltimore and USVI did not use shelter or advocacy services. Despite PTSD and depression problems, more than 60% of the women exposed to multiple types of IPV in Baltimore and USVI did not used services of a mental health counselor or a therapist (see Table 2).

Results of qualitative analysis

Qualitative analyses revealed a number of barriers to resource utilization or ability to receive adequate support by women exposed to multiple types of IPV. These included barriers at the following ecological levels: A) individual-level, B) relationship-level, and C) community-level. The *individual-level barriers* were defined as factors unique to the individual characteristics of women exposed to multiple types of IPV that inhibited them from seeking or receiving help. The following themes were identified under individual-level barriers: fear

of the intimate partner, fear of being alone or uncertainty about the future, embarrassment or shame, psychological/emotional state of mind, lack of awareness of resources, financial dependence on the abuser, perception of self and attachment and love for the abuser. The *relationship-level barriers* included barriers that prevented women from having no contact with the abuser. These included abuser's violation of restraining order and stalking behavior. The *community-level barriers* included obstacles such as inability to receive support from the police or the criminal justice system, and perceived ineffectiveness of services.

Individual-level barriers

Fear of the intimate partner: Women repeatedly pointed to the fear of the abusive intimate partner as a major obstacle to disclosing abuse or obtaining care. They were afraid of repercussions if they disclosed abuse or the abuse became public knowledge. For instance, one woman stated:

> I tried to wear long sleeves or fold my arms to cover them [bruises] up just to make sure they were concealed. I never went to get any help. I was definitely scared of him (U1179, Age 19, USVI).

Other women said:

> Women want to feel safe. They might just feel like if they tell and it gets out, they will just get in more trouble. (U1206, Age 21, USVI).
>
> I did not call the police because I would have had trouble for days. (B5851, Age 32, Baltimore)
>
> We don't want to … go to the police a lot of times because we don't want it to back fall on us because sometimes you go to the police about something … they really want to hurt you (B5808, Age 53, Baltimore).
>
> I did not ever talk to health care provider because I was scared. Just by the nurse being around, that's just like telling my family. I didn't feel safe in talking to her. I felt like maybe she know somebody in my family somewhere along the line or maybe she know a friend that knows my family and she talking to them about me and it get back (B5702, Age 48, Baltimore)

Fear of being alone or uncertainty about the future: Fear of being alone or uncertainty about the future made taking the step of seeking help impossible for some woman, as reflected in the following quotations:

> My life was basically on trying to satisfy him and I was to a point where I was trying to keep him because I didn't want to be alone … even though we had the worst fight in the world (B5851, Age 32, Baltimore).
>
> When I was actually just beginning to get away from him, I was really scared because I really didn't know what I was going to do (B5808, Age 53, Baltimore).

Psychological/emotional state of mind: Women expressed psychological/emotional state of mind as a barrier to seeking help. One woman described being psychologically/emotionally entrapped by her abuser which limited her ability to break free from the abusive relationship.

> He really got to me. He was really in my head. Like, I'm all you need in this world — just me you and the kids. So I was brainwashed. And it took me three years just to get over him (B5975, 30 years old, Baltimore).

A woman voiced her opinion that lack of readiness is one of the barriers to disclosing abuse:

> A person don't get help until they are ready and when you're ready you will reach out. Even if health care provider had asked, if I was not ready I would have not said anything (B5851, Age 32, Baltimore).

Embarrassment or shame: Some women described feeling a sense of shame and embarrassment when they were in abusive relationships, which in turn, prevented them from seeking help or disclosing abuse. One woman said,

> I wasn't able to talk to anybody about it] because I was embarrassed… . it was bad enough that I was getting beat. I never thought that I would be beat by a man … other than my father when I was growing up (B5702, Age 48, Baltimore).

Another woman said,

> I never really talked to nobody … because I don't like to put myself out there like that. Then people will take it and run with it and say he's abusive (B5519, Age 43, Baltimore).

A USVI participant described reputation as a factor in her decision to disclose abuse:

> I had physical injuries from the abuse. I sought medical treatment but, being who I am and who I know in the community, most of my injuries were not written, put down or legalized. I was treated under other names sometimes due to the doctors that I know. I worked in the hospital and have family members that work in the medical system so the wounds were covered up (U1319, Age 25, USVI).

> The police was called but it was covered up. My family is well known. I know most of the Virgin Islands Police Department, most of the officers, most nurses and doctors that work in the hospital (U1319, Age 25, USVI).

Lack of awareness of resources: Lack of knowledge about domestic violence resources presented a barrier to seeking or receiving help. One woman said that she did not know about the shelter services:

> I did not believe there is a shelter or anything to go to. I have never heard of one until MCH showed me a paper and number telling me about this place. But I have never heard of that before in my life. (U1179, Age 19, USVI).

Another woman could not leave an abusive relationship because she thought she had nowhere to go:

> I was pregnant. So I ended up having to stay with him because I had nowhere else to go (B5946, Age 34, Baltimore).

Perception of self: Some women were unable to manage abuse due to self-doubt, as reflected in the following quotations:

> By me being the only child I wasn't equipped enough to tell a person look, I don't like this, please don't do this to me (B5851, Age 32, Baltimore).

> By me being so young—I didn't know how to handle it (B5946, Age 34, Baltimore).

Attachment and love for the abuser: For some women, emotional attachment and love for the abuser were the reasons that they did not report to the police or seeking help. The following quotations describe women's perspectives:

> … having had feelings for him in the past, I didn't really want to get him really in trouble-trouble. I was concerned about him getting hurt by the police or him having to get locked up. I was more worried about him than I was about me (B5808, Age 53, Baltimore).

> … I loved him and even if people told me to leave him alone, I wouldn't (B5945, Age 30, Baltimore).

> I have had people in my family who have been abused who say—the guy loves you if he abuses you. So, in my mind I'm saying—well, he must love me because … we were going to do this … I mean to be honest, I loved him with all my heart (B5946, Age 34, Baltimore).

Financial dependence or need for housing: For some women, financial dependence on the abuser or need for housing, were barriers to seeking help. Two women shared their reasons for staying and not seeking help or break free from violence:

> I liked being with him because he … had money. So we got together (B5702, Age 48).

> He had his own little place and he had a little job and I probably—might not have been with him had I had my own [place] (B5808, Age 53, Baltimore).

Relationship-level barriers

Abuser's stalking behavior and violation of the restraining order: A woman reported situation in which she obtained a restraining order but her abusive partner violated it:

> The restraining order didn't do no good, because [23] said, "It's just a piece a paper. It's not going to stop me." And he proved it that it was not going to stop him. I got three restraining orders out against him, and he violated all three of them. He just didn't care (B5975, Age 30, Baltimore).

Her partner's stalking behavior affected her performance on her job and she had to quit:

> I basically had to leave my job because he was stalking me. He was leaving voice messages on the job phone for me. So they had to beef up security up there. I couldn't stay home, because … I left the shelter. Then I had to get the kids to school, get me to work, and still had to be on time, and then you can't take the

> same route all the time … because you never know where he is going to be at. It was really stressful (B5975, Age 30, Baltimore).

Community-level barriers

Inability to get help from the police/criminal justice system: Women's prior negative experiences with the police/criminal justice system were barriers to accessing services. One participant described her problem with obtaining a restraining order:

> My restraining order never went through. We were talking about what happened between me and him and he denied everything in the Police Department. So they dropped it. Going to police or going to court here is a joke … Something has to be literally life threatening … for them to actually do something (U1179, Age 19, USVI).

Another participant reported that she was not notified by the police when her abuser was released from jail, although the police were aware of her situation:

> I had to tell them to do their job. They are supposed to protect me. He just called me two days ago, telling he was going to send some gang members to come shoot me and kill me. I had to call the police to tell them he was out of jail. They didn't even know.

Further she reported police officers' inability to help:

> When my sister called the police and I asked them I want him out of my house … they said—you have to get an eviction notice in order to get him out, and it would take 30 days. So I got to live with this nigger for 30 days and he's sitting up here trying to kill me. So then police was like—you need to go get a peace order (B5975, Age 30, Baltimore).

Perceived ineffectiveness of community resources

A participant described her negative experience with the resources in the community:

> There is a site called VINELink safe where you put your information on the internet and they let you know if you are in an abusive relationship. They are supposed to notify me if he was being bailed out or released. I was hooked up with VINELink following the case, and it just so happened one day I'm going to the store and he's around the corner. Why didn't I get a phone call? (B5975, Age 30, Baltimore).

> The reason why I left the shelter was because they basically tried to get me to convert my whole life to up there. They had a daycare there, but they wanted me to transfer my daycare vouchers from the daycare. The longer I be there, they were going to start charging me rent. They want you to go out every day and try and find somewhere else to live and try to find a job … I can't just up and switch like that. I tried to go back to work. But my job wouldn't let me come back without a consent form, a release from the shelter. I had to explain to them [shelter staff] that I was in a safe environment . . , just so I don't have to stay up here and pay you all rent and still pay rent where I live at (B5975, Age 30, Baltimore).

Discussion

This mixed methods study used quantitative data to identify knowledge, access and utilization of resources by Black women with multiple types of IPV experiences. In addition, this study used qualitative data to identify women's barriers to accessing services or disclosing abuse. One third of the participants exposed to multiple types of IPV were not aware of domestic violence services in the community and lacked knowledge about restraining order as a resource. Thus, there is need for increased education and outreach regarding domestic violence services among Black women. Through enhanced knowledge, women facing multiple types of IPV can seek helpful services for addressing abuse in their lives.

Although domestic violence services, health care, and other services are especially critical for women exposed to multiple types of IPV, more than half of the women in our sample did not have access to community resources to help them manage their abusive relationships. One explanation of this finding could be the low socio-economic status of the majority of women in this sample. Low socio economic status has been found to be significantly related to the level of abuse minority women experience and their access to services.[24] Thus, efforts are needed to improve accessibility of services for low income Black women in abusive relationships.

More than half of the Black women with multiple forms of IPV experiences did not use health care resources, social resources or religious resources. This is supported by previous research that shows that Black women who are suffering IPV underutilize community services.[7, 8] A smaller percentage of Black women with multiple types of IPV experiences in USVI used resources than those in Baltimore. However, a greater proportion of women exposed to multiple types of IPV in both sites used police and a restraining order, when compared with other resources.

In a study of ethnically diverse sample of domestic violence victims, Black women when given an option of an active legal assistance program and a full range of domestic violence center services, more frequently selected the legal option. Even when they used advocacy support from a domestic violence center, it was more likely for a restraining order than for counseling.[25] This could be due to greater familiarity with the legal services or due to a greater visibility of the police in the Black residential areas than in that of the other ethnic groups.[25] Utilization of legal resources could also be an indication of women being at high risk for lethal violence.[26] In our sample, women with multiple types of IPV experiences were, on average, found to be at high risk for lethal violence victimization by their intimate partner based on their scores on the danger assessment, a lethality risk assessment measure for women in abusive relationships.[20] Further, in our study, a substantial proportion of Black women exposed to multiple types of IPV reported depression and PTSD, as found in research conducted on ethnically diverse sample of women exposed to multiple types of victimization.[5] However, 65.3% of the women with multiple types of IPV experiences in Baltimore and 75% of the women exposed to multiple types of IPV in the USVI did not use services of a mental health counselor or a therapist. Black women may not use mental health services due to stigma and misperceptions associated with mental health and IPV.[27]

Although women with poor mental health may engage in the legal system as a means of managing distress,[28] mental health problems may interfere with women's ability to utilize resources over time and lead to re-victimization.[28–30] Thus, interventions for Black women with multiple types of IPV experiences should address both mental health and safety needs.

In this study, women with multiple types of IPV experiences faced a number of barriers to seeking/receiving help such as shame/embarrassment and lack of awareness of resources. Many of the barriers identified among women exposed to multiple types of IPV are similar to those that have been previously reported among IPV victims in the literature. For instance, shame, embarrassment and limited knowledge of local resources have been identified as barriers to seeking help among victims of IPV in previous research.[31, 32] Further, evidence suggests that IPV negatively impacts women's self-esteem, which limits their ability to leave the abuser and seek help.[33] Self-doubt and low self-esteem,[34] fear of the abuser[34] attachment to the abuser[6] and uncertainty about the future,[35] have been identified as barriers among ethnically diverse samples of IPV victims (including Blacks).

Consistent with existing research on partner violence victims,[33] financial dependence on the abuser increased women's vulnerability to stay in the abusive relationship even if they wanted to leave. The other relationship barrier was the abuser's stalking behavior and violation of the restraining order. A participant reported living under a constant threat and losing her job due to her partner's stalking behavior. Such experiences can undermine women's decisions to further seek help from the criminal justice system.

A community-level barrier was difficulty accessing help from the law enforcement and the criminal justice system. This finding is supported by previous research[33, 36] in which partner violence victims encountered difficulties when they sought help from the police and in obtaining desired restraining orders. In a qualitative study of 30 Black and White battered women, White women considered police as a resource, whereas Black women did not consider the police as a potential resource.[37] This finding highlights the need for additional training of police officers to be effective in addressing the needs of Black survivors with multiple types of IPV experiences. Another community-level barrier was ineffectiveness of local resources. For instance, a woman had to leave a local shelter because it was inadequate to meet her needs. Evidence shows that many domestic violence agencies lack sufficient resources to meet multiple and complex needs of partner violence victims.[36, 37]

The findings in this study have important implications for health care, social service and community organizations. Practitioners (including the law enforcement) must be trained in culturally and gender sensitive assessments and interventions with Black women who are facing/or have faced abuse in their lives. Assessments should focus on multiple types of IPV and its impact on help-seeking. Additionally, community programs are needed to increase knowledge, access and utilization of services among Black women. Further, efforts should focus on eliminating barriers to resource utilization among Black women in abusive relationships.

This study has limitations. First, this study included Black women in the U.S. and the USVI, and therefore, the findings from this study cannot be generalized to Black women from

Africa or from other racial and ethnic groups, nor to Black women from other areas and socioeconomic groups in U.S. and the Caribbean. Second, this study was based on self-report and is therefore limited by retrospective bias and women's willingness to share information. Additionally, accessibility to IPV support resources differed between sites. Geography, transportation systems, and economic support for these resources may have influence perceived barriers by participants. Distinct cultural interpretations of IPV or stigma may also inform access to resources. In our prior quantitative research, a higher percentage of women in the USVI sites (17%–20%) than those in Baltimore (10%) perceived their communities to be accepting of violence.[38] In the present study, a very small number of women exposed to multiple types of IPV (n=3) in the USVI participated in the follow-up qualitative interviews. This limited our ability to identify differences in barriers to resource use among women in Baltimore and the USVI or to identify impact of cultural factors such as stigma on resource use in the two sites. However, despite the limitations, the focus of the present study on multiple types of victimizations and associated resource use among Black women is a significant contribution to the literature on IPV.

Acknowledgments

This study was supported by a subcontract with the Caribbean Exploratory NIMHD Research Center of Excellence, University of the Virgin Islands (P20MD002286). Drs. St.Vil and Alexander are supported by the NICHD (T322HD064428).

References

1. Black, MC.; Basile, KC.; Breiding, MJ., et al. The National Intimate Partner and Sexual Violence Survey (NISVS): 2010 Summary Report. Atlanta, GA: National Center for Injury Prevention and Control Centers for Disease Control and Prevention; 2011.
2. Catalano, S.; Smith, E.; Snyder, H., et al. Female victims of violence. U.S. Department of Justice; 2009. Available at: http://bjs.ojp.usdoj.gov/content/pub/pdf/fvv.pdf
3. Long L, Ullman SE. The impact of multiple traumatic victimization on disclosure and coping mechanisms for Black women. Feminist Criminology. 2013 Oct; 8(4):295–319. http://dx.doi.org/10.1177/1557085113490783.
4. LeFranc E, Samms-Vaughan M, Hambleton I, et al. Interpersonal violence in three Caribbean countries: Barbados, Jamaica, and Trinidad and Tobago. Rev Panam Salud Publica. 2008 Dec; 24(6):409–421. [PubMed: 19178780]
5. Young-Wolff KC, Hellmuth J, Jaquier V, et al. Patterns of resource utilization and mental health symptoms among women exposed to multiple types of victimization: a latent class analysis. J Interpers Violence. 2013 Oct; 28(15):3059–3083. Epub 2013 May 17. http://dx.doi.org/10.1177/0886260513488692 PMid:23686622 PMCid:PMC3962669. [PubMed: 23686622]
6. Hien D, Ruglass L. Interpersonal partner violence and women in the United States: An overview of prevalence rates, psychiatric correlates and consequences and barriers to help seeking. Int J Law Psychiatry. 2009 Jan-Feb;32(1):48–55. Epub 2008 Dec 19. http://dx.doi.org/10.1016/j.ijlp.2008.11.003 PMid:19101036 PMCid:PMC3468326. [PubMed: 19101036]
7. El-Khoury MY, Dutton MA, Goodman LA, et al. Ethnic differences in battered women's formal help-seeking strategies: a focus on health, mental health, and spirituality. Cultur Divers Ethnic Minor Psychol. 2004 Nov; 10(4):383–393. http://dx.doi.org/10.1037/1099-9809.10.4.383 PMid:15554800. [PubMed: 15554800]
8. Sabri B, Bolyard R, McFadgion A, et al. Intimate partner violence, depression, PTSD and use of mental health resources among ethnically diverse black women. Soc Work Health Care. 2013; 52(4):351–369. http://dx.doi.org/10.1080/00981389.2012.745461 PMid:23581838 PMCid:PMC3628556. [PubMed: 23581838]

9. Rodriguez M, Valentine JM, Son JB, et al. Intimate partner violence and barriers to mental health care for ethnically diverse populations of women. Trauma Violence Abuse. 2009 Oct; 10(4):358–374. Epub 2009 Jul 28. http://dx.doi.org/10.1177/1524838009339756 PMid:19638359 PMCid:PMC2761218. [PubMed: 19638359]
10. Bent-Goodley TB. Health disparities against women: whey and how cultural and societal influences matter. Trauma Violence Abuse. 2007 Apr; 8(2):90–104. http://dx.doi.org/10.1177/1524838007301160 PMid:17545567. [PubMed: 17545567]
11. Liang B, Goodman L, Tummala-Narra P, et al. A theoretical framework for understanding help-seeking processes among survivors of intimate partner violence. Am J Community Psychol. 2005 Sep; 36(1–2):71–84. http://dx.doi.org/10.1007/s10464-005-6233-6 PMid:16134045. [PubMed: 16134045]
12. Fugate M, Landis L, Riordan K, et al. Barriers to domestic violence help seeking: implications for intervention. Violence Against Women. 2005 Mar; 11(3):290–310. http://dx.doi.org/10.1177/1077801204271959 PMid:16043551. [PubMed: 16043551]
13. Bronfenbrenner U. Toward an experimental ecology of human development. Am Psychologist. 1977; 32:513–531. http://dx.doi.org/10.1037/0003-066X.32.7.513.
14. Heise LL. Violence against women: an integrated ecological framework. Violence Against Women. 1998 Jun; 4(3):262–290. http://dx.doi.org/10.1177/1077801298004003002 PMid:12296014. [PubMed: 12296014]
15. Tillman S, Bryant-Davis T, Smith K, et al. Shattering silence: exploring barriers to disclosure for African American sexual assault survivors. Trauma Violence Abuse. 2010 Apr; 11(2):59–70. http://dx.doi.org/10.1177/1524838010363717 PMid:20430798. [PubMed: 20430798]
16. Marshall LL. Development of the severity of violence against women scale. J Family Violence. 1992; 7:103–121. http://dx.doi.org/10.1007/BF00979027http://dx.doi.org/10.1007/BF00978700.
17. Smith PH, Earp JA, DeVellis R. Measuring battering: development of the Women's Experience with Battering (WEB) Scale. Women's Health. 1995 Winter;1(4):273–288. PMid:9373384. [PubMed: 9373384]
18. Prins A, Ouimette P, Kimerling R, et al. The primary care PTSD screen (PC-PTSD): development and operating characteristics. Primary Care Psychiatry. 2003; 9(1):9–14. http://dx.doi.org/10.1185/135525703125002360.
19. Andresen EM, Malmgren JA, Carter, et al. Screening for depression in well older adults: evaluation of a short form of the CES-D (Center for Epidemiologic Studies Depression Scale). Am J Prev Med. 1994 Mar-Apr;10(2):77–84. PMid:8037935. [PubMed: 8037935]
20. Campbell JC, Webster DW, Glass N. The danger assessment: validation of a lethality risk assessment instrument for intimate partner femicide. J Int Violence. 2009 Apr; 24(4):653–674. Epub 2008 Jul 30. http://dx.doi.org/10.1177/0886260508317180 PMid:18667689.
21. IBM Corp. IBM statistics for windows version 21.0. New York, NY: IBM Corp; 2012. PMid: 23239417
22. Braun V, Clarke V. Using thematic analysis in psychology. Qual Res Psychol. 2006; 3(2):77–101. http://dx.doi.org/10.1191/1478088706qp063oa.
23. Kahle EM, Bolton M, Hughes JP, et al. Partners in Prevention HSV/ HIV Transmission Study Team. Plasma cytokine levels and risk of HIV Type 1 (HIV-1) transmission and acquisition: a nested case-control study among HIV-1-serodiscordant couples. J Infect Dis. 2015 May 1; 211(9): 1451–1460. http://dx.doi.org/10.1093/infdis/jiu621 PMid:25389306. [PubMed: 25389306]
24. Kasturirangan A, Krishnan S, Rige S. The impact of culture and minority status on women's experience of domestic violence. Trauma Violence Abuse. 2004 Oct; 5(4):318–332. http://dx.doi.org/10.1177/1524838004269487 PMid:15361586. [PubMed: 15361586]
25. Hollenshead JH, Dai Y, Ragsdale MK, et al. Relationship between two types of help seeking behavior in domestic violence victims. J Family Violence. 2006; 21:271–279. http://dx.doi.org/10.1007/s10896-006-9021-7.
26. Sabri B, Stockman JK, Campbell JC, et al. Factors associated with increased risk for lethal violence in intimate partner relationships among ethnically diverse Black women. Violence Vict. 2014; 29(5):719–741. http://dx.doi.org/10.1891/0886-6708.VV-D-13-00018 PMid:25429191 PMCid:PMC4242409. [PubMed: 25429191]

27. Ward EC, Clark L, Heidrich S. African American women's beliefs, coping behaviors, and barriers to seeking mental health services. Qual Health Res. 2009 Nov; 19(11):1589–1601. http://dx.doi.org/10.1177/1049732309350686 PMid:19843967 PMCid:PMC2854663. [PubMed: 19843967]
28. Wright CV, Johnson DM. Correlates for legal help-seeking: contextual factors for battered women in shelter. Violence Vict. 2009; 24(6):771–785. http://dx.doi.org/10.1891/0886-6708.24.6.771. [PubMed: 20055214]
29. Krause ED, Kaltman S, Goodman L, et al. Role of distinct PTSD symptoms in intimate partner reabuse: a prospective study. J Trauma Stress. 2006 Aug; 19(4):507–516. http://dx.doi.org/10.1002/jts.20136 PMid:16929505. [PubMed: 16929505]
30. Perez S, Johnson DM. PTSD compromises battered women's future safety. J Interpers Violence. 2008 May; 23(5):635–651. Epub 2008 Feb 13. http://dx.doi.org/10.1177/0886260507313528 PMid:18272729. [PubMed: 18272729]
31. Wilson KS, Silberberg MR, Brown AJ, et al. Health needs and barriers to healthcare of women who have experienced intimate partner violence. J Women Health (Larchmt). 2007 Dec; 16(10): 1485–1498. http://dx.doi.org/10.1089/jwh.2007.0385 PMid:18062764.
32. Overstreet NM, Quinn DM. The Intimate Partner Violence Stigmatization Model and Barriers to Help Seeking. Basic Appl Soc Psych. 2013 Jan 1; 35(1):109–122. Epub 2013 Feb 4. http://dx.doi.org/10.1080/01973533.2012.746599 PMid:23524454 PMCid:PMC3601798. [PubMed: 23524454]
33. Wolf ME, Ly U, Hobart MA, et al. Barriers to seeking police help for intimate partner violence. J Fam Violence. 2003; 18(2):121–129. http://dx.doi.org/10.1023/A:1022893231951.
34. Peterson R, Moracco KE, Goldstein KM, et al. Moving beyond dislosure: women's perspectivs on barriers and motivators to seeking assistance for intimate partner violence. Women Health. 2004; 40(3):63–76. http://dx.doi.org/10.1300/J013v40n03_05. [PubMed: 15829446]
35. Postmus JL, Severson M, Berry M, et al. Women's experiences of violence and seeking help. Violence Against Women. 2009 Jul; 15(7):852–868. Epub 2009 May 19. http://dx.doi.org/10.1177/1077801209334445 PMid:19458091. [PubMed: 19458091]
36. Kulkarni S, Bell H, Wylie L. Why don't they follow through? Intimate partner survivors' challenges in accessing health and social services. Fam Community Health. 2010 Apr-Jun;33(2): 94–105. http://dx.doi.org/10.1097/FCH.0b013e3181d59316 PMid:20216352. [PubMed: 20216352]
37. Few AL. The voices of Black and White rural battered women in domestic violence shelters. Fam Relations. 2005; 54(4):488–500. http://dx.doi.org/10.1111/j.1741-3729.2005.00335.x.
38. Stockman JK, Lucea MB, Bolyard R, et al. Intimate partner violence among African American and African Caribbean women: prevalence, risk factors, and the influence of cultural attitudes. Glob Health Action. 2014 Sep 12.7:24772. http://dx.doi.org/10.3402/gha.v7.24772 PMid:25226418 PMCid:PMC4165044. [PubMed: 25226418]

Table 1

CHARACTERISTICS OF WOMEN WITH MULTIPLE TYPES OF IPV EXPERIENCES

	Total (N=163)	Baltimore (N=49)	USVI (N=114)
Age (Mean)	29.7	29.3	28.8
Education			
Less than high school	**25.3**	24.5	**25.7**
High school graduate	**38.3**	44.9	**35.4**
Some college	**23.5**	24.5	**23.0**
College graduate	**13.0**	6.1	**15.9**
PTSD *	**35.0**	**38.8**	**33.3**
Depression *	**60.1**	**71.4**	**55.3**
Risk for lethality (Mean)	**27.8**	30.2	**26.7**

* refers to significance; bold values in column 2, 3 and 4 refers to significant values (i.e., $p<.05$); The significance was tested using chi square and t-tests.

Table 2

KNOWLEDGE, PERCEIVED ACCESS AND UTILIZATION OF RESOURCES

	Total Number of Women with Multiple Types of IPV (N=163) % (N)	Women with Multiple Types of IPV in Baltimore (N=49) % (N)	Women with Multiple Types of IPV from USVI (N=149) % (N)
Knowledge			
Knowledge of health care resources			
Health care provider	57.0 (85)	65.2 (30)	53.4 (55)
Emergency medical services	62.4 (88)	61.4 (27)	62.9 (61)
Knowledge of any social resources			
Police	75.9 (63)	75.0 (15)	76.2 (48)
Restraining order	66.3 (63)	63.0 (17)	67.6 (46)
Shelter services	63.1 (89)	65.9 (27)	62.0 (62)
Crisis hotline/ advocate/ support	65.9 (81)	72.2 (26)	63.2 (55)
Mental health counselor/ therapist	65.0 (76)	71.9 (23)	62.4 (53)
Knowledge of religious resources	61.7 (74)	65.6 (21)	60.2 (53)
Perceived access			
Perceived access to any health care resources			
Health care provider	29.4 (48)	38.8 (19)	25.4 (29)
Emergency medical services	33.7 (55)	38.8 (19)	31.6 (36)
Perceived access to any social resources			
Police	24.5 (40)	18.4 (9)	27.2 (31)
Restraining order	22.1 (36)	20.4 (10)	22.8 (26)
Shelter services	33.1 (54)	34.7 (17)	32.5 (37)
Crisis hotline/ advocate/ support	27.6 (45)	24.5 (12)	28.9 (33)
Mental health counselor/ therapist	17.2 (28)	18.4 (9)	16.7 (19)
Perceived access to any religious resources	19.0 (31)	16.3 (8)	20.2 (23)
Utilization			
Health care resource utilization			
Health care provider	8.0 (13)	6.1 (3)	8.8 (10)
Emergency medical services	11.7 (19)	10.2 (5)	12.3 (14)
Any social resource utilization			
Police	**47.9 (78)**	**59.2 (29)**	**43.0 (49)**
Restraining order	**39.9 (65)**	44.9 (22)	**37.7 (43)**
Shelter services	**12.3 (20)**	**16.3 (8)**	10.5 (12)
Crisis hotline/ advocate/ support	**22.7 (37)**	**26.5 (13)**	**21.1 (24)**
Mental health counselor/ therapist	**28.2 (46)**	**34.7 (17)**	**25.4 (29)**
Religious resource utilization	**26.4 (43)**	**34.7 (17)**	**22.8 (26)**

Note: The significance was tested using chi?square tests; Values in bold presents significance (i.e. < .05)