2020

Predictors of Mental Health Services Use Among Survivors of Domestic Violence Emotional Abuse

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Walden University
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Abstract

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by

Liseth Sales

MA, National University, 2012

BS, California State University Stanislaus, 2010

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Clinical Psychology

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Abstract

Domestic violence (DV) affects over 80,000 million individuals a year in the United States. DV survivors who do not use mental health services are often revictimized or pass on patterns of abuse and unhealthy behaviors of DV to future generations. However, research on factors that inhibit DV survivors from seeking mental health care is limited. Using the behavioral model of health services use, which helps predict health services use by identifying predisposing, enabling, and need factors, this study investigated which predisposing, enabling, and need factors predict the utilization of mental health services by DV survivors who were emotionally abused. In this quantitative study, 152 DV survivors of emotional abuse were recruited and surveyed through social media and DV shelters located in California. Binary logistic regression analysis and chi-square testing were applied to find the factors—predisposing (i.e., gender and race), enabling (health insurance and yearly income), and need (functional impairment)—that predict the use of mental health services among DV survivors of emotional abuse. Predisposing factors of gender and ethnicity did statistically predict mental health service use; Caucasian individuals were more likely to use mental health services than Hispanic or Asian individuals and women were more likely to use mental health services than men. Enabling factors of possession of health insurance and annual income and need factor of functional impairment did not statistically predict mental health service use. The results can help mental health care providers reach DV survivors of diverse cultural and socioeconomic backgrounds, decrease the risk of revictimization, and more effectively address mental health problems caused by emotional abuse.

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Dedication

This research study is dedicated to all the domestic violence survivors who have suffered emotional, sexual, and physical abuse without anyone's knowledge. With this study, I seek to empower the powerless, give a voice to the voiceless, educate the community about the hardships of abuse, and promote mental health services to improve all those affected. It has been an honor to add to domestic violence research to help survivors find support and live healthy and satisfying lives despite their abuse.

Acknowledgments

First, I would like to thank my heavenly father for allowing me to accomplish my desire and bring it to pass. I could not have done it without his guidance and intervention. Second, I would like to thank my chair, Dr. Georita Frierson, my second committee member, Dr. Tracy Marsh, and my URR, Dr. Delinda Mercer, for all their feedback, patience, and support. Most importantly, a special thank you to my husband, Fredy, and my children who have allowed me to be absent at times to be able to complete all assignments and attend residencies. Fredy, my confidant, I am very thankful for your support, prayers, schedule and work changes, financial changes, and role changes to help me accomplish my goal. I could have not done it without all your support. Thanks to my mother and father for their emotional support and encouraging words. To my brothers and my sisters-in-law, for watching my children and allowing me to miss special gatherings when I had to work on pressing assignments. A special acknowledgement to my little sister, Breanna, who shared my journey with me and enthusiastically kept track of my internship hours and encouraged me to pursue my goals. Finally, I would like to acknowledge my second confidant, Jaspreet Rai, for her continuous emotional support and motivating words of, “just finish it!”

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Chapter 1: Introduction to the Study

Introduction

The National Coalition Against Domestic Violence (2015) reported that there were more than 10 million domestic violence (DV) survivors in the United States whose mental health was affected by the abuse they experienced. While mental health care can help DV survivors, many have not received any mental health care to help them cope with the trauma of abuse. DV survivors who have used mental health services reported it was beneficial, and they were able to regulate their emotions more effectively; however, there is limited research on factors that prevent DV survivors from using mental health services (Davies & Lyon, 2014; Syzdek, Addis, Green, Whorley, & Berger, 2014). In this quantitative study, I explored how a set of predisposing, enabling, and need factors impacted emotionally abused DV survivors' willingness to seek mental health services. Chapter 1 includes background information on DV in the United States, the problem statement, the purpose of the study, the research questions, the conceptual framework, the nature of the study, and the limitations and assumptions of the study.

DV impairs many areas of a survivor's life. Research has shown that many victims who endure DV not only suffer from mental health problems and have maladaptive coping skills, but they also commonly develop problems in their overall physical health, engage in risky behavior, and are hindered in educational, relational, and occupational success (Grossman, Spinazzola, Zucker, & Hopper, 2017; Gusic, Cardena, Bengtsson, & Sondergaard, 2016). Grossman et al. (2017) discovered that survivors of domestic violence, specifically survivors of emotional abuse, frequently experience

intense rage, aggression, sexual urges, and the need to be loved and protected like a child. A study of DV survivors revealed a strong association between emotional abuse and substance abuse due to the lack of positive coping mechanisms among survivors (Spinazzola et al., 2014). Spinazzola et al. (2014) found that clinginess and avoidant behavior are examples of DV survivors' disorganized attachment styles. DV survivors also frequently experience identity issues, emotional dysregulation, behavioral issues, and thought distortions (Grossman et al., 2017; Hester, Jones, Williamson, Fahmy, & Feder, 2017). The most salient recommendation for DV survivors is to seek mental health services (Thomas, Goodman, & Putnins, 2015).

Nour, Elhai, Ford, and Frueh (2009) discovered that individuals who need mental health services do not seek mental health assistance until they notice poor physical health, poor day-to-day functioning, and severe depression. Those with posttraumatic stress disorder (PTSD) and anxiety diagnoses are more likely to seek mental health services (Elhai, North, & Frueh, 2005). Research has shown that DV is associated with depression, suicidal behavior, anxiety, and PTSD (Goodman et al., 2016; National Coalition Against Domestic Violence, 2015). Most DV survivors have experienced powerlessness because of unpredictable violence that was out of their control; as a result, they may exhibit attachment issues, substance abuse, and the sense of having no self-control. However, many DV survivors do not use mental health services despite the trauma of the abuse (Dillon et al., 2013, Goodman et al., 2017; Spinazzola et al., 2014). Only 43.1% of victimized women seek formal mental health help; often, they make the decision to seek help after suffering a physical injury (Cuevas, Bell, & Sabina, 2014).

Problem Statement

Survivors of DV can experience an array of mental health disorders that result in personal, family, and community costs. Although there has been much research on the short- and long-term effects of abuse, there has been minimal research on the correlates between DV survivors and mental health services use (Klopper, Schweinle, Ractliffe, & Elhai, 2014). Bellido-Zanin, Vasquez-Morejon, Perez-San-Gregorio, & Martin-Rodriguez (2017) noted that many attempts have been made to analyze mental health use within the DV survivor community; however, even though relevant variables have been researched, additional variables must be examined to predict survivors' use of mental health services.

Further research is needed on DV survivors of different genders, ethnic/racial groups, and socioeconomic statuses who have endured different kinds of traumas, to understand the reasons that DV survivors fail to seek mental health services. Nikupeteri (2017) found that female DV survivors preferred to speak to family members and seek other nonprofessional help as they believed that professionals lacked knowledge or ignored the complexity of their situation. Nikupeteri (2017) discovered that female DV survivors considered professional interventions inadequate or inconsistent. Culture can be another barrier to seeking mental health services; survivors' cultural norms may interfere with early detection and intervention for mental illness (Arnault, Gang, & Woo, 2018, Nikupeteri, 2017).

Moreover, further research is needed on male DV survivors seeking mental health services, as men are less likely than women to seek formal help (Sierra-Hernandez, Han,

Oliffe, & Ogrodniezuk, 2014). Men who have suffered DV often minimize or deny symptoms, normalize their problems, or refuse to contradict dominant gender norms that portray men as strong and capable of controlling any situation (Sierra-Hernandez et al., 2014). Hines and Douglas (2016) indicated that the experiences of men who suffer from DV are often perceived as minor compared to the experiences of female DV victims. However, male survivors of DV are common. In a quantitative study of 1,557 male participants, Machado, Matos, and Hines (2016) revealed that 19% of men reported DV experiences—mostly in the form of psychological abuse—within the previous year. Overall, 1 in 5 men (5% to 50%) have experienced some type of DV (Bellido-Zanin et al., 2017). However, male survivors prefer to seek non-professional help or no help at all (Breiding, Chen, & Black, 2014; Desmarais, Reeves, Nicholls, Telford, & Fiebert, 2012; Hines & Douglas, 2014; Machado et al., 2016). Men seeking help is a phenomenon that is less researched, represents a gap in the literature, and needs to be measured in multiple ways to capture the range, extent, severity, and potential consequences (Follingstad & Rogers, 2013; Woodin, Sotskova, & O' Leary, 2013). Davis and Liang (2015) recommended measuring access to health care, possession of health insurance, the impact of income, and men who are not only monolingual Spanish and of diverse ethnicities.

Purpose of the Study

The purpose of this quantitative study was to explore how a variety of predisposing, enabling, and need factors impact emotionally abused DV survivors' willingness to seek mental health services. The predisposing factors that were examined in this study were race and gender, the enabling factors included annual income and

health insurance status, and the need factor was functional impairment. The DV survivors who participated in this study included adult men and women living in the state of California. In this study, I explored the extent to which predisposing factors, enabling factors, and need factors predict mental health use among emotionally abused DV survivors.

Cattaneo, Stuewig, Goodman, Kaltman, and Dutton (2007) found that DV survivors who did not seek help consistently experienced abuse. In contrast, individuals who seek mental health services experience decreased mental health symptoms over time and have a lower probability of being abused again (Beeble, Bybee, Sullivan, & Adams, 2009; Suvak, Taft, Goodman, & Dutton, 2013). Mental health care is important for survivors of DV; therefore, in this study, I explored the factors that cause survivors of emotional abuse to not seek mental health services. I hope that this study will contribute to better care for survivors of emotional abuse by identifying disparities that exist when outreaching to this population. Understanding the reasons that DV survivors fail to seek help can improve mental health care outreach strategies, prevent revictimization, and decrease survivors' psychological distress.

Research Questions

RQ1: Does the predisposing variable of gender and racial minority predict the use of mental health services among domestic violence survivors of emotional abuse?

$H_0$1: The variables gender and racial minority do not statistically predict the use of mental health services among domestic violence survivors of emotional abuse.

H_A1: The variables gender and racial minority do statistically predict the use of mental health services among domestic violence survivors of emotional abuse.

RQ2: Does the combination of enabling variables of possession of health insurance and high annual income and the need variable of functional impairment predict the use of mental health services among domestic violence survivors of emotional abuse?

H_02: The variables of possession of health insurance, high annual income, and functional impairment do not statistically predict the use of mental health services among domestic violence survivors of emotional abuse.

H_A2: The variables of possession of health insurance, high annual income, and functional impairment do statistically predict the use of mental health services among domestic violence survivors of emotional abuse.

Conceptual Framework

Behavioral Model of Health Services Use

For the conceptual framework in this study, I used the behavioral model of health services use (BMHU), which produces information concerning health service consumption by focusing on predisposing factors, enabling factors, and need factors (Andersen, 1995). Predisposing factors include personal and demographic characteristics, enabling factors include the sources from which an individual obtains services, and need factors include objective and/or subjective beliefs about one's illness (Andersen, 1995). BMHU is primarily used by psychologists to understand how various factors are related to another and how factors affect a patient's likelihood of using mental health care services. Graham et al. (2017) indicated that to understand mental health service use, new

access indicators are needed that emphasize contextual and individual characteristics in promoting access for defined populations. Gusic et al. (2015) noted that new methods are needed to investigate the relationship between stressful life experiences and mental health consequences.

BMHU is an empirically supported framework that helps yield information about health service use patterns to point out service disparities (Andersen, 1995). I used BMHU to examine the factors that hinder DV survivors of emotional abuse from seeking mental health care by examining the following three predictor categories: (a) predisposing factors (age, gender); (b) enabling factors (income, health insurance status); and, (c) need factors (objective and subjective evaluation of one's illness; Andersen, 1995).

Diathesis-Stress Model

The diathesis-stress model speculates that environmental influences, such as emotional abuse, impact human development and little attention paid to the negative effects can create further disturbances in development (Belsky & Pluess, 2009; Lewinsohn, Joiner, & Rohde, 2001). The diathesis-stress model theorizes that individuals with preexisting vulnerabilities—such as behavioral/temperamental (e.g., difficult temperament), physiological (e.g., highly physiologically reactive), or genetic—are more likely to be unfavorably affected by an environmental stressor (Belsky & Pluess, 2009). According to Belsky and Pluess (2009), individuals with such vulnerabilities are more likely to develop a psychopathological condition (e.g., depression, anxiety, PTSD) or function poorly when exposed to a stressor. In this study, the integration of the diathesis-

stress model helped me to further identify vulnerabilities that hinder DV survivors from pursuing mental health help. Using the diathesis-stress model and BMHU, I investigated the predictors that influenced male and female DV survivors of emotional abuse to seek mental health services.

Nature of the Study

In this quantitative research, I used a correlational design with surveys to explore the ways that factors of racial identity, gender, annual income, health insurance, and functional impairment impact the use of mental health services by DV victims of emotional abuse. Creswell (2014) noted that survey-based studies can be used to generalize from a sample to a larger population; in this way, inferences can be made about characteristics or attitudes of the chosen population. This method was appropriate because I made inferences about predisposing, enabling, and need factors and mental health service use. DV survivors of emotional abuse were recruited from local community shelters, churches, and social media and were provided with a SurveyMonkey link. The variables of racial minority, gender, annual income, and health insurance were collected via a demographic questionnaire.

In addition, participants received the Negative Life Events Questionnaire to identify emotional abuse (Pitzner & Drummond, 1997), the Walter Reed Functional Impairment Scale to measure functional impairment (Herrell et al., 2014), and a self-report tool adapted from the National Comorbidity Survey's Health and Service Utilization Assessment to measure mental health use (Elhai, Patrick, Anderson, Simons, & Frueh, 2006). To analyze the quantitative data collected through these questionnaires, I

conducted a binary logistic regression to determine if racial minority status, low annual income, lack of health insurance, and high functional impairment predict mental health services use.

Definitions of Key Terms

Behavioral model of health services use (BMHU): A theoretical framework used in this study (Andersen, 1995).

Diatheses-stress model: A theoretical framework used in this study. It will be referred to as DSM (Belsky & Pluess, 2009).

Domestic violence (DV): Willful intimidation, physical abuse, sexual abuse, emotional abuse, or any behavior to control or manipulate a family member residing in the immediate home (National Coalition Against Domestic Violence, 2015).

Emotional abuse: Also known as *psychological abuse*, often involves verbal abuse, including yelling, put downs, intimidation, humiliation, or condescending language (Moulding, 2017).

Functional impairment: Loss of, or limited, function in areas of life such as work, school, social, etc. (Herrell et al., 2014).

Mental health services use: Seeking mental health services.

Racial minority: Participants who are not Caucasian.

Assumptions

The study rested on the assumption that participants will answer truthfully on the research instruments as the instruments rely solely on self-reported information and are anonymous. Participants' data remained anonymous and confidential, and participants

were informed that participation was voluntary and they could withdraw at any time without consequences. It was assumed that emotionally abused survivors would be able to recognize they were emotionally abused in childhood or adulthood. In addition, it was assumed that DV and emotional abuse will continue to be a social issue affecting thousands of people.

Scope and Delimitations

The study focused on emotionally abused survivors of DV. In the study, I explored how race, gender, income, health insurance possession, and functional impairment impact mental health services use. DV survivors are often diagnosed with mental health diagnoses and require mental health services, however, many do not seek mental health help (Vidourek, 2017). I analyzed data by applying the BMHU framework, exploring relationships among predisposing, enabling, and need variables, and mental health service use. Delimitations of the study include participants in the study from DV shelters located in the central valley of California and social media through Facebook. All the participants were to be 18 years or older, have experienced emotional abuse, and currently not receiving mental health treatment. In addition, participants were given surveys in English. Due to only studying emotionally abused participants, the study may not be generalizable to physically and sexually abused survivors. However, results may be generalizable to emotionally abused survivors of different races and genders residing in the central valley of California.

Limitations

Participants for this study were recruited from the state of California in the United States; therefore, the results cannot be generalized to other states or countries. The participants were recruited from local shelters, churches, and social media; therefore, the sample does not wholly represent the DV survivor population. In addition, it can be difficult for DV survivors to participate in surveys due to the sensitive nature of the study, which could limit the amount of responses.

In addition, the study relied on self-reported information, and participants may not be entirely truthful in their reporting. The Negative Life Events Questionnaire is made up of items that capture DV indicators that can influence participants not to participate or respond untruthfully if they are experiencing distress. The Walter Reed Functional Impairment Questionnaire is the only tool capturing functional impairment and the WMH-CIDI Questionnaire is the only tool capturing data on whether the participants ever used mental health services. Even though the questionnaires have strong reliability and validity, the survey questions put together from these questionnaires may not be appropriate for this population.

Summary

DV is considered a chronic condition that is carried on from generation to generation (Thomas et al., 2015). Survivors of DV can experience a loss of physical safety, loss of social support, loss of financial stability, loss of home and rootedness, and loss of freedom (Thomas et al., 2015). Although mental health services can help DV survivors heal, DV survivors often weigh multiple factors before attempting to seek

mental health services (Davies & Lyon, 2014). Syzdek et al. (2014) found interventions that could increase the probability of men seeking mental health services. Nonetheless, the percentage of those who are seeking formal help continue to be 14%, and further research is needed to identify barriers. This study attempted to locate supplementary factors that hinder men who survived DV from seeking psychological services (Syzdek et al., 2014). This study collected and analyzed data on the factors that prevent DV survivors from pursuing mental health services services (Syzdek et al., 2014). The results may help enhance treatment access, improve outreach efforts, and increase the awareness of healthcare providers, researchers, and policymakers regarding the special needs of the DV population.

In Chapter 1, I discussed the prevalence of DV, the effects of DV, and problems that can arise when DV survivors do not use mental health services. I also discussed the need for further research to identify predictors that inhibit DV survivors from seeking mental health services. The purpose of the study, research questions, and social change were identified, and the study's conceptual frameworks were introduced. I also discussed the assumptions and limitations of the study. In Chapter 2, I offer an in-depth review of current research literature, identify the gap in research and independent and dependent variables, and explain the connection between the theoretical frameworks and the study variables.

Chapter 2: Literature Review

Introduction

DV negatively affects the quality of life and health of its victims. The mental health of over 10 million DV survivors continues to be affected by the abuse they endured (Goodman et al., 2016; National Coalition Against Domestic Violence, 2015). Research demonstrates 3 in 10 women and 1 in 10 men are negatively impacted by DV in the United States simultaneously devastating familial and community settings (Wilson et al., 2015). To decrease DV victims and to avoid future revictimization and its negative effect on those around victims, further research is needed in identifying what hinders DV survivors from seeking mental health services and ameliorating DV repercussions.

DV can be defined as a pattern of abusive behavior by a family member in any relationship to gain or conserve power and control over another member in the family (National Coalition Against Domestic Violence, 2015). DV can include physical, sexual, economic, and emotional abuse and behaviors such as intimidation, manipulation, humiliation, isolation, coercion, blaming, hurting, or injuring (Goodman et al., 2016; Wilson et al., 2015; Vidourek, 2017).

Emotional abuse can occur by experiencing and/or witnessing domestic violence and it is significantly associated with the development of mental health problems (Moulding, 2017; Vidourek, 2017). Emotional abuse may also be referred to as *psychological abuse* or *maltreatment* and defined as exposure to recurrent events of insults, degradation, humiliation, threats, ostracism of affection, isolation, exploitation,

and obligation of excessive and unrealistic demands (Grossman, Spinazzola, Zucker, & Hopper, 2017; Hester et al., 2017; Moulding 2017; Schulz et al., 2017; Vidourek, 2017).

The Office of Women's Health (2017) also described emotional abuse as constantly monitoring behavior, preventing one from seeing family and friends, humiliating one in front of others, and threatening to hurt or harm oneself or others. A qualitative research reveals constant criticism and monitoring, controlling body weight, pressures to undertake socially constructed gender roles, caregiving for others, inferences of selfishness, being undermined, and being invalidated are all forms of emotional abuse (Moulding, 2017). Emotional abuse has been found to be more harmful than physical abuse and more greatly related to PTSD than physical abuse (Vidourek, 2017).

Recent research on emotional abuse has been found to be closely linked to personality disorders, such as borderline, narcissistic, paranoid, and schizotypal (Schulz et al., 2017). Difficulties regulating emotions, nonacceptance of current emotion, and inappropriate emotion expressions are strongly predicted by emotional abuse and more than sexual and physical abuse (Schulz et al., 2017). Other mental health problems associated with emotional abuse include depression, anxiety, PTSD, eating disorders, substance abuse, problems with self-concept, self-harming behaviors, and attempted suicide (Hymowitz et al., 2017 & Vidourek, 2017). Current research demonstrates individuals experiencing DV and suffering from mental health symptoms often do not use mental health services. DV survivors who do not seek mental health services run a higher risk of being revictimized (Cattaneo et al., 2007; Suvak et al., 2013). The purpose of this quantitative study was to explore how race (predisposing factor), gender (predisposing

factor), annual income (enabling factor), health insurance (enabling factors), and functional impairment (need factor) impact DV survivors of emotional abuse seeking mental health services.

Literature Search Strategy

The literature review I conducted used a comprehensive search strategy. The search strategy included health sciences and human services databases. Walden University's library databases were used, including PsycARTICLES and PsycINFO. Articles are peer-reviewed and written in the last 5 years. Search terms that were applied included *domestic violence, seek help, service use, mental health use, emotion abuse, service use, behavioral model of health service use*, and *diathesis-stress model*. Boolean terms included *domestic violence* AND *seek help*, *domestic violence* AND *service use*, and *behavioral model of health service use* AND *domestic violence*. Key journals included *Psychological Trauma: Theory, Research Practice, and Policy*; *Psychology of Violence*; *Psychology of Men and Masculinity*; *Psychological Services*; and *Journal of Counseling Psychology*.

Search engines that were used included EBSCOhost and Google Scholar to find associations of DV, including National Coalition Against Domestic Violence, The Office of Women's Health, and United States Women Against Violence. Keywords and phrases used included: *definition of domestic violence, definition of emotional abuse, statistics about domestic violence, demographics of domestic violence*, and *consequences of domestic violence*.

Theoretical Foundation

Behavioral Model of Health Services Use and Its Origin

Several researchers have explored factors that influence mental health service use with different theoretical bases. Arnault et al. (2018) stated that to explore sociocultural factors that predict mental health use, it is important to implement a theoretical framework that serves diverse cultures. In this study, I needed to assess sociocultural dimensions to design specific community-based interventions that promote mental health service use, which is why I implemented the behavioral model of health services use (BMHU).

BMHU was created by Ronald M. Andersen in 1995 and it provides measures of access to medical care (Andersen, 1995; Graham et al., 2017; & Klopper et al., 2014). The framework indicates access of health services is considered to be a function of the following three characteristics: (a) predisposition factors that may include biological characteristics (i.e., gender, age), social structural (i.e., education, occupation), and health belief attributes (i.e., attitudes and values), which are sociocultural characteristics of the individual that exist prior to the illness; (b) enabling resources, including social and economic variables that impact an individual's access to care (i.e., income, health insurance) that are logistical aspects of acquiring care; and (c) need factors (i.e., object and subjective evaluations of illness), the most immediate causes for health use, which may be functional impairment or health problems that create the need for mental health care services (Andersen, 1995; Graham et al., 2017; Klopper et al., 2014).

Analysis on Past Use of BMHU

BMHU theory has been used by researchers to understand what encourages and discourages mental health service use. Graham et al. (2017) used BMHU to examine what predisposing, enabling, and need factors caused individuals suffering from depression to use or not use mental health services. Graham et al. researched predisposing characteristics (age, employment status, and country of birth); enabling characteristics (housing status, financial problems, and frequency of contact with family); need characteristics (number of mental health conditions and measurement of psychological distress); and mental health service use (number of mental health consultations with any professional). Graham et al. found the variables associated with the need characteristics and mental health service use were consistent with Andersen's BMHU theory. In addition, the need characteristics were the strongest predictors of mental health services use for depressed people (Graham et al., 2017).

Klopper et al. (2014) examined predisposing characteristics (race, age, marital status, and attitudes about treatment); enabling characteristics (insurance); and need characteristics (perceived need and PTSD severity with mental health care use and use intensity among DV survivors living in shelters). The authors hypothesized PTSD symptom severity would be related to the association of perceived need and mental health services use. Results demonstrated the predisposing variable of attitude toward treatment significantly predicted mental health care use and the need variable of PTSD symptoms severity significantly predicted mental health care use intensity.

Diathesis-Stress Model and Use of Mental Health Services

The diathesis-stress model was first implemented in psychology by clinical psychologist Paul E. Swedow in the 1960s when explaining the diagnosis of schizophrenia (Jeronimus et al, 2017). The Diathesis-Stress Model can help researchers study the development of psychopathology, determine who is more likely to develop a mental health diagnosis, and understand why some individuals are more at risk for developing a disorder than others (Jeronimus et al., 2017). Having a vulnerability could be a possible reason for developing a mental health disorder if a stressor is faced. Diatheses, or vulnerabilities, can include biological, cognitive, life experiences, or situational factors (Jeronimus et al., 2017). Researchers have explored how stress has caused the development of mental health diagnoses and the need for mental health care use.

Gusic et al. (2015) studied possible trauma events exposure, PTSD, and dissociative experiences in a multiethnic sample. It was found that possible trauma events were strongly associated with dissociative experiences more than with PTSD and dissociative experiences. Gusic et al. found the life stress of emotional abuse was closely associated to dissociative experiences more than the stressful event of physical abuse. The researchers also found family-related maltreatment, parental depression, and negative parenting related to individuals experiencing emotional abuse in the future. Gusic et al. (2015) indicated a need in developing more methods to examine the relationship between negative life experiences and mental health effects. Doing so is

important to decrease future victimization and people experiencing mental health diagnoses.

Importance of Using BMHU and Diatheses-Stress Model

To promote mental health services use among DV survivors, it is important to understand what assists and impedes services use. Andersen's BMHU model has been successful in describing services use among other populations and similar research can benefit the population of DV survivors. It is important to consider different predisposing, enabling, and need factors to better develop and implement intervention that promotes mental health services use for DV survivors. Graham et al. (2017) indicated that to understand mental health services use, there needs to be new production of access indicators that emphasize the importance of contextual and individual characteristics in promoting access for defined populations. Graham et al. (2017) recommended replication of Andersen's BMHU model with different data sets from a range of regions examining services use in a variety of backgrounds.

It is important to examine what correlates are significant predictor variables of mental health services use and not neglect to include important predictor variables, as this will allow a better interpretation of results and identify the relations between domains in estimating mental health use (Klopper et al., 2014). Gusic et al. (2015) state researchers need to be aware of how life vulnerabilities and stress affect victimization prevalence rates and mental health rates as those who have experienced traumas, such as emotional abuse, may develop mental health problems. Gusic et al. (2015) indicate factors linking life stress to mental health diagnoses include gender, ethnicity, and socioeconomic status,

and these factors should be further researched as such factors may lead to more future stress.

Current Empirical Literature Related to Research Questions and Variables

BMHU and Different Methodologies

Klopper et al. (2014) conducted a quantitative study of 248 DV survivors recruited from shelters using surveys. The purpose of the study was to identify predictors of mental health care service use utilizing BMHU. Klopper et al. (2014) applied a univariate analysis and hypothesized that several predisposing variables (i.e., age, race, marital status, and intentions to seek mental health services use) and enabling variables (i.e., health insurance possession) would predict mental health care use and use intensity, but the need variables (i.e., PTSD symptom severity and subjective perceived need) would represent greater associations. They tested greater intentions to seek mental health help was associated with younger ages. The participants answered demographic questions, health and service utilization assessment, stressful life events questionnaire, PTSD symptoms scale-self-report, perceived need questions, and intentions to seek treatment questions. Among the sample, 82% reported three or more traumatic events involving some type of abuse. Results showed a positive treatment attitude was related to increased services use and service use intensity. It was found that age was not a moderator of seeking mental health services. It was also found that being Caucasian and having increased PTSD symptoms is associated with mental health use intensity. According to Klopper et al. (2014) predisposing and enabling variables accounted for

14% of variance in mental health treatment use and intensity and was significant for predicting mental health care use.

Graham et al. (2017) conducted a cross-sectional study using data from the Australian National Survey of Mental Health and Wellbeing from participants who reported a depressive episode in the last 12 months. The purpose of the study was to use BMHU and examine the relationships between predisposing variables (age, marital status, sex, education level, ethnicity, and employment status), enabling variables (financial status and frequency of contact with family and friends), and need variables (psychological distress, mental health, general health, depression severity, and co-morbidities) use structural equation modeling techniques to establish a model of the relationships among the identified factors and mental health services use and examine whether the identified model of service use differs for people who had and had not received helpful mental health information. The participants had been surveyed with the Composite International Diagnostic Interview (CIDI-3) to identify depression and psychological distress was measured with the Kessler Psychological Distress Scale (K-10). Graham et al. conducted confirmatory factor analysis, polyserial correlations, Pearson's correlations, Kaiser-Meyer-Olkin measures, chi-squared statistics, the Satorra-Bentler, the normed fit index, and the comparative fit index, indicative of a good fit, and error of approximation to examine and determine which variables would be the best representation of predisposing, enabling, and need characteristics. The results showed the best variables were: predisposing factors (age, employment status, and country of birth), enabling factors (housing status, financial problems, and frequency of contact with

family), need factors (number of mental health conditions, psychological distress, and mental health service use), number of mental health consultations with any professional, number of medications taken for mental health in the past two weeks, and type of service accessed for mental health help. However, results showed the groups formed did not fit the data. Nonetheless, the variables associated with mental health need and mental health service use were consistent with BMHU model of health service use. Results also showed the greater a person perceived need the more likely they were to have used mental health services. It was also found that the more the individual was social the less likely they were to use mental health services. A multi-group analysis found those who did receive helpful information on mental health had indirect effect on mental health services use.

Ghafoori et al. (2014) investigated disparities in mental health care use with metropolitan, disadvantaged, trauma-exposed adults utilizing BMHU. The study was quantitative and 135 participants were recruited from an urban community health clinic in Southern California. The predisposing variables researched were: age, gender, race, level of education, years in the United States, and attitudes towards seeking mental health help. The enabling variables researched were: health insurance coverage, household income, social support, and receipt of public benefits. The need variables researched were: PTSD, depression, generalized anxiety disorder symptom severity. Results revealed the sample was predominantly middle aged, male, African American, high school educated, United States born, no health insurance, very low income, exposed to multiple traumas; however, no factors were associated with mental health service use. It was also found that increased occupational disability significantly predicted utilization of mental health

services. Research also supported low-income adults who face an array of stressors and have increased risk for trauma and violence do not receive mental health services despite the need (Ghafoori et al., 2014). Ghafoori et al. (2014) indicate additional research is needed as the participants were not a broad representation of the urban, impoverished trauma survivors. In addition, the sample size was insufficient for comparing racial differences and the study needs to be replicated with more precise indicators of mental health service use.

Overall, BMHU research found strong associations among the variables of need (e.g., standing mental health diagnosis), predisposing (e.g., positive attitude towards treatment), mental health use, and increased frequency of mental health use. DSM research found stressful life experiences cause mental health diagnoses and lead to mental health use. BMHU helps describe mental health use among different populations whilst DSM helps identify how life vulnerabilities affect mental health use.

Literature Review

Lelaurain, Graziani, and Monaco (2017) studied 90 studies on DV to identify help-seeking and inhibiting factors in the years 2000 to 2017. Out of the 90 studies, 81 were represented by females and 9 represented exclusively by men. Methods utilized included: 4 longitudinal studies, 5 mixed-methods, 16 focused groups, 22 interviews, and 44 questionnaires. In addition, 43 studies were descriptive, 17 exploratory, and 12 comparatives. It was found that 10 studies were grounded on theory, 1 phenomenological, 1 ethnographic, 1 researched action principles, and only 2 studies aimed to create a model of help-seeking impediments. The following was found to be

strongly associated with not obtaining mental health services: physical violence and violence severity, lack of trust in institutions and health professionals, gender-roles expectations and social norms around men's and women's behaviors, social stigma and feeling embarrassed about disclosing DV, religious expectations, and moral values. Sociodemographic factors found younger victims used mental health services, 11 studies showed higher educated participants sought help, but four studies showed the opposite. A total of 12 studies showed that participants with higher income sought help, but four studies demonstrated otherwise. A total of four studies showed that men do not seek help and 21 cases demonstrated that ethnicity is the main factor that contributes to DV survivor not using mental health services. Lastly, the following factors also contribute to DV survivors not utilizing mental health services: returning to the violent relationship, their current emotional distress and feeling powerless, and having children. Limitations to this study include reviewing articles from only two databases which limits access to other literature, only utilizing works published in English in French, and most of the studies being conducted in North America. Lelaurain et al. (2017) noticed the need to further research utilizing theoretical frameworks and investigating additional combinations of predisposing and enabling variables.

Nikupeteri (2017) indicated mental health professionals need to pay more attention around what factors hinder a DV victim from seeking professional help. Nikupeteri stated neglecting the complexity of the issue can victimize DV survivors more or discourage them from contacting help. Not addressing mental illness makes DV

survivors from different cultural groups more vulnerable to psychological distress (Arnault et al., 2018).

Survivors and Racial Minority

According to Logan et al. (2017), considering a variety of ethnicities, specifically ethnic minorities, is important to understand mental health services use, however, there is little evidence that focuses on such differences. Logan et al. (2017) found migrants of ethnic minority residing in Australia reported poor mental health use. Logan et al. researched Australian-born participants, Middle-Eastern-born participants, and South East Asian-born participants and it was found that Australian-born participants were more likely to seek mental health services than the ethnic minorities. It was found that there was no significant difference between South East Asian-born and Middle-Eastern-born participants in seeking services. It is suggested to analyze ethnic minority groups separately to better understand service use (Logan et al., 2017). Another limitation found in their study was the fact that the data collected was preexisting; new data would allow further understanding of the culture and its impact on current utilization of health services.

Arnault et al. (2018), reported not use mental health services for those who are in need creates a major obstacle in maintaining public health as it interferes with early detection and intervention. Cultural barriers have been found to be significantly important when it comes to nonmental health services use. Arnault et al. (2018) researched 402 South Korean women and results demonstrated that only 15.3% of 27.6% Korean DV survivors use mental health services. For these survivors, it depended if they perceived

their mental health to be imbalanced or if their support group were upset with their mental illness (Arnault et al., 2018). The authors found this to be true due to the cultural importance of preserving their reputation. Therefore, for the South Korean survivors the attitude of mental health services affects perceived need and help-seeking intentions. Arnault et al. informed limitations in their study included not use a larger and more diverse population. It is suggested to consider additional cultural variables in future studies to further understand help-seeking behaviors.

A qualitative study using semistructured interviews studied 26 faith-individuals of African-descent living in United Kingdom and use of mental health services (Mantovani et al., 2016). It was found that African-Caribbean participants conceptualized using mental health services as a weakness as faith-based individuals should be seeking and having faith in God. Some African-Caribbean participants reported acculturation and stigma towards mental illness and utilization of services were associated as often individuals are rejected in their own community. It was found that being labeled as a victim caused many individuals to be ostracized and isolated (Mantovani et al., 2016). Nonetheless, limits to the study included using a small sample as it could not possibly represent African-descended communities. In addition, the results obtained cannot represent other ethnicities, therefore, diverse populations need to be researched.

Research shows that over 90% of Malaysian people require mental health services, however, are not treated (Shoesmith et al., 2018). Shoesmith et al. studied help-seeking behavior with 130 participants in Bahasa Malaysia. The qualitative study shows these participants had predispositions about seeking mental health services, therefore,

their attitudes toward the services prevented them from seeking help. Malaysian participants prefer to seek spiritual help and are more accepting of spiritual diagnoses versus mental health diagnoses and seeking mental health help. It is perceived that the word "mental" represents madness, unexplainable information, permanent, and severe. Participants informed social labels and stigma are the reasons for using psychiatric services as last resort, if at all. However, a limitation of this study is the ethnic group only partially represents one ethnicity and additional ethnic groups need to be studied around seeking mental health services.

According to Seamark and Gabriel (2018), American individuals are more likely to use mental health services over British individuals. It was discovered in their qualitative study that people in Britain are stopped by stigma and the notion that expressing emotions should not occur. The American culture normalizes the need for utilization of mental health services while the British culture tends to minimize their symptoms to lessen the need to use mental health services. Therefore, it was found that awareness and perception of help, social and cultural influences, and stigma and rejection are factors that impede Britain participants to use mental health services.

A quantitative study researched 292 Caucasian undergraduate college students and their behavior of utilizing mental health services when needed (Pace et al., 2018). It was discovered that 31.1% of the participants preferred to seek help on mental health websites than going to a mental health professional. Also, 50% of participants reported that using face-to-face mental health services would be the last resort, however, it was not related to stigma. According to Pace et al., individuals experiencing high stress levels in

college years who do not utilize mental health services are at high risk of developing mental illnesses and having other negative outcomes. It was reported that first-year college students are not always aware of their mental health, therefore, promoting mental health services could have Caucasian college students use mental health services.

Survivors and Gender

Cuevas et al. (2014) analyzed data collected from SALAS; a data collected of 2000 Latino women who were victimized psychologically. Participants were of Mexican and Cuban descent. It was found that 75.3% of the women sought informal help and 43.1% sought formal help, but the most common type of formal help included medical help. In addition, formal help from police was found to be closely associated with decrease psychological distress. Linear regressions demonstrated that utilizing professional help was not correlated with psychological distress (i.e. depression, dissociation, and anxiety) for Latina women and the factor of dissociating was closely related to using mental health services. Cuevas et al. (2014) state SALAS did not acquire a nationally representative sample of Latina women, but somewhat a national sample of Latina women residing in high-density Latino areas. Also, another limitation includes victimization experiences varying in length of time from when psychological distress was reported which could have impacted the strength of relationships between variables. Lastly, the population only represented female victims, therefore, male victims need to be investigated.

Another gap in the literature is the tendency to not investigate male DV survivors as it is often a misconception that females are the main victims of DV. According to Puy,

Abt, and Romain-Glassey (2017), little research exists on male victims of DV and the use of services. A mixed-methods study investigated 110 males who suffered DV and their behavior on looking for help or not. It was found that when men were offered psychological help they often rejected it due to being "strong enough," feelings of failure regarding their relationships, feeling ashamed and incomprehension, doubts that the justice system would believe them and would be considered the perpetrator instead, and being hopeful for their abusive relationship to improve (Puy et al., 2017). Men survivors were more likely to consult with legal help to produce a record of incidents, but rarely with the intention to seek mental health help. Therefore, avoidance of appearing vulnerable or being considered a perpetrator are factors that contributed to male DV survivors to not use mental health help. Limitations to the study included the population not being sufficient to represent male DV survivors as the sample produced from hospital and lawyer referrals.

Cavanaugh, Messing, Eyzerovich, and Campbell (2015) studied 662 abused women. A total of 342 were Latina women, 188 were African American, and 70 were European American women. The women were considered high risk with suicidal ideation and were asked the likelihood of using mental health services. The authors hypothesized women who were unemployed, having less than a high school diploma, and being married would be strongly associated to European American women, but not African American in utilizing mental health services. Findings demonstrate European American women and Latino women who have undergone some type of abuse have suicidal ideations, lethal relationships, chronic illnesses, are younger, and are more likely to use

mental health services over African American women. The authors recommend future research should conduct a longitudinal study to examine risk factors for suicide among different ethnic groups of women abused to better understand such variables and improve prevention.

Machado et al. (2016) conducted an exploratory study with 89 Portuguese DV male survivors and analyzed the prevalence of victimization and help-seeking behaviors. All males reported some type of DV, but psychological abuse was the most common abuse reported. It was found that the majority of the men did not utilize mental health services due to not identifying themselves as victims, feeling shame, and not trusting professional treatment. Out of the 89 males 76.4% did not utilize professional help and 23.6% did seek help, however, the help that was sought was mostly informal. The formal support that was sought only included health professionals and social support services, not psychological help. Nonetheless, the limitations that were reported included collecting data from surveys online which restricted the sample to males who had access to the Internet (Machado et al., 2016). In addition, the author recommends a large sample with more diverse characteristics to enable more detailed analysis as the sample was limited to Portuguese heterosexual males. Machado et al. (2016) says further research is necessary to help men overcome DV victimization.

Villatoro et al. (2014) reported the level of perceived family support was significantly associated with the probability of Latino men using informal help and religious services but not psychological help. Villatoro et al. found perceived need for mental health services and social perceptions of need for care within their close network

were also significant predictors of service use. Hernandez (2014) found men who do utilize mental health services perceive their problem as normal or common and have psychoeducation on their problems and symptoms. In addition, Hernandez found men who redefine and adopt masculine identities allow for behaviors that permit them to engage in help-seeking behaviors.

Syzdek et al. (2014) interviewed 23 men used motivational interviewing to study the effect of gender-based motivational interviewing on help-seeking behaviors. Results showed the men rather think of informal help (i.e. friends, parents, or relatives) versus formal help (i.e. doctor, counselor, or psychiatrist). The behaviors of help seeking were due to their distress level and lack of insurance. Syzdek et al. found traditional men in the ages 19 to 57 have a difficult time seeking formal help even though they were later able to experience the benefits of formal help. Nonetheless, a limitation to the study included having low power, therefore, unable to detect statistical significance and was only able to estimate effect sizes. The authors suggest studying additional concrete barriers such as having or not having health insurances and more precisely measure the effect.

Davis and Liang (2014) inform Latino men are the most in need of mental health services when compared to non-Latino men. Findings show a possible reason for Latino men needing services more than other ethnicities is due to structural barriers associated with immigration status (Yousaf, Popat, & Hunter 2015). Davis and Liang (2014) found only 1 in 11 Latino men, who have a mental health diagnosis, seek mental health services. They found Mexican Americans with mental disorders are less likely to utilize mental health services as they are socialized to exude strength. Nonetheless, a

correlational analysis indicated that not utilizing mental health services was not significantly associated with machismo. Davis and Liang found age was significantly associated with the individual using mental health services. Findings indicate older Latino men conform less to traditional masculinity standards as they see more value in obtaining help for their psychological distress as they age. A limitation with this study was not utilizing scales and instruments that are normed for Spanish-speaking participants. Also, as the Latino men that were studied were more of Mexican-American descent caution is needed in generalizing the findings to other Latino men.

Survivors and Attitude Toward Treatment

Bellido-Zanin et al. (2017) found if the DV survivor is a caregiver then the survivor is more than likely to use mental health services as they feel the burden of caring for others. Their research also demonstrates having no social support has the most predictive power on seeking mental health services. However, on the contrary, Mullen and Crowe (2017) found individuals who sought mental health help did find the treatment helpful. In addition, they found those who sought help also reported higher levels of life satisfaction. Research showed help-seeking behavior leads to increased resiliency. In addition, if the individual believes to not have a mental health illness, then, the likelihood of seeking help will decrease.

In addition, Cheng et al. (2018) indicate mental health use increased when the individual had received psychological treatment in the past and had a positive experience. Being able to recognize current symptoms that were present in the past also increases the likelihood of contacting psychological help (Arnault et al., 2018; Cheng et al., 2018). If

the individual perceives to have lower stress level, functioning at a high level on their day-to-day, then help seeking behavior decreases. Howell and Miller-Graff (2016) state help seeking behavior is influenced by the belief in the likelihood that the behavior will have the expected outcome, therefore, the attitude toward professional help will determine the behavior of engaging or not in mental health services.

DV research demonstrates mental health use decreases when the DV victim perceives the professional to give inadequate treatment, when the intervention does not meet their current need, when the help is not helpful, when the professional lacks the knowledge and does not fully understand the complexity of his or her situation, and when unable to identify the risk of serious violence (Nikupetari, 2017; Cheng et al., 2018). DV survivors often manage their own mental health symptoms with informal help such as friends or relatives. Therefore, they frequently fail to perceive themselves as victims, hence, not seeking formal help. Swift et al. (2017) demonstrate when individuals are assigned or recommended to professional help and it does not match their expectations, they are less likely to begin treatment.

Survivors, Income, and Health Insurance

Villatoro, Dixon, and Mays (2016) indicate Latinos underutilize mental health services due to decrease accessibility to health insurance and financial barriers. Latinos that are undocumented immigrants struggle with mental health diagnoses such as anxiety, depression., and substance use. There are 11.2 million undocumented immigrants without health insurance (Villatoro et al., 2016). It has been reported after a Medicaid expansion in the United States that occurred in 2014 uninsured Latinos dropped from 36% to 23%,

however, mental health services still are not used as often. It is argued the insurance benefits had too many restrictions and could have possibly impacted the utilization of mental health services. Villatoro et al. also state undocumented Latinos do not seek health coverage for the fear of deportation, therefore, hindering mental health services utilization.

Roby and Jones (2016) state the Affordable Care Act (ACA) provides funding and programs to encourage the integration of mental health services in primary care settings. However, the provision of care does not guarantee high-quality care and the high-quality care in the primary care settings are important to reach underserved populations. Research shows being of ethnic minority is a characteristic of an underserved population and for specific ethnic minorities primary care settings is their form of reaching out to professional care for mental health services (Roby & Jones, 2016, Machado et al., 2016, Puy et al., 2017). Roby and Jones state it is imperative for primary care providers to promote mental health services care through their coordination, however, health coverage issues rise state-to-state based on the payment policies and coverage decisions for mental health services. An issue that was identified is the inability to bill for same-day services, that is for medical and mental health services provided in the same day at the primary care setting. Those who try to receive medical and mental health same-day services are of ethnic-minorities, low-income, and with transportation limitations (Roby and Jones, 2016). Schaper, Padwa, Urada, and Shoptaw (2016) also demonstrated individuals who were informed of their need for substance abuse and

mental health treatment at their primary care physician's office avoided seeking services out of fear of getting arrested, losing parental rights, and losing health coverage.

Graaf and Snowden (2018) indicate 25% of youth who have mental health disorders and are considered Serious Emotional Disturbance (SED) use mental health services. The youth who are not using services is due to minimal health coverage in mental health services and cost barriers. SED youth who are privately insured are less likely to use for mental health services than those with public insurance such as Medicaid, however, often the youth insured privately are not eligible to be insured publicly. Some parents are taking their SED youth to child welfare or juvenile justice systems to obtain free mental health services; however, some end up losing custody of their child in the process. Therefore, it is imperative the Medicaid and/or community-based programs relax eligibility in order for those who are in need for mental health services could use it with their health coverage (Graaf & Snowden, 2019).

Ottaviani and Vandone (2015) found possessing health insurance is closely associated to age and being self-employed. It was found older people and self-employed individuals had a higher probability of having health insurance due to the perception of potential risk of needing to utilize health services in the future. Dickey, Budge, Katz-Wise, Garza, (2016) found transgender individuals are less likely to have health coverage and a primary case physician than from those who are not transgender. It is stated health care disparities are a significant issue and a contributing factor to transgender not seeking professional services (Dickey et al., 2016).

Major Themes in Literature

The literature demonstrated predisposing and enabling factors are more likely associated with an individual using mental health services. The most common predisposing variables related to utilization of mental health services are age, having employment, and being of North American descent. Participants who were not of North American descent did not utilize mental health services due to problems with stigma and a poor attitude towards mental health services. The individuals who were of minority race preferred seeking help informally with family members, and formally with primary physicians or religious leaders. In addition, men did not use mental health services due to issues with mental health stigma and instead preferred to seek help with legal professionals. Another theme included individuals using mental health services when there was psychological distress or disability in the occupational setting. Some of those who did use mental health services also had in common being informed of what mental health services consisted of. Overall, those who had a strong support system and had a poor attitude towards professional psychological services did not use mental health services and those who had a perceived need to address psychological distress and were of North American descent did use mental health services. Lastly, it was identified individuals who were not seeking mental health services was also due to being uninsured or having too many restrictions in their current health coverage. It was also evident further research is needed in identifying additional predisposing, enabling, and need factors that predict mental health use.

Summary and Conclusion

The literature demonstrates over and over the need to further research different predisposing, enabling, and need variables. The majority of the literature reveal the need for researching specifically predisposing and enabling variables. Recommendations for future predisposing variables include expanding on age range as current research focuses on middle and young aged, male gender, and different ethnic minorities. Literature showed an array of research with British, Asian, Australian, Latino, Caucasian, and African American participants, however, the literature was not specific to DV survivors of emotional abuse. There was an overall high emphasis on the need to study diverse populations, in different geographical areas, and of ethnic minority. Also, the literature gap included not having enough research on enabling variable of possession of health insurance and also specifically to DV survivors. Need variables that require further research include studying different types of trauma as the emphasis has been war related, community violence, physical, and sexual abuse. Researchers also recommend the application of different theoretical frameworks, measuring instruments, and gather new data as many studies analyzed preexisting data. Chapter three offers an in-depth review of the research design and rationale, the methodology that will be used including population, sampling strategy, and instrumentation. In addition, data analysis, threats to validity, and ethical procedures will be discussed.

Chapter 3: Research Method

Introduction

The purpose of this quantitative research study was to examine the relationship between predisposing factors, enabling factors, and need factors and DV survivors using mental health services. To address the literature gap, it is necessary to further understand how racial minority status, gender, annual income, lack of health insurance, and functional impairment predict whether a DV survivor will utilize mental health services. Research demonstrates a dearth of literature around the factors that hinder survivors from seeking services; therefore, additional research is needed. In this chapter, I identify the population of interest, sampling, procedures, instrumentations, and data collection methods. The chapter concludes with a discussion of the threats to the study's validity and a discussion of ethical considerations.

Research Design and Rationale

In this study, I used a quantitative logistic regression research design. In quantitative regression logistic research designs, data are described to understand the relationship between a dependent binary variable and nominal independent variables (Creswell, 2012). The binary logistic regression requires the dependent variable to have dichotomous outcomes as opposed to a linear regression where the outcome of the dependent variable is continuous (Creswell, 2012). This study's dependent variable of mental health services use had outcome answers of yes or no. This research did not involve manipulation of participants or controlled groups; therefore, experimental or

quasi-experimental designs would not have been appropriate. Surveys were administered, and a logistic regression analysis was applied.

The purpose of using surveys was to generalize from a sample to a population to make inferences about a behavior (Creswell, 2012). The survey method was preferred for this study because surveys allow quick data collection and processing, cost efficiency, and the benefit of finding attributes of a large population from a small group of individuals (Creswell, 2012). The surveys were self-administered questionnaires provided via the Internet.

The strength between the predictive factors of race/ethnicity, gender, annual income, possession of health insurance, and functional impairment on the use of mental health services was assessed. I specifically examined if race/ethnicity and gender were related to the use of mental health services among DV survivors. In addition, I examined if possession of health insurance, annual income, and functional impairment were related to the use of mental health services among DV survivors. Behavior inferences were generalized from DV survivors with this logistical regression study. Few scholars have focused on predictive factors that influence DV survivors to not use mental health services. The lack of treatment among this population is putting DV survivors in a vulnerable position of being revictimized.

Methodology

Population

In this study, I examined DV survivors who have a history of emotional abuse. In addition, I focused on men and women who identify as racial minorities in order to

understand if cultural and traditional differences from that of Caucasian-Americans are predictors of mental health services usage. Racial minorities included Hispanic/Latinos, African Americans, Asians, Native Americans, Pacific Islanders, and those of a non-Caucasian race (U.S. Census Bureau, 2018). DV research often represents Caucasians, so studies that focus on racial minorities are needed.

Sampling and Sampling Procedures

Simple random sampling is a strategy where a group of participants are selected from a larger group for study (Muneer, Shabbir, & Khalil, 2017). Simple random sampling was applied to obtain a better representation of the population. Random sampling eliminated biases, which is important when drawing conclusions from the results (Creswell, 2012). The inclusion criteria for participants included being at least 18 years old, a history of experiencing emotional abuse, and currently not using mental health services. Participants were recruited in community shelters and through social media. Flyers were posted outside the shelters with a Survey Monkey link. In addition, the Survey Monkey link was posted to social media.

Binary logistic regression researchers state that binary logistic regressions require a minimum sample size of 10 participants per predictor variable; however, 20 participants per predictor is preferred (Hosmer, Lemeshow, & Sturdivant, 2013; LeBlanc & Fitzgerald, 2000). This study had a total of five predictor variables; therefore, the sampling method and data analysis required 100 participants.

Instrumentation and Operationalization of Constructs

A demographic questionnaire was provided at the beginning of the survey to record participants' age, gender, race/ethnicity, annual income, and health insurance status. The California Census data were reviewed for the year 2018 to provide annual income breakdowns (U.S. Census Bureau, 2018). In addition, participants identified the type of insurance by choosing one of the following options: state or local government, federal, private, or other (Cohen, Terlizzi, & Martinez, 2018; U.S. Department of Health and Human Services, 2013).

The negative life events questionnaire. The negative life events questionnaire was provided to evaluate DV (Pitzner & Drummond, 1997). Abuse items are grouped into four sets: (a) psychological/verbal abuse scale, (b) control scale of abuse, (c) physical/sexual abuse scale, and (d) negative life events. However, in this study, I only used the psychological/verbal abuse scale to identify the participants who have endured emotional/psychological abuse. The survey questions are on a 5-point Likert-scale, ranging from 0 (the event has not occurred) to 5 (very often). Sample questions included: During your childhood or adulthood, has a significant person in your life, "humiliated you?" "screamed or yelled at you for no reason?" and "called you unpleasant names like crazy, idiot, or stupid?" The negative life events questionnaire demonstrates acceptable reliability and supports criterion validity (Pitzner & Drummond, 1997). The authors granted permission to use the survey for this study. Permission to use the Negative Life Events Questionnaire is presented on Appendix D.

The reliability of the Negative Life Events Questionnaire demonstrates that each scale had high internal consistency (Pitzner & Drummond, 1997). Cronbach's alpha showed that Psychological/Verbal Abuse Scale score is 0.95, for Control Abuse Scale is 0.87, for Physical/Sexual Abuse Scale the score is 0.89, and the full-scale coefficient alpha was very high at 0.96 (Pitzner & Drummond, 1997). Results demonstrated that no scale item weakened from the scale's internal consistency. Test-retest reliability coefficients for the Psychological/Verbal, Control, Physical/Sexual Abuse, and Negative Life Events Scales are moderately to highly reliable (Pitzner & Drummond, 1997). The Psychological/Verbal Abuse Scale and Control Scale of Abuse show good construct validity through an exploratory factor analysis. In addition, the Psychological/Verbal Abuse Scale is a powerful predictor of negative mood (Pitzner & Drummond, 1997).

The Negative Life Events Questionnaire was created to fill a gap by creating a set of negative life events consistent with traumatic events that may occur over one's lifespan (Pitzner & Drummond, 1997). The research had two hypotheses; the first hypothesis was that measures of abuse would be closely associated with current negative mood and psychosomatic complaints. The second hypothesis was that current symptomology independent to negative life events. Both hypotheses were shown to have significant results. The study was conducted in three stages: a) construction of negative life events questionnaire and abuse scales; b) test-retest reliabilities of the measures; and c) concurrent validity of the measures. Pitzner and Drummond (1996) mailed 509 questionnaires to individuals in Perth, Australia in the first stage, studied 63 university students in the second stage, and 116 participants that participated in the first stage

participated in the third stage. The three abuse scales and the negative life events scale showed to be reliable throughout the 7-week period.

The Walter Reed functional impairment scale. The Walter Reed Functional Impairment Scale is a 14-item scale that measures functional impairment (Herrell et al., 2014). The survey questions are on a 5-point Likert scale, ranging from 0 (no difficulty at all) to 5 (extreme difficulty). Sample questions include: How much difficulty do you currently have with the following, "your ability to complete assigned tasks," "your ability to interact with social groups (church, sports, clubs)," and "your ability to have close relationships." The Walter Reed Functional Impairment Scale demonstrates acceptable reliability and supported criterion validity (Herrell et al., 2014). The authors also granted permission to use this survey for the study. Permission to use The Walter Reed Functional Impairment Scale is presented on Appendix F.

The reliability of the 14 scale items were analyzed using the Cronbach's alpha. The reliability score was 0.92 and the score did not increase by removing items. Results showed that the performance of measurements showed similar trends across each item (Herell et al., 2014). The scale is suitable for predicting functional impairment and additional research is needed to generalize results to other populations (Herrell et al., 2014). IRT analyses suggest that terms on items can be modified in the interest of face validity without affecting the overall scale (Herrell et al., 2014). In addition, IRT analyses show that the response categories could be split in dichotomous categories without impacting results.

The Walter Reed Functional Impairment Scale was created to assess military or other professional individuals who are routinely exposed to traumatic events (Herrell et al., 2014). Herrell et al. (2014) identified that standard measures of impairment used with chronically ill populations were not suitable, and created this scale in order to measure functioning in 4 domains: physical, occupational, social, and personal. A total of 3,380 soldiers were asked to rate their functioning in the 4 domains on the 5-point Likert scale. Results demonstrated that a small percentage of soldiers with mental health symptoms reported greater functional impairment on occupational and social settings. Soldiers who reported high levels of functional impairment were more likely to meet criteria for major depressive disorder, PTSD, and high levels of somatization.

The world mental health composite international diagnostic interview. The World Mental Health (WMH) Composite International Diagnostic Interview (CIDI), or WMH-CIDI instrument, is a 50-item national comorbidity survey that measures mental health services use (Harvard Medical School, 2005). The instrument measures mental health symptoms, functioning, physical disorders, treatment, risk factors, and socio-demographics; however, only the seven items that measure service utilization under the treatment measure will be applied in this study. Half of the survey items are answered with “Yes, No, Don’t Know, or Refused.” The other half of the items are answered numerically. For example, “How many professionals did you ever talk to about these problems?” and “How old were you the first time you got helpful treatment for these problems?” The WMH-CIDI instrument demonstrates acceptable reliability and supports criterion validity. To obtain permission to utilize this instrument, the researcher reached

out to the developers in Harvard Medical School via electronic mail and was informed that using subsections of the measure does not require consent from the maker. Permission to use WMH-CIDI is presented on Appendix H.

WMH-CIDI was created because comparable surveys were limited to assessing mental disorders (Kessler & Ustun, 2004). With the WMH-CIDI, new variables could be measured, such as risk factors, consequences, correlates of treatment, and treatment adequacy (Kessler & Ustun, 2004). The tool was built with two sections and was created in a manner in which sections could be used optionally and administered to subsamples rather than to an entire sample. The tool aimed to assess both internal impairment (i.e. mental health symptoms) and external impairment (i.e. functioning) on all sections of the tool. Those who met criteria for a mental health diagnosis on part I of the internal assessment were asked to provide information on whether they ever received professional services to address their symptoms. If the participant responded yes to receiving services, then the information was coupled with demographic information to study patterns and predictors of treatment contact (Kessler & Ustun, 2004). Results showed pervasive patterns of delay of treatment after the first onset of mental health disorders and largely associated to age and illness severity (Kessler & Ustun, 2004).

The WMH-CIDI is an expansion of the original Composite International Diagnostic Interview (CIDI) tool (Kessler et al., 1998; Kessler & Ustun, 2004). Previous CIDI validity studies did now show consistent validity; therefore, a focus of the WMH-CIDI expansion was to gain validity (Kessler & Ustun, 2004). The developers of WMH-CIDI focused on four methodological domains: 1) incomprehension of terms; 2) not

understanding the task implied by the questions; 3) the lack of motivation to answer accurately; and, 4) not being able to answer some diagnostic questions accurately. The WMH-CIDI was made clearer by reordering questions in order to remove the contextual effects and adding clarifying clauses. Task comprehension was addressed by developing and giving a statement that contained a clear rationale for administering the interview and emphasizing the significance of the survey for social policy purposes. Contingent reinforcement was addressed by training interviewers to reinforce respondent performance and giving feedback such as, "This next question may be difficult, so please take your time before answering," and concluding with an expression of gratitude. Kessler and Ustun (2004) stated that contingent reinforcement prompts, along with explanations of the importance of careful and accurate information, led to considerable improvement in interviewees' recollections of health-related events. Lastly, the ability to answer accurately was improved by asking questions specifically designed to obtain information from participants' episodic or semantic memories. Depending on how the question was designed, the individual was invited to infer or estimate, rather than try to remember, as it can have adverse effects on the quality of reporting. With these new changes, the WMH-CIDI was able to obtain clinical validity.

Data Analysis

I used Statistical Package for the Social Sciences (SPSS), version 24.0, to describe and analyze data (IBM Corp., 2017). The researcher used a binary logistic regression process to investigate the relationship between DV survivors' race/ethnicity, gender, income, health insurance, functional impairment, and mental health services

utilization. First, the researcher used binary logistic regression to investigate the relationship between gender, race/ethnicity, and mental health services use. Second, the researcher used binary logistic regression to investigate the relationship between possession of health insurance, annual income, functional impairment, and mental health services use. Binary logistic regression procedures allow researchers to assess the extent of relationships between binary dependent variables and nominal independent variables (Frankfort-Nachmias, Nachmias, & DeWaard, 2014).

Research Question 1. Does the predisposing variable of gender and racial minority predict the use of mental health services among DV survivors of emotional abuse? Binary logistical regressions were computed among variables in order to determine if there was a relationship between variables. Logistical regressions examine the probability of a certain event happening and determining its relationship with other variables (Frankfort-Nachmias, Nachmias, & DeWaard, 2014). Chi-squares tests of independence were computed to examine the relationship between gender and mental health service use and race/ethnicity and mental health service utilization. Chi-square test of independence help determine the relationship between categorical variables (Cohen, 1988).

Research Question 2. Does the combination of enabling variables of possession of health insurance and high annual income and need variable of functional impairment predict the use of mental health services among DV survivors of emotional abuse? In order to determine if there was a relationship among variables, a binary logistic regression was computed. Chi-squares tests of independence were computed to examine

the relationship between possession of health insurance and mental health service use and annual income and mental health service use. A point biserial correlation analysis was computed to examine the relationship between functional impairment and mental health service use. Point biserial correlations were computed to measure the strength of the association between the continuous independent variable of functional impairment and dichotomous dependent variable of mental health service use (Cohen, 1988).

Threats to Validity

Possible threats to internal validity include not obtaining sufficient participants and attain ample data to answer the research questions and fill a gap in the literature (Shono, Ames, & Stacy, 2016). Consequently, a small sample will not provide enough data, therefore, external validity would be threatened as results cannot be generalized to the DV population (Shono, Ames, & Stacy, 2016). In addition, participants who start the questionnaire can decide to not complete it due to its length, thus, threatening whether sufficient data has been collected. However, the researcher will not stop surveying until obtaining the needed 100 participants. An additional threat to internal validity may occur if participants who have experienced physical and sexual abuse decide to answer the survey with physical and sexual abuse experiences in mind. In order to decrease the threat, the researcher will emphasize the importance of answering the survey in relation to emotional abuse only.

Ethical Procedures and Consistency

Survey Monkey was used in order to assure that the electronic mail used by the participant to submit the survey was to sever connection to the electronic mail and further

secure confidentiality. The participants were provided with informed consent forms which outlined the research purpose and goals. In order for the participants to continue with the survey process, they were required to agree to all terms outlined in the consent form. The consent form contained contact information of the researcher and the university research participant advocate. In addition, the consent form displayed the purpose of the research and the risks and benefits of participating. Participants were given the toll-free phone number and address of the community emergency response team should they experience emotional distress when answering survey questions. The community emergency response team is able to provide free emotional support services through their hot line or their walk-in services. Those who were connected to an individual therapist was also encouraged to contact their therapist if needing additional emotional support. The participants were told that their participation is voluntary, that they can skip questions, and that they can stop their participation at any time without penalty. The researcher did not collect identifiable information from participants such as name, phone numbers, or address. Each participant was assigned a confidential identifier number. Data was stored in password protected memory stick. The data will be kept for five years and after the five years the researcher will dispose of data by deleting it.

Summary

Chapter 3 provided information on the framework that was used to conduct the study. In addition, it was informed that the researcher utilized binary logistic regression, chi-square tests, and a point biserial correlation analysis to assess the relationship between variables. The Negative Life Events Questionnaire, The Walter Reed Functional

Impairment Scale, WMH-CIDI Questionnaire, and demographic questionnaire were used in this research. The instruments helped collect data regarding DV emotional abuse experience, functional impairment, mental health services utilization, and demographic information on race/ethnicity, gender, annual income, and health insurance. Lastly, ethical considerations were discussed.

Chapter 4: Results

Introduction

The purpose of this study was to explore how the predisposing factors of gender and race, enabling factors of income and health insurance, and need factors such as functional impairment, influence the decision of DV survivors of emotional abuse to use mental health services. In this study I addressed the following research questions:

RQ1: Does the predisposing variable of gender and racial minority predict the use of mental health services among domestic violence survivors of emotional abuse?

$H_0$1: The variables gender and racial minority do not statistically predict the use of mental health services among domestic violence survivors of emotional abuse.

H_A1: The variables gender and racial minority do statistically predict the use of mental health services among domestic violence survivors of emotional abuse.

RQ2: Does the combination of enabling variables of possession of health insurance and high annual income and the need variable of functional impairment predict the use of mental health services among domestic violence survivors of emotional abuse?

$H_0$2: The variables of possession of health insurance, high annual income, and functional impairment do not statistically predict the use of mental health services among domestic violence survivors of emotional abuse.

H_A2: The variables of possession of health insurance, high annual income, and functional impairment do statistically predict the use of mental health services among domestic violence survivors of emotional abuse.

In this chapter, I will review data collection information, results, and assumptions, and I will conclude with a summary.

Data Collection

Data collection occurred over the course of 6 weeks. Data were obtained from four DV shelters in California and from a specially created Facebook page for this research study. The recruitment flyer was posted on Facebook and was also posted by the coordinators of four DV shelters in their public area. Recruitment flyers displayed qualifying factors and invited participants to take the survey on SurveyMonkey. The SurveyMonkey link was on the Facebook page and on the recruitment flyers. Participants were encouraged to directly contact me via email or the messaging system from Facebook for any questions or concerns. Messages that were sent via Facebook were soon after deleted for confidentiality. Recruitment flyers were not posted in the churches as mentioned in Chapter 3 due to the shelter-in-place order issued by the government during the COVID-19 pandemic (CDC, 2019).

There were a total of 188 responses, however, only 152 were deemed eligible. Responses that were not eligible were due to disqualifying questions or for answering "no" to every emotional abuse and functional impairment question. Qualifying items included being at least 18 years old, having experienced emotional abuse during childhood or adulthood, and currently not being connected to therapy services. This study had a total of five predictors, requiring 100 participants. I recruited a total of 152 eligible participants, providing an additional 52 participants above 100.

Descriptive Statistics

The most frequently observed category of gender was female (n = 118, 78%). The most frequently observed category of age was 25–34 (n = 57, 38%). For the racial minority category, nine participants of Asian ethnicity participated, three of American Native descent, four of African American descent, 16 of Hispanic descent, one of Pacific Island descent, 15 who reported to be mixed ethnicities, and 82 participants reported they were White. The most frequently observed category of ethnicity was Hispanic or Latino (n = 83, 55%). The most frequently observed category of race was White (n = 80, 53%). The most frequently observed category of income was $50,000 to $74,999 (n = 33, 22%). The most frequently observed category of possession of health insurance was Yes (n = 142, 93%). The most frequently observed category of type of insurance was private (i.e., Health Maintenance Organizations, Preferred Provider Organizations; n = 100, 66%). The most frequently observed category of mental health service use was Yes (n = 78, 51%). Frequencies and percentages are presented in Table 1.

Table 1

Frequency Table for Nominal Variables

Variable	n	%
Gender		
Female	118	77.63
Male	34	22.37
Age		
18–24	2	1.32
25–34	57	37.5
35–44	44	28.95
45–54	16	10.53
55–64	8	5.26
65+	0	0.00
Ethnicity		
Caucasian	41	26.97
Other	4	2.63
Hispanic or Latino	83	54.61
Asian/Pacific Islander	17	11.18
African American	5	3.29
Native American or American Indian	2	1.32
Race		
Caucasian	80	52.63
Assyrian	1	0.66
American Indian or Alaska Native	3	1.97
Mixed	15	9.87
Chinese	1	0.66
African American	4	2.63
Hispanic	10	6.58
Salvadorian	3	1.97
Mexican	14	9.21
Asian Indian	7	4.61
Portuguese	2	1.32
Other Pacific Islander	1	0.66
Latino	3	1.97
Missing	8	5.26
Income		
Less than $20,000	25	16.45
$20,000 to $34,999	27	17.76
$35,000 to $49,999	20	13.16
$50,000 to $74,999	33	21.71
$75,000 to $99,999	19	12.50
Over $100,000	26	17.11
Missing	2	1.32
Have health insurance		
Yes	142	93.42
No	8	5.26
Missing	2	1.32
Type of insurance		
State or local government (i.e., Medicare, Medicaid, Veterans Health Administration)	35	23.03
Private (i.e., HMO, PPO)	100	65.79
Federal (i.e., Federal employees health benefits)	8	5.26
Missing	9	5.92
Mental health services use		
Yes	78	51.32
No	74	48.68
Missing	0	0.00

Note. Due to rounding errors, percentages may not equal 100%.

Table 2

Frequency Table for Gender, Insurance, Income, functional Impairment and Mental Health Service Use

Variable	Mental Health Services Use *N*	
	Yes	No
Gender		
Female	67	51
Male	11	23
Health insurance	74	69
Annual income	78	72
Functional impairment	78	74

Descriptive statistics were used to examine the trends of the functional impairment variable. The observations for functional impairment had an average of 0.86 (SD = 0.72, SEM = 0.06, Min = 0.00, Max = 4.09), suggesting that participants fell in the normal range of functioning. The summary statistics can be found in Table 3.

Table 3

Summary Statistics Table for Interval and Ratio Variables

Variable	*M*	*SD*	*N*	Min	Max
Functional Impairment	0.86	0.72	152	0.00	4.09

Note. '-' denotes the sample size is too small to calculate statistic.

Results

In this section, I detailed the primary analysis for each research question and its corresponding hypotheses. I also reviewed Variance Inflation Factors (VIF) and correlation coefficients to test assumptions for each research question.

RQ1: Does the predisposing variable of gender and racial minority predict the use of mental health services among domestic violence survivors of emotional abuse?

$H_0$1: The variables gender and racial minority do not statistically predict the use of mental health services among domestic violence survivors of emotional abuse.

H_A1: The variables gender and racial minority do statistically predict the use of mental health services among domestic violence survivors of emotional abuse.

Analysis for RQ1. A chi-square test of independence was conducted to examine the relationship between gender and use of mental health services. Gender consisted of two levels: female and male. Mental health service use consisted of two levels: Yes and No. Prior to analysis, the assumptions of a chi-square test of independence were assessed. The assumption for adequate cell size was assessed, which requires all cells to have expected values greater than zero and 80% of cells to have expected values of at least five (McHugh, 2013). All cells had expected values greater than zero, indicating that the first condition was met. In addition, all the cells had expected frequencies of at least five, indicating the second condition was met.

The results of the chi-square test were statistically significant based on an alpha value of 0.05, $\chi2(1) = 6.30$, $p = .012$, suggesting that there was a significant relationship between gender and mental health service use. Therefore, results demonstrated that females were more likely to seek mental health services than men. Table 4 presents the results of the chi-square test between gender and mental health service use.

Table 4

Chi-Square Test of Independence between Gender and Mental Health Service Use

	Mental Health Service Use				
Gender	Yes	No	χ^2	*df*	*P*
Female	67[60.55]	51[57.45]	6.30	1	.012

Male	11[17.45]	23[16.55]

Note. Values formatted as Observed [Expected].

A chi-square test of independence was conducted to examine the relationship between ethnicity and use of mental health services. Race/Ethnicity consisted of five levels: Asian/Pacific Islander, Black or African American, Hispanic or Latino, Other, and White. Mental health service use consisted of two levels: Yes and No. Prior to analysis, the assumptions of a chi-square test of independence were assessed. All cells had expected values greater than zero, indicating the first condition was met. However, a total of 60.00% of the cells had expected frequencies of at least five, indicating the second condition was violated. This can be attributed to the low frequencies for the Black and Other ethnicity groups. Therefore, the findings of the chi-square will be interpreted with a level of caution.

The results of the chi-square test were statistically significant based on an alpha value of 0.05, $\chi2(4) = 27.68$, $p < .001$, suggesting that there was a significant relationship between race/ethnicity and mental health service use. Therefore, results demonstrated that White participants were more likely to seek mental health services than any other race/ethnicity. Table 5 presents the results of the chi-square test for race/ethnicity and mental health service use.

Table 5

Chi-Square Test of Independence between Race/Ethnicity and Mental Health Service Use

	Mental Health Service Use				
Race/Ethnicity	No	Yes	χ^2	*df*	*p*
Asian/Pacific Islander	10[8.28]	7[8.72]	27.68	4	< .001

Black or African American	1[2.43]	4[2.57]
Hispanic or Latino	54[40.41]	29[42.59]
Other	1[2.92]	5[3.08]
Table 4 (Continued)		
White	8[19.96]	33[21.04]

Note. Values formatted as Observed [Expected].

A binary logistic regression was conducted to examine whether gender and race/ethnicity were significant predictors of mental health service use. The predictor variables corresponded to gender and race/ethnicity. The outcome variable corresponded to mental health service use with two levels: yes and no. Due to the categorical nature of gender and race/ethnicity, the variables were dummy coded prior to entry into the regression model. For gender, males were treated as the reference group. For race/ethnicity, Whites were treated as the reference group.

Prior to analysis, the assumption for absence of multicollinearity was tested with variance inflation factors (VIFs). The assumption was met due to all the VIFs being below 10. Table 6 presents the findings of the VIFs.

Table 6

Variance Inflation Factors for Predictor Variables (RQ1)

Variable	VIF
Gender (reference: male)	1.03
Female	
Race (reference: White)	
Hispanic	1.54
Black	1.10
Asian	1.42
Other	1.11

The model was evaluated based on an alpha of 0.05. The overall model was significant, $\chi2(5) = 34.85$, $p < .001$, suggesting that gender and race/ethnicity were significant predictors of mental health service use. The regression coefficient for gender was statistically significant, B = 1.06, OR = 2.87, p = .022, indicating that females had higher odds of using mental health services in comparison to males. The regression coefficient for race/ethnicity (Hispanic) was significant, B = -2.03, OR = 0.13, p < .001, indicating that White individuals had higher odds of using mental health services in comparison to Hispanics. The regression coefficient for race/ethnicity (Asian) was significant, B = -1.63, OR = 0.20, p = .012, indicating that White individuals had higher odds of using mental health services in comparison to Asians. Race/ethnicity (Black) and race/ethnicity (Other) were not significant predictors in the model. Table 7 summarizes the results of the regression model.

Table 7

Logistic Regression Results with Gender and Race/Ethnicity Predicting Mental Health Service Use

Variable	*B*	*SE*	χ^2	*p*	*OR*
Gender (reference: female)	1.06	0.46	5.21	.022	2.87
Male					
Ethnicity (reference: White)					
Hispanic	-2.03	0.46	19.04	< .001	0.13
Black	0.04	1.21	0.00	.976	1.04
Asian	-1.63	0.65	6.32	.012	0.20
Other	0.43	1.19	0.13	.717	1.54

Note. $\chi2(5) = 34.85$, $p < .001$.

RQ2: Does the combination of enabling variables of possession of health insurance and high annual income and the need variable of functional impairment predict the use of mental health services among domestic violence survivors of emotional abuse?

$H_0$2: The variables of possession of health insurance, high annual income, and functional impairment do not statistically predict the use of mental health services among domestic violence survivors of emotional abuse.

H_A2: The variables of possession of health insurance, high annual income, and functional impairment do statistically predict the use of mental health services among domestic violence survivors of emotional abuse.

Analysis for RQ2. A chi-square test of independence was conducted to examine the relationship between income and use of mental health services. Income consisted of six levels: less than $20,000, $35,000–49,999, $50,000–$74,999, $75,000–$99,999, and $100,000+. Mental health service use consisted of two levels: Yes and No. Prior to analysis, the assumptions of a chi-square test were assessed. All the cells had expected values greater than zero, indicating that the first condition was met. All the cells had expected frequencies of at least five, indicating the second condition was met.

The results of the chi-square test were not significant based on an alpha value of 0.05, $\chi 2(5) = 6.56$, $p = .256$, suggesting that there was not a significant relationship between income and mental health service use. Table 8 presents the results of the chi-square test of independence.

Table 8

Chi-Square Test of Independence between Income and Mental Health Service Use

	Mental Health Service Use				
Income	No	Yes	χ^2	*df*	*p*
Less than 20,000	13[12.00]	12[13.00]	6.56	5	.256
20,000-34,999	16[12.96]	11[14.04]			
35,000-49,999	11[9.60]	9[10.40]			
50,000-74,999	16[15.84]	17[17.16]			
75,000-99,999	9[9.12]	10[9.88]			
100,000+	7[12.48]	19[13.52]			

Note. Values formatted as Observed [Expected].

A chi-square test of independence was conducted to examine the relationship between type of insurance and use of mental health services. Type of insurance consisted of three levels: federal, private, and state or local. Mental health service use consisted of two levels: No and Yes. Prior to analysis, the assumptions of a chi-square test of independence were conducted. All cells had expected values greater than zero, indicating the first condition was met. A total of 66.67% of the cells had expected frequencies of at least five, indicating the second condition was violated. This can be attributed to the low frequencies for federal type of insurance. Therefore, the findings of the chi-square will be interpreted with a level of caution.

The results of the chi-square test were not statistically significant based on an alpha value of 0.05, $\chi2(2) = 4.10$, $p = .128$, suggesting that there was not a significant relationship between type of insurance and mental health service use. Table 9 presents the results of the chi-square test between type of insurance and mental health service use.

Table 9

Chi-Square Test of Independence between Type of Insurance and Mental Health Service Use

	Mental Health Service Use				
Type of Insurance	No	Yes	χ^2	*df*	*p*
Federal	4[3.86]	4[4.14]	4.10	2	.128
Private	43[48.25]	57[51.75]			
State or Local	22[16.89]	13[18.11]			

Note. Values formatted as Observed [Expected].

A point biserial correlation analysis was conducted to examine the relationship between functional impairment and mental health service use. A point biserial correlation is a special case of the Pearson correlation. Cohen's standard was used to test the strength of the relationship, in which coefficients between .10 and .29 represent a small effect size, coefficients between .30 and .49 represent a moderate effect size, and coefficients above .50 indicate a large effect size (Cohen, 1988). The findings of the point-biserial correlation were not statistically significant, rpb = 0.07, p = .361, suggesting that there was not a significant association between functional impairment and mental health service utilization. The correlation coefficient suggested that there was a small association between the two variables. Table 10 presents the results of the correlation.

Table 10

Point Biserial Correlations for Functional Impairment and Mental Health Service Use

Combination	r_{pb}	Lower	Upper	*p*
Functional Impairment – Mental Health Service Use	0.07	-0.09	0.23	.361

Note. The confidence intervals were computed using α = 0.05; *n* = 152

A binary logistic regression was conducted to examine whether income, type of insurance, and functional impairment predict mental health service use. The predictor variables corresponded to income, type of insurance, and functional impairment. The outcome variable corresponded to mental health service utilization with two levels: yes and no. Due to the categorical nature of income and type of insurance – these variables were dummy coded prior to entry into the model. For income, the reference group corresponded to less than $20,000. For type of insurance, the reference group corresponded to state insurance. Functional impairment was a continuous level predictor.

Prior to analysis, the assumption for absence of multicollinearity was tested with variance inflation factors (VIFs). The assumption was met due to all the VIFs being below 10. Table 11 presents the findings of the VIFs.

Table 11

Variance Inflation Factors for Predictor Variables (RQ2)

Variable	VIF
Income (reference: less than $20,000)	
$20,000 to $34,999	1.72
$35,000 to $49,999	1.78
$50,000 to $74,999	2.40
$75,000 to $99,999	2.00
Table 10 (Continued)	
$100,000+	2.15
Type of insurance (reference: state)	
Federal	1.51
Private	1.88
Functional impairment	1.15

The model was evaluated based on an alpha of 0.05. The overall model was not significant, $\chi 2(8) = 10.13$, p = .256, suggesting that income, insurance, and functional impairment do not predict mental health service utilization. Table 12 summarizes the results of the regression model.

Table 12

Logistic Regression Results with Income, Type of Insurance, and Functional Impairment Predicting Mental Health Service Use

Variable	*B*	*SE*	χ^2	*p*	*OR*
Income (reference: less than $20,000)					
$20,000 to $34,999	-0.79	0.63	1.55	.213	0.46
$35,000 to $49,999	-0.46	0.76	0.37	.543	0.63
$50,000 to $74,999	-0.34	0.65	0.27	.602	0.71
$75,000 to $99,999	-0.37	0.71	0.27	.604	0.69
$100,000+	0.48	0.71	0.45	.502	1.61
Type of insurance (reference: state)					
Federal	0.56	0.91	0.38	.539	1.75
Private	0.85	0.54	2.46	.117	2.34
Functional Impairment	0.35	0.26	1.81	.178	1.42

Note. $\chi^2(8) = 10.13$, $p = .256$.

Summary

The predisposing variable female and predisposing variable White-race did significantly predict the use of mental health services among DV survivors of emotional abuse. The null hypothesis that indicated the variables gender and racial minority do not statistically predict the use of mental health services among DV survivors of emotional abuse was rejected. The alternative hypothesis that indicated the variables gender and

racial minority do statistically predict the use of mental health services among DV survivors of emotional abuse failed to reject.

The combination of enabling variables of possession of health insurance and high annual income and need variable of functional impairment did not significantly predict the use of mental health services among DV survivors of emotional abuse. The null hypothesis that indicated the variables of possession of health insurance, high annual income, and functional impairment do not statistically predict the use of mental health services among DV survivors of emotional abuse failed to reject. The alternative hypothesis that indicated the variables of possession of health insurance, high annual income, and functional impairment do statistically predict the use of mental health services among DV survivors of emotional abuse was rejected. Chapter 5 will include an in-depth discussion of the study's findings by interpreting the findings, inform of limitations, future recommendations, and will conclude with the implication of social change.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this quantitative study was to identify the relationships between predisposing (gender, race), enabling (income, health insurance), and need (functional impairment) factors and mental health services utilization among emotionally abused DV survivors. I conducted the study to identify predictors of mental health services use by emotionally abused DV survivors. A regression coefficient analysis showed that Caucasian individuals were more likely to use mental health services than Hispanic or Asian individuals. A regression coefficient analysis also showed that women were more likely to use mental health services than men. Possession of insurance, income, or functional impairment did not predict mental health services use. In this chapter, the results are discussed in relation to the research questions and hypotheses, I offer recommendations to help future studies with generalizability, and I make final conclusions about the study.

Interpretations of the Findings

Gender and Race/Ethnicity

The alternative hypothesis of RQ1 demonstrated that gender and race/ethnicity do statistically predict mental health services use among DV survivors of emotional abuse. This study replicated what previous research has found—that race/ethnicity and gender are predictors of who will use mental health services (Cavanaugh, Messing, Eyzerovich, & Campbell, 2015; Cuevas et al., 2014). There are several reasons gender and race/ethnicity predict mental health service use among DV survivors. One of the reasons

may be due to women having a greater tendency to seek mental health services compared to men as women cares less about appearing “weak” (Cavanaugh, Messing, Eyzerovich, & Campbell, 2015; Cuevas et al., 2014). Women have been stereotyped to be the abused gender as opposed to men (Puy et al., 2017). Female DV survivors are not known to be worried about how they may be judged or perceived by society as male DV survivors do (Cavanaugh et al., 2015).

Another reason gender and race/ethnicity are predictors of mental health services utilization among DV survivors of emotional abuse may be due to acclimation; researchers have found that natural born citizens of the United States or well-acclimated U.S. residents are more comfortable with the idea of seeking professional help (Lelaurain et al., 2017; Seamark & Gabriel, 2018). Natural born citizens and well-acclimated residents feel well rooted in their communities and may have strong support systems that allow them to seek help (Seamark & Gabriel, 2018).

In addition, individuals of Caucasian descent have demonstrated positive attitudes toward mental health services (Lelaurain et al., 2017). Caucasians have reported less biases and stereotypes toward the use of professional help. Studies have shown Hispanics and Asians have negative attitudes toward mental health; their cultures tend to teach that only “crazy” people use mental health services (Cuevas et al., 2014). Research has shown that African Americans tend to rely more on religious intervention and have a negative attitude toward mental health services (Mantovani et al., 2016).

Health Insurance, Income, and Functional Impairment

The alternative hypothesis for RQ2 demonstrated possession of health insurance, annual income, and functional impairment to not be statistically predictive factors of mental health use among DV survivors of emotional abuse. This could be due to the numerous and various DV resources accessible to DV survivors. The community resources available to DV survivors are often free of cost and do not require health insurance (California Victim Compensation Board, 2016). Often, providers help survivors obtain government health insurance, as the Affordable Care Act states that they cannot deny coverage to individuals who have experienced DV (National Council of Urban Indian Health, 2019). Many states in the United States have budgets established to pay for mental health services, medical services, and living arrangements for DV victims (National Center for Victims of Crime Compensation Board, 2016).

In addition, many DV centers offer their services specifically to those who report a low annual income (National Center for Victims of Crime Compensation Board, 2016). DV services organizations also provide free food, shelter, and financial and legal services (National Center for Victims of Crime Compensation Board, 2016). Therefore, it can be argued that health insurance and annual income are not important matters to DV survivors, as they have access to free community DV services.

Research has shown that DV survivors who are caregivers to others are more likely to seek professional help because others depend on them (Ghafoori et al., 2014). Research has demonstrated that DV survivors who need help will uproot their children from their schools, communities, social groups, and family as long as they are safe

(Ghafoori et al., 2014). DV survivors will do whatever it takes to protect the individuals they care for and functional impairment may not be an impediment. Research shows that DV survivors need to experience a perceived need for mental health services; however, if the survivor is caregiving, they may not be aware of the perceived need for mental health help (Ghafoori et al., 2014). Perhaps DV survivors need to perceive themselves as vulnerable and victims in order to be aware of any functional impairment.

Interpretation of the Findings in Relation to Gender

I designed the study to address the gap in the literature regarding the underuse of mental health services among DV survivors of emotional abuse, gender, and race. Findings demonstrated that gender was a significant predictor of use of mental health services. Women were more likely to use mental health services compared to men. In this study, it was observed that female survivors between ages 25–34 are more likely to use mental health services. Women may be more prone to use mental health services due to being considered the main victims of DV and not experiencing increased stigma as men do (Puy et al., 2017). Women who are abused and decide to use mental health services experience less public stigma and negative attitudes toward psychological services (Stewart, Jameson, Curtin, 2015). In addition, women seek mental health services when experiencing the need to express their emotions and needing validation on their personal psychological problems (Watson & Hunter, 2015). Research also demonstrates that women who are financially stable have higher levels of acculturation and have poor coping strategies are more likely to seek mental health services (Sabina, Cuevas, & Scahlly, 2015).

Research on male DV survivors tends to be underreported, contributing to the dearth of research in that area (Syzdek et al., 2014). This study's findings also indicated that men were less likely than women to report that they were victims of DV and less willing to use mental health services. Out of a total of 34 male participants, 23 reported not using mental health services despite the emotional abuse they endured. Puy et al. (2017) reported that men were more likely than women to seek legal services, but rarely sought mental health services. In addition, research has shown that men tend not to use mental health services out of fear of appearing not strong enough (Puy et al., 2017; Machado et al., 2016; Villatoro et al., 2014).

Interpretation of the Findings in Relation to Race/Ethnicity

Findings demonstrated that race/ethnicity was a significant predictor of use of mental health services. Results showed that White individuals were more likely to use mental health services than Hispanic or Asian individuals. Results on race also support prior findings that White individuals are more likely to use mental health services compared to those of other racial and ethnic groups (Seamark & Gabriel, 2018; Lelaurain et al., 2017). Literature on Hispanic DV survivors has shown that females tend to seek professional services more than males, however, they will often begin with medical services and use mental health services as a last resort (Cuevas et al., 2014). There was a total of 83 Hispanic participants, of whom 54 indicated they did not seek mental health services regardless of being DV survivors. There is significantly less literature focusing on Asian DV survivors than on Hispanic DV survivors. In our study, there were 17 participants of Asian descent, 10 of whom indicated they did not use mental health

services despite being survivors of emotional abuse. Therefore, our research also confirms prior studies indicating that Asian individuals are less likely to report DV or use mental health services to address the effects of abuse (Arnault et al., 2018).

In addition, our study included a total of 5 Black or African American DV survivors and 4 indicated use of mental health services. However, with a small number of individuals representing this racial group, the results are difficult to interpret. Although the majority of Black or African American participants indicated use of mental health services, there was no independent statically significant effect. Associated literature shows a dearth of research on DV in this ethnic group (Mantovani et al., 2016). There were five participants who indicated their race as "Other," and most of the participants did not identify their race.

Interpretation of the Findings in Relation to Income

Income did not have a statistically significant effect on utilization of mental health services. However, the average income of respondents was $50,000 to $74,999, which is a range that encompasses the median U.S. household income, according to the United States Census Bureau (United States Census Bureau, 2018). Furthermore, income did not have a significant relationship with mental health use. Research has shown that individuals with a high income are more likely to seek mental health services than those with median or low income (Villatoro, Dixon, & Mays, 2016). Those who have low income are less likely to use mental health services compared to those with median income (Villatoro et al., 2016). Individuals with a high income often have higher education than those with low income (Villatoro et al., 2016; Villatoro et al., 2016).

Individuals with higher education are more likely to have positive attitudes towards mental health services, therefore, more likely to seek professional services (Villatoro et al., 2016).

Interpretation of the Findings in Relation to Possession of Health Insurance

Possession of health insurance did not predict mental health service utilization. There were 142 participants who reported possession of health insurance. However, despite the large sample, there was no significant relationship between insurance coverage and use of mental health services. To further investigate whether possession of health insurance was a predictor of use of services, a chi-square test was conducted by type of insurance. There were four coverage options: federal (N = 8), private (N = 100), state/local (N = 35), and other (N = 4). Out of 153 participants, 100 reported having private health insurance (e.g., Health Maintenance Organization [HMO], Preferred Provider Organization [PPO], Point-of-Service [POS]). Among those with federal health insurance (i.e., Federal Employees Health Benefits), 4 of 8 participants indicated they had not used mental health services. In other groups, 43 of 100 participants with private health insurance and 22 of 35 participants with state/local health insurance (e.g., Medicare, Medicaid, Veterans Health Administration) reported they had not used mental health services, despite being survivors of emotional abuse. The literature on health insurance and use of mental health services has indicated that individuals were not using services due to lack of health insurance (Roby & Jones, 2016; Schaper, Padwa, Urada, & Shoptaw, 2016), however, our study demonstrated no relationship between insurance

coverage and utilization of services. Sabina et al. (2015) found that the poor use of mental health services are factors beyond healthcare and economic barriers.

Interpretation of the Findings in Relation to Functional Impairment

There were 152 DV survivors who answered questions about functional impairment, such as the ability to perform well at work, the ability to interact in social groups (e.g., church, sports, clubs), and the ability to maintain close relationships (e.g., spouse, girlfriend/boyfriend). A point biserial correlation showed a small association between functional impairment and use of mental health services, but this effect was not statically significant. The research literature has indicated that DV survivors of physical abuse will seek medical services when they feel physically ill, but not mental health services (Cavanaugh et al., 2015; Cuevas et al., 2014). The study's findings showed that the average participant functioned adequately. Studies on DV survivors report use of mental health services when PTSD and depression symptoms are severe and cause functional impairment, therefore, results showed the opposite (Cuevas et al., 2014; Syzdek et al., 2014). It can be argued that the participants may not have experienced severe mental health symptoms or did not report on their functioning, resulting in no significant relationship between functioning and use of mental health services.

Interpretation of the Findings in Relation to Behavioral Model of Health Service Use

BMHU provides information on mental health service consumption by focusing on predisposing, enabling, and need variables (Andersen, 1995). BMHU was the appropriate framework to use in this study as previous studies recommended researching

novel predicting factors. The BMHU model helped me identify multiple factors that influence health service use and health behavior. Using the BMHU model made it possible to study factors that may have been overlooked in previous studies due to having secondary data (Babitsch, Gohl, & Lengerke, 2012). This study found predisposing variables to be more statistically significant than enabling and need variables.

Findings are consistent with the literature, indicating that predisposing variables comprise one category of variables that is more likely to predict utilization of services (Ghafoori, Fisher, & Korestevela, 2014; Lelaurain et al., 2017). The literature is consistent with identifying predisposing and need variables as predictive factors. My research found gender and race/ethnicity to be significant predisposing factors. Overall, findings have shown that the main predisposing predictor variables for use of mental health services are gender and ethnicity; specifically, female gender and White ethnicity are positive predictors of use of services (Cuevas et al., 2014; Pace et al., 2018). Other research has found predisposing variables, such as level of education (higher level of education), age (young and middle age), and employment to be positive predictors of use of mental health services (Cavanaugh et al., 2015; Davis & Liang, 2014).

Additional research has identified the need predictors for DV survivors as severe mental health symptoms, psychological distress, and disability in the occupational setting (Bell & Sabina, 2014; Seamark & Gabriel, 2018; Syzdek et al., 2014). However, this study found that need variable of functional impairment was not statistically significant. In addition, enabling factors of income and possession of health insurance were not statistically significant. Literature is consistent with my enabling variable findings as

enabling factors tend to not be strong predictor factors (Graham et al., 2017; & Klopper et al., 2014). Researchers have used BMHU and applied univariate analysis to find patterns in data and cross-sectional studies with pre-existing data, and have collected and assessed data using Binary logistics, chi-square statistics, and Kaiser-Meyer-Olkin measures (Graham et al., 2017; Klopper et al., 2014). Our study applied binary logistic regression, chi-square tests, and point biserial correlation, as prior research has shown these analyses to be effective.

Limitations of the Study

Limitations of this study include recruitment from shelters and churches in the state of California, preventing generalization of the results to other states and geographical areas. Even though there was participation in the study through Facebook, the level of representation from other states or countries is unknown, therefore the sample does not fully represent the general DV population. Also, the shelter in place order due to COVID-19 may have prevented participation. I was not able to post recruitment flyers in churches as previously planned as churches had been closed to the public. It is recommended to continue researching predictor factors that influence DV survivors to not use mental health services by expanding the research in other living areas. The limitation of lacking generalizability can be prevented by studying different geographical areas, recruitment locations, and broadening the social media collection.

This research only used the Facebook platform as a form of participant recruitment and additional participants could be recruited through other social media means. Other social media platforms that could be considered are Instagram, Snapchat,

Tweeter, and LinkedIn. Use of other social media domains could help reach diversity in age and race that face-to-face recruitment could not reach. In addition, social media could reach DV participants who suffer from severe anxiety and other mental health symptoms that prevent them from participating directly with the researcher. In order to know the generalizability of the data the survey could include a demographic question where the participant can identify their state of residence.

In addition, participants were primarily Hispanic and Caucasian, therefore the results cannot be generalized to other racial and ethnic groups. The sensitive nature of the study may have limited the involvement of male participants and ethnicities other than Hispanic, Asian, and Caucasian. The binary logistic regression between gender and ethnicity was limited due to underrepresentation of the Black/African American, Native American, and Other variables. The data was interpreted with caution due to the assumptions regarding sample size, requiring at least five participants representing each variable, not being met. There was a similar frequency limitation for type of insurance. Therefore, recruitment in different locations can help reach a more diverse population than the one represented in this study.

In addition, the lack of statistical significance of functional impairment, which was identified as a significant need predictor in prior studies, suggests potential caveats of relying on self-reports where participants may not answer truthfully. It is recommended for future studies to use different functional impairment measures to confirm whether functional impairment is consistently not a predictor factor of mental health service utilization. In addition, it is recommended to measure the questions

differently in the survey. I used a rating scale from 0 to 5, 0 meaning no functional impairment difficulties, and 5 indicating significant functional impairment difficulties, which at the end provided average percentages of functional impairment. Future research should find a measuring tool that measures functional impairment more simply.

Recommendations

Future research is needed to expand the knowledge of variable predictors for DV survivors of emotional abuse. Research on emotionally abused survivors continues to be limited and would benefit from identification of other predisposing variables and new enabling and need factors that predict mental health services use (Cattaneo et al., 2007; Suvak et al., 2013). Research has shown that the most studied traumas are physical abuse, sexual abuse, and combat trauma (Cuevas et al., 2014). Predictor factors linking life stress to mental health diagnoses include gender, ethnicity, and socioeconomic status, and these factors should be studied further as, if not addressed, they may increase future stress (Gusic et al., 2015).

The sample size was considerable, however, a wider representation of ethnicity and combination with other predisposing and enabling variables is needed to further understand culture and its impact on current use of health services (Ghafoori et al., 2014). In addition, further investigation focused on male DV survivors is recommended to improve prevention of abuse and overcome victimization, as this population continues to be understudied (Davis & Liang, 2014). Further research is still needed on the issue of health insurance, as the literature on this topic is limited and findings vary widely; some research has suggested that lack of health insurance prevents DV survivors from

accessing mental health services, yet our study showed that possession of health insurance did not have a significant association with use of mental health services (Roby & Jones, 2016; Schaper, Padwa, Urada, & Shoptaw, 2016). Restrictions on insurance benefits have been reported, therefore, clarification of whether a participant has coverage for mental health services is necessary to investigate the effects of whether provision of mental health services under an insurance plan is an enabling predictor of service use (Villatoro, Dixon, & Mays, 2016). Lastly, it is recommended that different measures and theoretical frameworks are used to explore other factors that may predict use of mental health services.

Implications

The findings of this research can lead to social change by identifying the factors that predict when a DV survivor of emotional abuse will not seek nor use mental health services. Survivors of DV emotional abuse may suffer from mental health symptoms, physical symptoms, functional impairment, harming behaviors, attempted suicide, and personality issues (Hymowitz et al., 2017; Vidourek, 2017). Emotional abuse may cause PTSD to the same extent it is caused by physical and sexual abuse; therefore, mental health services are critical. Survivors who do not seek mental health services are at risk of being re-victimized, experiencing worsening symptoms, and passing on DV effects to later generations (Vidourek, 2017). In addition, DV survivors tend to return to the violent relationship while feeling powerless (Lelaurain et al., 2017). Not addressing mental illness makes DV survivors from different cultural groups more vulnerable to psychological distress (Arnault et al., 2018). Therefore, the ability to recognize predictors

of mental health service use among DV survivors may help identify those who are most vulnerable, develop prevention plans, reduce DV victimization, and prevent modeling of unhealthy behavior for future generations. The symptoms that DV survivors of emotional abuse endure impact the individual, the family system as a result of family separation, and society via high costs of DV services. Social change can occur in individual, family, and societal settings. It is recommended that DV therapists develop awareness of characteristics of the most vulnerable within the DV survivor population. It is recommended that therapists familiarize themselves with research findings regarding cultural factors affecting their clients who are DV survivors and identify different predictor variables.

Conclusion

DV affects thousands of individuals, families, and communities yearly in the United States. The DV survivors experience mood problems, daily functioning problems, suicidality, personality issues, and substance abuse issues. In addition, DV survivors of emotional abuse may experience trauma and the same victim effects that a survivor of physical and sexual abuse endures. It is important that DV survivors use mental health services to address all the negative outcomes of maltreatment. Survivors who do use mental health services have found a relief in symptoms, increased daily functioning, and improved emotional wellbeing.

As previously mentioned, many DV survivors prefer seeking other professional services, such as legal and medical services, before they consider seeking mental health help. Some survivors have opted to not seek any help at all and continue suffering. Not

addressing the repercussions of DV affects the individual, but also the family system as relational dynamics tend to stay unhealthy, and at times dangerous. In addition, not addressing the victim effects of DV creates the problem of passing on unhealthy traits to future generations. Consequently, the DV effects affect the community as DV victimizations increase over the years which increases the need for resources and funds. Not reaching the DV survivor community negatively impacts the survivor, but also the individuals around.

It is important to continue exploring what factors hinder DV survivors from not using mental health services. Identifying new predisposing, enabling, and need factors that predict mental health service use can help reach the DV survivor community that has yet to be reached. Identifying service use disparities with the DV survivor's population can improve outreach strategies, accessibility of services, and further understand their needs.

This study's finding supported previous research findings around predisposing factors continuing to be a predictor variable. This study identified that DV survivors of female gender and of Caucasian race/ethnicity are more likely to utilize mental health services. The enabling factors of possession of health insurance and annual income were not predictors of mental health use. Previous research has found that enabling factors are not consistent predictors of service use. Lastly, the need factor of functional impairment was also not determined to be a predictor of mental health service use.

My study found contradicting evidence from previous research regarding need factors as previous studies did find need factors to be service predictors. There could be

numerous reasons why this research showed that possession of health, annual income, and functional impairment were not service use predictors. Limitations such as sheltering in place due to COVID-19 and limiting participation, not recruiting enough variability in races/ethnicities, and staying within Central Valley, California geographical areas could have been reasons for which enabling and need factors did not predict service use. Therefore, new research should focus on finding new predisposing, enabling, and need predictor factors to continue identifying what will help a DV survivor to use mental health help.

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Appendix A: Recruitment Flier

Have you experienced abuse in a relationship?

Participants are invited to participate in a research study conducted by Liseth Sales, a doctoral candidate at Walden University. The purpose of this study is to explore what factors hinder domestic violence survivors from using mental health services. The information that will be gathered could help prevent revictimizations and intensification of domestic violence effects.

<u>You may be eligible to participate in this study if:</u>
-You are 18 years and older
-Have experienced emotional abuse as a child or adult
-Not currently receiving counseling services

If you would like to participate in this study, please contact Liseth Sales at liseth.sales@waldenu.edu **or find me on my Facebook Page under Liseth Sales. A survey asking about emotional abuse, daily functioning, and service use will be provided.**

If you have any questions, you may contact Liseth Sales directly. You may also contact Liseth's faculty advisor, Dr. Georita Frierson, at georita.frierson@waldenu.edu.

Appendix B: Demographic Survey for All Participants

Demographic Questionnaire

1. Are you 18 years or older?
Yes
No

2. Are you currently receiving counseling/therapy/psychological services?
Yes
No

3. What is your gender?
Male
Female
Other

4. What is your race?

5. What is your yearly income?
51,000 or lower
52,000-72,000
73,000 or higher

6. Do you possess health insurance?
Yes
No

Appendix C: Negative Life Events Questionnaire

Negative Life Events Questionnaire
During your childhood or adulthood, has a significant person in your life…

7. Humiliated you?
Yes
No
Can't Remember

8. Blamed you for somebody else's wrongdoing?
Yes
No
Can't Remember

9. Criticized you for the way you look and the way you dress?
Yes
No
Can't Remember

10. Told you that you were not as good as other people?
Yes
No
Can't Remember

11. Screamed or yelled at you for no reason?
Yes
No
Can't Remember

12. Called you unpleasant names like "crazy," "idiot," or "stupid"?
Yes
No
Can't Remember

13. Made jokes about you in front of other people?
Yes
No
Can't Remember

14. Not believed you (e.g. you were making it up/lying?)
Yes
No

Can’t Remember

15. Told you that you were wrong when you said or did something?
Yes
No
Can’t Remember

16. Ignored you when you looked for physical affection?
Yes
No
Can’t Remember

17. Forced you to take responsibility for most of the house chores?
Yes
No
Can’t Remember

Appendix D: Permission to Use Negative Life Events Questionnaire

PsycTESTS

Negative Life Events Questionnaire

PsycTESTS Citation:
Pitzner, J. K., & Drummond, P. D. (1997). Negative Life Events Questionnaire [Database record]. Retrieved from PsycTESTS. doi: https://dx.doi.org/10.1037/t19696-000

Instrument Type:
Inventory/Questionnaire

Test Format:
Abuse items were grouped into sets under five headings and were answered on a scale of severity from never (1) to very often (5). Item responses for traumatic events were: the event has not occurred (0); the event has occurred once only (1); and the number of times the event has occurred if it is more than once (2, 3 ...).

Source:
Pitzner, Joanne K., & Drummond, Peter D. (1997). The reliability and validity of empirically scaled measures of psychological/verbal control and physical/sexual abuse: Relationship between current negative mood and a history of abuse independent of other negative life events. Journal of Psychosomatic Research, Vol 43(2), 125-142. doi: https://dx.doi.org/10.1016/S0022-3999(96)00370-4, © 1997 by Elsevier. Reproduced by Permission of Elsevier.

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Appendix E: Walter Reed Functional Impairment Scale

Walter Reed Functional Impairment Scale
How much difficulty do you CURRENTLY have with the following…
(0 no difficulty-5 extreme difficulty)

18. Your overall work performance
19. The quality of your work
20. Your ability to complete assigned tasks
21. Your ability to multi-task
22. Your problem solving at work
23. Your ability to get along with your co-workers
24. Your ability to interact with social groups (church, sports, clubs)
25. Your ability to get along with family or friends
26. Your ability to have a close relationship (e.g. spouse, girlfriend/boyfriend)
27. Your ability to handle personal responsibilities (keeping appointments, running errands)
28. Your ability to get your bills paid on time

Appendix F: Permission to Use Walter Reed Functional Impairment Scale

PsycTESTS®

Walter Reed Functional Impairment Scale

PsycTESTS Citation:
Herrell, R. K., Edens, E. N., Riviere, L. A., Thomas, J. L., Bliese, P. D., & Hoge, C. W. (2014). Walter Reed Functional Impairment Scale [Database record]. Retrieved from PsycTESTS. doi: https://dx.doi.org/10.1037/t36177-000

Instrument Type:
Rating Scale

Test Format:
The Walter Reed Functional Impairment Scale consists of 14 items rated on a 5-point scale (no difficulty at all to extreme difficulty).

Source:
Herrell, Richard K., Edens, Edward N., Riviere, Lyndon A., Thomas, Jeffrey L., Bliese, Paul D., & Hoge, Charles W. (2014). Assessing functional impairment in a working military population: The Walter Reed Functional Impairment Scale. Psychological Services, Vol 11(3), 254-264. doi: https://dx.doi.org/10.1037/a0037347.

Appendix G: The World Mental Health Composite International Diagnostic Interview

The World Mental Health Composite International Diagnostic Interview (WMH-CIDI)

29. Did you ever in your life have a session of psychological counseling or therapy that lasted 30 minutes or longer with any type of professional?
Yes
No
Don't Know
Refused

30.Which one of the following types of professionals did you ever see about problems with your emotions or nerves?
A. Psychiatrist
B. Psychologist
C. Social Worker
D. Counselor
E. Any Other Mental Health Professional Such as Psychotherapist or Mental Health Nurse
F. None
G. Refused

Appendix H: Permission to Use The World Mental Health Composite International Diagnostic Interview

Thank you for your email,

We are currently working on the CIDI-5 to assess DSM-5 diagnoses and we are no longer supporting the DSM-IV survey. Training is required to use any section of the CIDI-5 and I can provide the contact information at the University of Michigan if you are interested.
However, if you are only interested in using Service Use section, we do not score any algorithms for that section so you can simply download the Paper and Pencil version (PAPI V7.1) from the website (http://www.hcp.med.harvard.edu/wmhcidi/download-the-who-wmh-cidi-instruments/)

Please cite this article in any papers:
Kessler, R.C., & Ustun, T.B. (2004). The World Mental Health (WMH) Survey Initiative Version of the World Health Organization (WHO) Composite International Diagnostic Interview (CIDI). *International Journal of Methods in Psychiatric Research,* 13(2), 93-121.