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Treatment Barriers Confronted by African American Women in Past Abusive Relationships

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MPhil, Walden University, 2020

MS, University of Phoenix, 2009

BS, Thomas Edison State University, 2007

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

Intimate partner violence (IPV) is a widespread problem that impacts 5.3 million women annually in the United States, and African American women experience IPV at a 35% rate higher than Caucasian women and 2.5 times higher than other races. The purpose of this qualitative phenomenological study was to examine the treatment barriers confronted by African American women in past abusive relationships. This research addressed the extent to which IPV affected African American women regarding the challenges resulting from IPV, the relevant impacts, and the treatment barriers. The ecological systems theory developed by Bronfenbrenner in 1979 was used as the theoretical basis for this study. One-on-one interviews were used to collect data from a sample of 15 African American women survivors of IPV who were over 18 years of age. Descriptive statistics, including frequencies and distributions derived from SPSS (version 21) were employed to describe the study sample. An NVivo 12 qualitative analysis tool was used to analyze the data collected from interview transcripts to answer the research questions. The study results document treatment barriers that include treatment costs, shame, discrimination, negative stigma, and distrust. The key themes include the closure of the microsystem, cultural inhibitions and treatment cost as macrosystem barriers, connecting with providers and opening the relationship microsystem, and the need for belief and acceptance. This study is significant to positive social change at individual, family, societal, and policy levels. Researchers and practitioners will be informed about strategies to implement support groups run by African Americans and social policies to address institutionalized racism African American women survivors of IPV experience.

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Dedication

I want to dedicate this dissertation to my two daughters Shaheedah and Mya. My loves, you have encouraged, inspired, and motivated me to pursue my dreams and to finish this dissertation. You guys are the reason why I never gave up on completing my PhD. You cheered me on at times I was discouraged and made me laugh at times when I felt like crying. I strive to persevere, defeat all odds, be a good role model, and show what dedication and hard work becomes. As a young girl, growing up in Newark, NJ, I would often experience doubt for success. I dedicate this dissertation to everyone that has overcome adversity. Through strong will and determination, anything is possible. I want to encourage positive thoughts, self-love, patience, persistence, kindness, empathy, bravery, optimism, gratitude, and forgiveness to everyone.

I also want to dedicate this dissertation to all affected by violence and trauma, with a special dedication to anyone who lost a life to an intimate partner.

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Lastly, to all my loved ones, friends, and colleagues that I have connected with while in the PhD program, “We did it!”

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Chapter 1: Introduction to the Study

Interpersonal violence against women is a problem associated with deleterious consequences for societies and families (Lacey & Mouzon, 2016). Consequently, proper understanding of the treatment barriers that women in abusive relationships confront is critical in the detection, assessment, treatment, and prevention of such interpersonal abuse (Hall & Fields, 2015; Levine, 2018). This is especially true for African American women, as historically and culturally, this population tend not to seek professional assistance when they become victims of domestic violence due to various socio-economic and cultural barriers (Anyikwa, 2015). These women may face high levels of social discrimination and judgment regarding their experiences of intimate partner violence (IPV), which then impacts their willingness and subsequent access to treatment (Healey, 2010; Valandra et al., 2016). However, researchers have yet to explore the barriers to treatment for ethnic minority women within the cultural context fully. There has been an absence of systematic studies that focus on African American women in abusive heterosexual relationships (Al'Uqdah et al., 2016; Cunningham et al., 2018). Therefore, I examined interpersonal violence in the African American community and treatment barriers that are confronted by African American women who have been in past abusive heterosexual relationships.

Background of the Study

Domestic violence is a global issue that impacts millions of women, children, and men across all social classes and religious backgrounds (Foushee, 2016). Studies have shown that there are many risk factors associated with domestic violence including a

history of childhood abuse and exposure to parental/family violence (Howard et al., 2010; Yan & Karatzias, 2016). For the purposes of this study, I focused on a form of domestic violence called IPV. IPV is also known as "spousal abuse" and is described as a single or recurring act of abuse by a current or former intimate partner (Miller et al., 2014; Park, 2016; Rodriguez et al., 2009). The abuse may be mental, physical, or sexual in nature (Miller et al., 2014; Park, 2016; Rodriguez et al., 2009).

The Centers for Disease Control and Prevention (2015) has estimated that 4,450,807 women in the United States are assaulted each year by an intimate partner (see also Breiding, 2015). Moreover, domestic violence maintains the highest rate of repeated victimization compared to any other violent crime (Howard et al., 2010; Miller et al., 2014). IPV is the most common form of violence toward women and is a leading contributor to the global burden of mental health problems among women (Sabri et al., 2015; Beck et al., 2014). However, women may feel ashamed and embarrassed when disclosing IPV to professionals (Sabri et al., 2015).

Factors Associated with Domestic Violence

Studies have linked socioeconomic factors such as poverty to increased incidents of domestic abuse or violence. For example, risk factors associated with being a victim of domestic violence may include living in poverty or communities with high levels of violence (Howard et al., 2010; Hitchens & Payne, 2017). Partner abuse is compounded by social problems such as poverty, homelessness, and high rate of substance abuse (Bubriski-McKenzie & Jasinski, 2014; Hitchens & Payne, 2017; Lucea, et al., 2013). The high prevalence of IPV among African American women can be attributed, in part, to

socioeconomic factors (Haeseler, 2013; Nicolaidis et al., 2010). Mental health resources for minority women effected by IPV in poverty-stricken communities are inadequate. For example, numerous African American women effected by IPV in these communities have not been able to obtain the mental health services they need because of financial limitations and other socioeconomic factors (Haeseler, 2013).

Cultural variables have also been shown to affect domestic violence in a complex way (Hitchens & Payne, 2017). African American women are more likely to experience discrimination based on race, ethnicity, sex, class, historical collective trauma, among other cultural factors (Bubriski-McKenzie & Jasinski, 2014; Hitchens & Payne, 2017; Lucea, et al., 2013). Discriminatory experiences have resulted in decreased likelihood to seek formal help from mental health professionals, as they might perceive these professionals as another source of discrimination (Valandra et al., 2016; Williams & Jenkins, 2015). African American women survivors of abuse are less likely to disclose the incident of abuse compared to White women because of their experience with negative social attitudes toward victims of sexual assault (Bryant-Davis et al., 2009; Sabri et al., 2015). African American women affected by IPV view the health care system as being racially biased with lack of communication and treatment (Nicolaidis et al., 2010; Cheng & Lo, 2015). Collectively, there is a need for culturally sensitive mental health assessment and interventions for survivors of IPV among African American women (Taha et al., 2015).

Further, African American women are pressured into assuming the role of a strong Black women; they are discouraged from seeking mental health care because the

family or community views it as a sign of weakness (Nicolaidis et al, 2010). African American female clients may feel that there is a negative stigma associated with seeking mental health services (Sabri et al., 2015). IPV stigma operates at the sociocultural, individual, and interpersonal levels, leaving victims to feel rejected, devalued, and excluded (Overstreet & Quinn, 2013). In addition to stigma, fear of retaliation and embarrassment are other factors that inhibit these women from seeking help (Sabri et al., 2015; Valandra et al., 2016). Cultural factors that pose a barrier to seeking help may include negative attitudes toward the victims such as blaming the victim and questioning their credibility by family, friends, or legal authorities (Bryant-Davis et al., 2009; Haeseler, 2013; Sabri et al., 2015).

Other variables such as therapist characteristics (e.g., lack of knowledge in IPV) contribute to the reduced likelihood of African American women to seek mental health treatment. To provide services to battered victims in health care settings, training is essential (Stover & Lent, 2014). When clinicians lack the training in domestic violence, detecting IPV may become difficult (Rodriguez et al., 2009; Simmons et al., 2016). Studies have shown that few clinicians screen for mental health conditions like depression with domestic violence survivors, particularly with ethnic minority patients (Rodriguez et al., 2009; Tavrow et al., 2016). In other instances, some African American female clients feel discriminated against by the clinicians (Cheng et al., 2015). The media may promote negative stereotypes of African American men as sexually aggressive and violent, insinuating that domestic violence increasingly affects African American women,

which can impact providers' treatment practices when serving African American clients (Weeks et al., 2008; Valandra et al., 2016).

At the institutional level, the health care system presents additional barriers for African American female victims of domestic violence. Physicians have reported challenges that include fear of offending or angering the victim, lack of IPV training, lack of time, and belief that IPV is not an issue with the type of patients they service (DeBoer et al., 2013). Many professionals providing care to IPV patients may also view the work as low paying, frustrating, and boring (Sprague et al., 2012). Thus, some health care providers choose not to see patients without insurance coverage. Moreover, providers have often felt less positive about spending extra time when screening for domestic violence because of fiscal restraints within the health care environment (Weeks et al., 2008; DeBoer et al., 2013). Training health care clinicians to provide care with appropriate attitudes and sensitivity toward ethnic minority patients is critical (Alvarez et al., 2016; Rodriguez et al., 2009; Roush & Kurth, 2016).

Additionally, to increase awareness among providers and institutions, training in screening and multicultural sensitivity should be conducted within the health care system to better assist female IPV survivors of ethnic minority groups. Researchers have shown the effectiveness of universal screening in reducing IPV (Choi et al., 2015; Nelson et al., 2012). Health care organizations such as the American Medical Association, U.S. Preventive Services Task Force, and the Joint Commission on Accreditation require IPV screening for all patients. There has been an increase in the number of programs that provide clinicians practicing in a hospital setting with the training to identify domestic

violence victims and properly refer them for additional mental health care (Ambuel et al., 2013). However, many health care professionals express frustration because they are required to screen all patients, and screening might overshadow other major medical issues or concerns (Roush et al., 2016). Health care professionals may also feel uncomfortable with discussing the topic of domestic violence with a patient, holding that it is a personal and private matter (Roush et al., 2016). Finally, workload and time issues are a concern for health care providers when screening domestic violence victims (Alvarez et al., 2016).

Specific Mental Health Issues and Treatment Associated with IPV Victims

Post-traumatic stress disorder (PTSD) and depression are the most prevalent mental health disorders that are associated with victims of domestic violence (Flicker et al., 2012; Howard et al., 2010). Victims of IPV may also experience suicidal behavior, eating disorders, and social dysfunction (Lutwak, 2018). Women victims of domestic violence are more likely to develop substance abuse patterns or other maladaptive behaviors as compared to women without a history of IPV (O'Brien et al., 2016). Depression and PTSD impact the function of an IPV victim, including their ability to establish and maintain relationships as well as impair their ability to perform routine activities of self-care and other daily tasks (Flicker et al., 2012; Helfrich et al., 2008).

Treatment for IPV may allow victims to resolve their past traumas, create healthier relationship patterns, and improve any mental health issues. Treatment options for the mental health effects of IPV include social support, spiritual support, and counseling. Talking to a mental health specialist can be beneficial for IPV survivors

because mental health professionals are trained to help clients process their thoughts and feelings associated with the abuse as well as provide appropriate coping skills. Supportive counseling from professional and peer groups may be effective in helping IPV survivors to improve their self-esteem and affect regulation capacity, assertiveness, social supports, coping abilities, and self-efficacy (Zosky, 2011). However, empirically supported treatments remain understudied with ethnic minority groups (Arnette et al., 2007; Miller et al., 2014; Simmons et al., 2016; Taha et al., 2015). Therapeutic intervention that is culturally sensitive would enhance coping skills that is commonly employed by individuals within that community while addressing common factors to all individuals (Arnette et al., 2007; Simmons et al., 2016).

Social support can be another effective treatment option for African American women impacted by IPV. Social support may help mediate the relationship between IPV and its negative mental health effects (Bryant-Davis et al., 2009). African American female survivors of IPV may find more comfort in social support from their community rather than disclosing the victimization to police officers or medical professionals (Bryant-Davis et al., 2009). Utilizing social support has helped survivors of IPV to address the traumas associated with IPV (Bryant-Davis et al., 2009). Family and friends have been found to be the most useful and helpful source for survivors of IPV (Sullivan et al., 2018).

Finally, spirituality can be a form of intervention and support for the mental health of IPV women (Watson-Singleton et al., 2017). Most African Americans hold religious and spiritual beliefs that provide guidance in their lives (Sullivan et al., 2018).

This form of coping may involve using religious beliefs and spiritual practices to solve problems and improve negative emotions associated with difficult experiences (Arnette et al., 2007; Lilly et al., 2015). Spiritual coping is personal and provides a sense of purpose and meaning in one's life (Arnette et al., 2007; Lilly et al., 2015). The main goal of this approach is to increase the power, self-esteem, intimacy, and intervention efficacy to decrease the severity and symptoms of IPV.

Statement of Problem

In the United States, IPV is a widespread problem that impacts 5.3 million women annually (Arnette et al., 2007; Modi et al., 2014; Park, 2016). Domestic violence was declared the biggest health crisis of the 1980s by U.S. Surgeon General C. Everett Koop (Park, 2016; Modi et al., 2014). Among victims of IPV, African Americans are disproportionately represented, experiencing IPV at a rate 35% higher than that of White women and approximately 2.5 times that of women of other races (Arnette et al., 2007; Lacey et al., 2016).

Given this problem, it was important to study the extent to which IPV impacts African American females. A gap in the literature existed regarding ethnically diverse women, such as African American females, who are affected by IPV and experience barriers to mental health treatment (Rodriguez et al., 2009; Valandra et al., 2016). A study was needed to gather qualitative information from African American females and provide insight on the treatment barriers and the overall healthcare system as it relates to IPV treatment.

Purpose of the Study

The purpose of the study was to explore barriers to treatment for African American IPV victims and their views of the healthcare system. This study was critical because research has reported that women in abusive relationships face treatment barriers that impact their access to mental health care and treatment outcomes. However, information related to African American IPV victims is lacking. It was hoped that this study would provide an understanding of these barriers in order to enhance treatment outcomes.

Research Questions

This study was qualitative in nature and addressed the following research questions:

Research Question 1: What are the overall experiences of African American women survivors of IPV regarding the impact of IPV from an ecological perspective?

Research Question 2: What are the treatment barriers faced by this group of individuals from an ecological framework?

Research Question 3: From an ecological perspective, what are the views and experiences of African American women survivors of IPV with the health care system?

Research Question 4: What additional resources do survivors of IPV need in order to repair their traumas and thrive?

Theoretical Framework

The theoretical framework for this study was the ecological systems theory, specifically the microsystem and macrosystem (Darling, 2007). The ecological systems

theory, developed by Bronfenbrenner in 1979, is focused on mental processes that guide individual lifespan development. The ecological systems theory emphasizes that the person and environment shape experiences. In accordance with Bronfenbrenner's ecological systems theory of human development, everything is interrelated (Darling, 2007).

The ecological systems theory consists of five structures of development: microsystem, mesosystem, exosystem, macrosystem, and chronosystem (Bronfenbrenner, 2000; Bronfenbrenner & Ceci, 2003). The microsystem consists of relationships and interactions with immediate family members—for example, the abuser and the abused. The mesosystem consists of relationships and interactions with persons or systems in the environment such as with extended family. The exosystem consists of settings that do not directly involve the individual, but the individual may be affected by what happens within the setting. The healthcare system may be a setting in which the individual may be affected. Next, the macrosystem consists of culture and subculture systems from which stereotypes may arise. Lastly, the chronosystem consists of environmental factors that involve external and internal changes. Internal changes could include the aging process of an individual, and external could include the untimely death of a loved one.

The micro and macro system were selected among the five systems for this study because they were considered the most feasible structures for the study (Bronfenbrenner, 2000). This theoretical approach guided this study in the exploration of the experience of African American women survivors of IPV. Chapter 2 presents a more thorough explanation of these systems.

Nature of the Study

A qualitative phenomenology methodology was used for this research study. Participants were interviewed to explore treatment barriers African American women in abusive relationships confront. A phenomenological examination was applied to this study, as the intention is to explore the lived experiences of African American women in abusive relationships (Moustakas, 1994). Data were gathered to explore the life experience of these women regarding barriers to treatment and unique experiences of the health care system. Qualitative analysis was used to determine themes related to the research questions.

Definitions of Terms

Abuse: The act of mistreating or injuring another person verbally, psychologically, or physically.

African American: A person having origins in any of the Black racial groups, living in the United States (U.S. Census Bureau, 2014).

Domestic violence: Domestic violence was used to mean the physical, sexual, or psychological abuse of an intimate partner, which is associated with a host of direct (injury, rape, or death) and indirect (stress-related illnesses, such as cardiovascular and immune diseases) consequences to those exposed and results in an enormous public health issue in the United States (Stover & Lent, 2014).

Intimate partner violence (IPV): Threatened, attempted, or completed, physical, sexual, and/or emotional abuse by a current or former partner or spouse (Centers for Disease Control and Prevention, 2014).

Mental health: A state of complete physical, mental, and social well-being. This state does not merely equate with the absence of disease. Mental health is related to the promotion of well-being, the prevention of mental disorders, and the treatment and rehabilitation of people effected by mental disorders (World Health Organization, 2014).

Survivor: An individual who has lived beyond tragedies in life. In this study, the term *survivor* refers to abused women who were able to successfully leave their abuser.

Assumptions, Scope and Delimitations, Limitations

Assumptions

There are major implications and theories related to the experience of IPV. It was assumed that these theories can be used to help understand what women of the African American community in abusive relationships face and the impact on mental health. It was assumed that the questions in the study assessed the information needed to address research questions and that all participants would answer questions openly and honestly.

Scope and Delimitations

The scope of the study is gender-specific and included a sample of African American women in or have been in an exclusively heterosexual abusive relationship. Since these women do not always obtain the help when involved in abusive relationships, it is important to understand internal and external barriers to accessing treatment. The scope of the study was also delimited by the theoretical framework, the ecological systems theory, specifically the microsystem and macrosystem (Darling, 2007). This theory helped explain micro and macro system factors that serve as barriers for participants. Though there may be other factors that impact outcomes, this theory was

chosen in order to understand barriers to treatment that can be improved by programs designed to help these women.

Limitations

This study is limited to African American women who are in a heterosexual abusive relationship or have been in a heterosexual abusive relationship. The geographic location of the participants is a potential limitation due to cultural considerations in specific areas of the country, which could impact individual and social viewpoints. Participants in the study are also from low socioeconomic status, which could result in differing viewpoints regarding IPV compared to views of women from higher economic backgrounds. Thus, findings may not generalize to other populations or locations.

Significance of Study

This study addresses an under-studied area concerning African American women affected by IPV and treatment barriers. Women affected by IPV have considerable mental health challenges, including depression and PTSD. Symptoms experienced by battered women are consistent with PTSD as a result of multiple victimization experiences (Jones et al., 2001; Lilly et al., 2015; Miller et al., 2014). But African American female survivors of IPV face many barriers when seeking mental health treatment, including socioeconomic status, discrimination, negative stigma, distrust in the health care system, and other significant cultural factors (Nicolaidis et al., 2010). African American women have expressed negative experiences with health care providers that included minimal time spent during appointment, inadequate explanation of services being provided, and a lack of emotional support (Nicolaidis et al., 2010). Therefore, this

study will positively impact the community by aiding women facing IPV through various support avenues after experiencing IPV.

Summary

In the United States, IPV is a problem that affects 5.3 million women annually (Modi et al., 2014). Treatment for IPV allows victims the opportunity to resolve their mental health issues (Beck et al., 2016). However, there have been limited research studies on African American women survivors of IPV that address their experience with IPV and explore treatment barriers. The purpose of this study was to explore barriers to treatment by female, African American IPV victims and their associated views of the healthcare system. Results of this study may be critical for women in abusive relationships facing treatment barriers to mental health and treatment outcomes in addition to providing a better understanding of the overall experience of African American women survivors of IPV.

This chapter presented the background of the study, statement of the problem and a summary of research, the study purpose and research questions, a theoretical framework, assumptions, scope and delimitations, and limitations, nature of the study, definitions, and the significance of the study. Chapter 2 includes a review of literature related to the study topic. The review provides support for the current study, including a discussion of key issues in understanding IPV with an overview of IPV, mental health problems, abusive relationships and mental health, abusive relationships in societal context, treatment barriers, and overcoming treatment barriers. Chapter 3 explains the methods that were used to gather and interpret the data.

Chapter 2: Literature Review

Introduction

The purpose of this literature review was to explore research on African American women survivors of IPV and related treatment barriers to provide support for the current study. IPV is a serious public health issue that involves multiple forms of abuse by a partner (Centers for Disease Control and Prevention, 2014). African American women experience IPV 2.5 times more often than women of other races and at a rate 35% higher than White women (Arnette et al, 2007; Lacey et al., 2016). However, barriers to mental health services by minority women survivors of IPV are not well understood, though they may reflect factors associated with individuals' beliefs, practices, and lack of resources (Rodríguez et al., 2009; Sabri et al., 2015). Discrimination, therapists' lack of training, limited mental health services, and the lack of IPV screening are treatment barriers identified by therapists and the mental health care system (DeBoer et al., 2013; Rodgers, Grisso, Crits-Christoph, & Rhodes, 2016; Samples et al., 2012). The following sections present the literature search strategy, theoretical foundation, and a synopsis of the current literature regarding topics of IPV treatment barriers. This is followed by a summary and conclusions.

Literature Search Strategy

The PsycINFO database was utilized to gather scholarly articles pertinent to the study. Search terms included *domestic violence*, *intimate partner violence*, *treatment barriers*, *women*, *African American*, *ethnic minority*, *mental health care*, *health care barriers*, *health care screening*, and *mental health effects*. PsycARTICLES research

database was also utilized using similar search terms including *mental health services, stigma,* and *battered women*. The articles produced from this search strategy offered additional resources from the references of previous authors. The Walden online library has a "Find Similar Results" tool to locate articles not found in the original search using search terms, which I used to locate articles where there was little current research.

Theoretical Foundation

The theoretical framework for this study was the ecological systems theory, specifically the microsystem and macrosystem (Darling, 2007). Developed by Bronfenbrenner (1979), the ecological systems theory focuses on mental processes that guide individual lifespan. The ecological systems theory posits that the person and environment shape experiences; thus, human development is impacted by their environment (Bronfenbrenner, 2000). Further, systems of relationships are interrelated and impacted by context, culture, and history (Darling, 2007). The interrelationship between individual development, contextual variability, and individual difference embody the core of the ecological systems theory (Darling, 2007). This theoretical approach guided the present study in the exploration of barriers faced by African American women survivors of IPV. The ecological systems theory consists of five structures of development: microsystem, mesosystem, exosystem, macrosystem, and chronosystem (Bronfenbrenner, 2000), but this study focused on the micro and macrosystem because they address family and cultural group, which are relevant to the study.

Microsystem

The microsystem consists of relationships and interactions with immediate family members (Bronfenbrenner, 1979). In the context of IPV, the abuser and the abused reflect the microsystem. The microsystem considers the immediate setting for the individual. The central force in development is being an active person, shaping environments, evoking responses from the environment, and reacting to them (Darling, 2007). An individual's interactions or proximal processes occur during development and may demonstrate the potential for effective psychological functioning (Eamon, 2001). Enduring patterns of proximal process are usually located within parent and child, peer activities, group or solitary play, learning, and performing complex tasks (Bronfenbrenner & Ceci, 2003). For the interactions to be effective within the microsystem, they must occur with regularity over an extended period throughout development (Eamon, 2001). These interactions shape behaviors and may impact attitudes and actions related to IPV and access to treatment. Interrelationships IPV survivors have with their family, friends, and community may serve as a treatment barrier.

Further, the immediate environment within the microsystem can either help or impede development, which impacts an individual's attitudes and behaviors across the lifespan (Eamon, 2001). Whether genetically or environmentally determined, child characteristics influence developmental outcomes and reactions to life circumstances (Eamon, 2001). These early experiences shape development and responses and may impact how African American women respond to IPV. Socioeconomic factors such as

stress and coping could affect the developmental outcome of an individual. In the home environment, if poverty is an issue, the strain of stressors of life's circumstances can cause psychological distress (Eamon, 2001). Some coping skills to relieve the strain of stress in the home environment may include being an active participant for obtaining social resources (Watson-Singleton et al., 2017). A diminished coping ability creates a sense of powerlessness that can affect self-esteem, control, a sense of personal efficacy, making it difficult to engage in active problem solving (Eamon, 2001). These issues may also serve as treatment barriers for IPV victims.

Macrosystem

The macrosystem consists of culture and subculture systems from which stereotypes may arise. The structure of the macrosystem includes the influences of the broader cultural and socioeconomic environment of the individual (Eamon, 2001). The macrosystem also includes the individual's ethnicity and race. Bronfenbrenner referred to the macrosystem as the blueprint that, in part, determines social structures and activities that occur in immediate system levels (Eamon, 2001). An individual's cultural beliefs, customs, and cultural practices influence behavior and developmental outcomes. Culture-related stigma concerns, such as being called "crazy" when seeking mental health treatment, are among cultural practices that influence behavior (Rodriguez et al., 2009). Cultural beliefs within the religious communities of African Americans reinforce nondisclosure of IPV issues and maintaining violent relationships despite the negative effects because of stigma (Rodriguez et al., 2009).

Though they may create a barrier, African American cultural values and roles such as religion, extended family, strong support, and affection are vital forces to cope with violence (Bryant-Davis, 2005). Disadvantaged African Americans who are confronted with limited economic resources and chronic psychosocial stressors hold the belief that hard work and self-determination are required to cope with and overcome adversities (Stevens-Watkins et al., 2013). Socioeconomic status is a factor that influences the relationship between abusive relationships and ethnicity (Al'Uqdah et al., 2016). Thus, higher levels of IPV in the African American community may be related to these macrostructural factors and influence treatment barriers. The relationship and cultural factors influencing African American women need to be examined in order to understand treatment barriers they face and ensure optimal intervention programs.

Literature Related to Key Concepts

The legacy of discrimination and slavery influences the social and economic standing of African American women and impacts their mental health. Ethnically diverse women confront prejudice and discrimination based on their ethnic background and fear of being labeled as less intelligent, which may pose one of many barriers for using mental health services (Rodriguez et al., 2009). Cultural emphasis on self-reliance may lead to some African American women to assume that utilizing mental health services would be similar to announcing weakness (Rodriguez et al., 2009), so many African American women do not confront unhealthy relationships where their relationships and mental health are affected. This study was focused on the treatment barriers confronted by African American women in abusive relationship (Scheffler & Miller, 2008). The

literature review will further explain the factors that influence major treatment barriers. The following sections provide a review of the current literature that includes studies related to the study constructs. The topics presented are consistent with the study variables of IPV, barriers to treatment, and related issues. This discussion is followed by a summary and conclusions.

Key Issues in Understanding Intimate Partner Violence

Major issues involved in IPV treatment barriers include demographic and socioeconomic status of African American women, provider bias, and attitudes toward abusive relationships. These factors need to be understood to ensure optimal treatment of this population (Raskin & Crook, 2005). Perceptions about domestic violence are also important to better understand and address the issue and minimize treatment barriers. The difficulty with creating effective intervention strategies to address IPV lies within the manner by which African American women understand domestic violence and perceive the impact on their mental health (Bent-Goodley, 2004). The National Black Women's Health Project recognized domestic violence as a major issue for African American women, but some African Americans may refuse to perceive it as an issue (Avery, 1990).

Overview of Intimate Partner Violence

Domestic violence may involve abuse from a partner, but the study of this phenomenon as it relates to African American females is limited. The following sections present issues involved in IPV. These include perceptions of IPV and physical health status of victims.

Perceptions of Intimate Partner Violence

Over the past 20 years, empirical research has accumulated regarding domestic violence and African American women, but many questions linger about African American perceptions of domestic violence (Bent-Goodley, 2004; Dillon et al., 2013). Absence of a clear understanding of how African Americans interpret domestic violence and its impact is a major problem, making it unfeasible to create effective intervention strategies to address this problem (Bent-Goodley, 2004).

Domestic violence has often been associated with abuse or beatings by an intimate partner. In a study conducted with African American women participants about their perception of domestic violence, Bent-Goodley (2004) revealed that after being provided with the definition of domestic violence, many participants felt that beatings and abuse should be differentiated. Clarification about what is considered abuse, such as slapping, pushing, and shoving, was defined as less serious, whereas considered beatings to be domestic violence (Bent-Goodley, 2004). But in the absence of a clear understanding of domestic violence, victims may face challenges with acknowledging the problem and seeking help.

In general, the existing research points to the need for a better understanding of diverse perceptions of domestic violence and to find culturally competent methods of addressing the inaccessibility of treatment services (Bent-Goodley, 2004). Existing research also suggests that there needs to be more culturally appropriate public education addressing domestic violence as well as more research on domestic violence in communities of color (Bent-Goodley, 2004).

Physical Health Status

IPV is associated with depression, PTSD, anxiety, self-harm, and sleep disorders with some variation in prevalence of IPV across cultural settings (Dillion et al., 2013; Sabri et al., 2018). IPV is also linked to poor physical health, somatic disorders, chronic disorders and pain, and gynecological problems (Dillon et al., 2013). Physical health issues related to IPV victims may include broken bones, facial trauma, cardiovascular conditions, and gastrointestinal illnesses (Howard et al., 2010). Rape, unwanted pregnancies, stress-related illnesses, substance use, suicide, and homicide are also among the physical health issues of IPV (Bent-Goodley, 2004). Therefore, domestic violence presents many serious physical health risks (Bent-Goodley, 2004; Dillon et al., 2013). It is estimated that "more than 1.5 million women nationwide seek medical treatment for injuries related to abuse each year" (Stark, 2001, p. 347). Further, IPV attacks on African American women include a high risk of injury to the head and brain, which means they may be more susceptible to sustaining traumatic brain injury (Banks & Ackerman, 2002; Furlow, 2010). Ultimately, the poor physical health status of African American women may serve as a barrier to treatment, which may impact mental health outcomes (Lichtenberg et al., 2008).

Mental Health Problems

The mental health problems faced by victims of IPV are detailed in this section to help understand the different factors considered in this study. The symptoms of mental disorders are mentioned to identify the effects of abusive relationships within a mental health context. The most common mental health issues associated with IPV include

depression, suicidal behavior, and PTSD (Howard et al., 2010). Many researchers have also found that IPV led to anxiety, self-harm, and sleep disorders (Comeau and Davies, 2012; Dillon et al., 2013; Ouellet-Morin et al., 2015; Mapayi et al., 2013). Depression and PTSD are among the most prevalent mental health disorders diagnosed in relation to IPV (Campbell, 2002). This depression may be present with or without the additional diagnosis of PTSD (Golding, 1999).

Post-Traumatic Stress Disorder

PTSD is prevalent among African American women survivors of sexual assault by a current partner (Bryant-Davis et al., 2009). Symptoms of PTSD may fall into three categories: re-experiencing the traumatic event, avoidance and numbing, and hyper arousal (Jones et al., 2001). Re-experiencing a traumatic event such as with domestic violence, the victim may have nightmares and flashbacks. Other symptoms such as sleeplessness, hyper vigilance, and irritability are symptoms of PTSD in the hyper arousal stage (American Psychological Association, 2013; Jones et al., 2001; Rosen, 1999; Thompson et al., 1999). IPV women survivors experiencing PTSD symptoms may avoid familiar places where their abusers may be able to locate and track them (Brush, 2000; Helfrich et al., 2008).

Depression

Depression is a common mental health disorder that is related to victims of domestic abuse (Ouellet-Morin et al., 2015). The symptoms of depression have been associated with the mental impairment and day-to-day performance of the individual (American Psychological Association 2013). Depression includes classic symptoms of

sadness, hopelessness, social isolation, guilt, loss of energy, and suicidality (Nicolaidis et al., 2010). Depression can also affect victims' ability to parent, establish and maintain relationships, pursue goals, maintain physical appearance, perform at work, and make good decisions (Helfrich et al., 2008). Symptoms of depression may cause confusion, an inability to concentrate, and forgetfulness, resulting in reduced ability to be self-sufficient and live independently (Helfrich et al., 2008). The length, severity, and type of abuse (psychological, physical, or sexual) are important factors in the severity of mental illness symptoms (Howard et al., 2010). Additionally, depression is common among African American battered women and survivors of sexual assault, particularly in the weeks following the assault (Bryant-Davis et al., 2009; Rickert et al., 2000). African American women with a history of IPV suffered from depression more than women of other ethnic groups (Robertiello, 2006).

Suicide Risk

Research has demonstrated that there is an increased risk for suicidal behavior of African American women who are victims of IPV (Meadows et al., 2005). IPV more than doubles the risk of suicide attempts among African American women in comparison to women of other cultural background (Meadows et al., 2005). Abused women with depressive symptoms also have increases in the occurrences of suicidal ideation (Howard et al., 2010). Up to 80% of suicide attempts were committed by women who referenced IPV as a significant stressor and motivator for self-harm (Meadows et al., 2005).

Many researchers reported that IPV experience is linked to increased risk of depression and depression is linked with suicide (Devries et al., 2013). Devries et al.

(2013) conducted a systematic review and meta-analysis of longitudinal studies published before 2013 to explore these links. Specifically, the authors reviewed over 22,000 records from 20 databases to determine links between physical and/or sexual intimate partner or dating violence and depression or major depressive disorder, dysthymia, mild depression, or suicide attempts. Findings from 16 studies with 36,163 participants that met inclusion criteria were that for women, IPV was related to incident depressive symptoms, with 12 of 13 studies showing a positive direction and 11 studies demonstrating statistical significance. IPV was also associated with increased number of suicide attempts for women. The authors concluded that IPV is associated with depressive symptoms in women and this is linked to suicide attempts.

Anxiety

Anxiety is a consequence of IPV (Zacarias et al., 2012). Zacarias et al. studied 1442 women, aged 15–49 years, who had been exposed to IPV. The researchers found that IPV victimization during the previous 12 months was linked to symptoms of depression, anxiety, and somatization. However, significant effects were not independently related to depression, anxiety, and somatization. The authors explained that this lack of independent relationship may have been influenced by women's self-report of these symptoms and the notion that controlling behaviors, rather than the abusive acts, was more impactful on mental health outcomes of the participants. The study found that there was a link between symptoms of anxiety and smoking, control over partner, comorbidity with depression, and somatization. Alternatively, anxiety was inversely related to control by partner and social attachment.

Mapayi et al. (2013) found that IPV led to anxiety as well as depression. Mapayi et al. (2013) examined IPV in Nigeria to better expand on IPV in diverse cultures. Mapayi et al. (2013) surveyed a sample of women attending the Enuwa Primary Health Care Center, Ile-Ife, to determine the link between IPV, anxiety, and depression. The descriptive, cross-sectional study included 373 women who were assessed with the Composite Abuse Scale, the Hospital Anxiety and Depression Scale, and a sociodemographic scale. Results of this study revealed that 36.7 % of participants reported IPV within the past year, and of this group, 5.6 % reported anxiety, and 15.5 % reported depression. Both anxiety and depression were found to be significantly related to IPV.

Substance Use

According to the Centers for Disease Control and Prevention (2015), consequences of IPV include: using harmful substances, cigarette smoking, alcohol consumption, driving under the influence, and illicit drug use. Holden, McKenzie, Pruitt, Aaron, and Hall (2012) conducted a cross-sectional study of 602 women who experienced IPV. For this study, participants provided self-reports of their experiences of abuse during and after pregnancy. The participants included multiple races and ethnicities: "American Indian/Alaska Native (n=4), Asian (n=6), African American (n=428), Multi-racial (n= 1), Native Hawaiian/Pacific Islander (n=2), White (n=48), and Hispanic (n=109)" (Holden et al., 2012, p. 226). The participants ranged in age from 11 to 45 years. Of the 602 participants, 24 reported using drugs or alcohol during their

pregnancy and 15 reported using drugs or alcohol in their past. The participants also reported their experience of problems handling substance or alcohol use.

Mason and O'rinn (2014) reported that IPV is a serious problem for many women. IPV is related to physical injury as well as substance use problems. According to these authors, up to 50% of women participating in mental health treatment and/or substance use treatment programs reported a history of IPV. These authors conducted an extensive review of the literature to explore related articles from 2005 to 2014. IPV impacts include substance use and substance use is involved in IPV as a risk factor.

Abusive Relationships and Mental Health

It is necessary to understand the complexity of abuse and its effect on the wellbeing and mental health of women in abusive relationships. There is a cycle of violence that can be used to describe what these women experience. The cycle of violence includes an incident or any type of physical, emotional, or sexual abuse. The cycle begins with a tension building stage during which the abuser is first angered and verbally abusive, and communication breaks down. During this tension phase, the victim tries to calm the abuser and may feel like they need to "walk on egg shells". As the tension mounts, it eventually leads to the explosive abuse incident. After the abuse, the making up or honeymoon phase begins. During this phase, the abuser may apologize and promise that no abuse will ever happen again. The abuser may deny or minimize the abuse or blame the victim for it. The next phase in the cycle includes a lack of abuse. This is the calm phase when the victim hopes the abuse has ended and the abuser acts as if it never happened. There is an absence of abuse at this time and the abuser may present

the victim with gifts. As the cycle continues, the tension again builds and so on. Each stage can last a different amount of time ranging from hours to a year or more. Making-up and calm stages may decrease or all-together disappear as time continues (Katerndahl et al., 2010; Walker, 1979).

There are various models to define what is considered abuse. The *sociocultural model* posits that there is a defined class of behaviors in each culture group that can be categorized as abusive. While some behaviors may be considered abusive in one culture, they may not be considered abusive in another culture (Baker et al., 2010; Hitchens et al., 2017). The *motivational model* of psychological abuse posits that psychological abuse occurs if the intention of the abuser is to harm or denigrate the partner. Finally, the *impact model* holds that the impact on the victim, rather than the abusive behavior, is key in understanding what constitutes abuse and how to treat it. Each of these models helps to understand what the victim of partner abuse experiences and the necessary direction of treatment (Altshuler, 2008; Herbert & Mackenzie, 2014). There are a variety of reasons for abusive relationships and behaviors and there are consistent outcomes such as hurt, anger, shame, and projection and identifications. Each of these factors requires further understanding, which supports the need for the current study.

Abusive Relationships in Societal Context

There are various contributing risk factors associated with IPV among African Americans, including poverty, high rates of unemployment, exposure to community violence, and exposure to IPV within the family of origin (Williams et al., 2008). Poverty and unemployment result in increased vulnerability for the victim and the perpetrator of

IPV (Campbell et al., 2002; Lacey et al., 2016; Tolman, 2011). Exposure to community and IPV violence is increased by poverty and unemployment; poor women may not have the means to provide themselves with protection from this exposure to violence (Campbell et al., 2002; Lacey et al., 2016, Tolman, 2011).

The term context as used in this work refers to the environment of or setting in which domestic violence occurs. As such, domestic violence service providers must become more aware of how various structural, cultural, and situational factors intersect and con- tribute to domestic violence in the African American community (Williams, Oliver & Pope, 2008, pg. 233). These kinds of relationships result in low socioeconomic status of women. Discriminations due to age, gender, sexual orientation, ethnicity and status of women are also noticed in a considerable manner. This suggests IPV occurs in a wider variety of settings. Economic distress and residing in disadvantaged neighborhoods are among societal factors for IPV among African American women (Campbell et al., 2002; Rodgers et al., 2016; Tolman, 2011). Many African American women impacted by violence and abusive relationships, may face high levels of hardships, discrimination, and judgment within the society, which serve as barriers to treatment (Cheng & Lo, 2015; Hart & Klein, 2013; Healey, 2010). Barriers to obtaining treatment reduce the ability of women to access support. It is important to understand the different treatment barriers faced by these women that serve to compound their experience and risk of violence.

The condition of African American women is difficult to seek support around the abusive relationships and to support themselves to consult and lead a better life. Minority women are more impacted by IPV in the Unites States compared to other groups

(Stockman, Hitomi, & Jacquelyn, 2015). Gaps remain in the understanding of how contextual factors intersect to facilitate the occurrence of IPV among African American women (Williams et al., 2008). What is known about IPV among ethnic minorities has served as a catalyst for training IPV service providers to be aware of cultural differences in effectively treating minority battered women (Stockman et al., 2015; Williams et al., 2008).

Treatment Barriers

Multiple treatment barriers impact African American women seeking help. Without addressing these barriers, it would be very challenging for victims to access treatment and support. Researchers has identified multiple individual and institution barriers as described below.

Individual denial is often the first defense mechanism that abused victims use (Haeseler, 2013; Rodriguez et al., 2009). This pattern of denial must be overcome to help victims seek and benefit from treatment. To help a substance dependent woman to seek treatment for substance use, their denial of addiction must be addressed. Similarly, to assist a female in an abusive relationship, denial must be overcome. In addition, treatment barriers such as socio-economic barriers, relationships, patient-related barriers, social barriers, and other related barriers to treatment must be overcome, as discussed in detail below.

Socioeconomic Barriers

Socioeconomic status is considered to be one of the most prevalent factors associated with IPV (Aubuchon-Endsley et al., 2014; Bryant-Davis et al., 2009).

Socioeconomic status issues may relate to financial dependence. African American women with receiving public assistance may not be able to afford treatment. The socio-economic barriers result in abused women being less likely to enter treatment programs (Rogers et al., 2016).

Relationships

The types of relationships that abused women have tended to be based on low self-esteem and a diminished views of the self. This self-view impacts the relationship, despite the fact that the female has the primary role of caregiver in the family (Haeseler, 2013; Sampson, 2007). This poor relationship with the self and the abuser can result in the female staying in the abusive relationships for a long time without seeking treatment, which impacts their mental health negatively

Internal Barriers

There are internal barriers that impact the abusive relationship and outcomes. These internal barriers include low levels of motivation, denial problems, psychological problems, and negative social attitudes for women (Finfgeld-Connett, 2015). Some families within the African American community may disapprove of a women receiving mental health care (Rodriguez et al., 2009; Simmons et al., 2015). Other internal barriers include the presence of PTSD. The internal barriers also include the substance using partners who support their substance use; women receive encouragement to keep using substances and when they enter treatment, they may encounter resistance from their abusive husbands (Chambless, 2009; Lacey et al., 2015). Women may lack an awareness

of their substance use and this may keep them from sharing their substance use with mental health care providers (Chambless, 2009; Lacey et al., 2015).

Social Barriers to Healthcare

Social barriers may stigmatize women who are abused and this can impact their motivation to seek treatment (Aubuchon-Endsley et al., 2014). Abused women lack the support they need from families and society and they may not get the encouragement they need to enter into treatment programs. Discrimination and lack of effective screening creates a barrier to treatment access (Aubuchon-Endsley et al., 2014; Messing et al., 2015). Social barriers may serve to reduce efforts by clinicians to routinely screen African American women for IPV (Postmus, 2015; Rodriguez et al., 2009). According to Rodriguez et al., 2009 and Aubuchon-Endsley et al. (2014) discrimination by clinicians towards IPV African American women has been reported in many studies. While researchers reported potential barriers to treatment, most information is from older studies, supporting the need for the current study to further explore this issue.

Overcoming Barriers

Bronfenbrenner's ecological systems theory proposes that structures and processes of social environments influence individual thoughts and behaviors, which is why this framework is useful in understanding its influence concerning African American IPV victims (Becker et al., 2012). Overcoming barriers to treatment requires first the acceptance of being an IPV victim and the understanding of treatment barriers. Knowledge of treatment barriers can allow African American women in need of services and interventions to overcome these barriers (Becker et al., 2012). Bronfenbrenner's

microsystem consists of factors that shape an individual's social identity, which affects intrapersonal barriers that include: an individual's perception that services are not necessary or useful; that protection of their partner is important; and that mistrust in service providers, shame, and accessing services could possibly risk children being taken out of the home (Becker et al., 2012; Bronfenbrenner, 1979). IPV victims carefully consider factors that may interfere with the use of services such as, transportation, child-care, employment demands, and stable residence (Becker et al., 2012). Despite all the treatment barriers, African American women have been known to overcome these obstacles and access services.

Future research is necessary to determine factors that facilitate help-seeking behaviors and treatment intervention. Preliminary research suggests that microsystem factors impact tendencies for ethnic minority women to seek treatment (Becker et al., 2012). African American women in abusive relationships may overcome treatment barriers through social support, religion, and coping with therapeutic intervention. The following section will discuss variables that have been known to assist in the treatment process for IPV victims.

Social Support

Victims of violence need support to overcome their experience and change their situation (Aubuchon-Endsley et al., 2014; Campbell et al., 2002). Fraser et al. (2002), Choi et al. (2016), Lucea et al. (2013), Samples et al. (2014), and Simmons et al. (2015) suggested that literature on racial disparities within domestic violence programs tends to focus on the role of culture in shaping beliefs, behaviors, and support tendencies.

Aubuchon-Endsley et al. (2014) and Fraser et al. (2002) noted that minorities may be less inclined to seek help from counseling and social service providers because they perceive these agencies as lacking in cultural sensitivity. Fraser et al., suggested that the literature also hypothesize that African American women victims of domestic violence may be less likely to seek mental health services due to a lack of knowledge about the services, and instead may rely upon support from family and friends.

Social support from friends and family may provide African American women in abusive relationships with a comfort of connectedness, understanding, and meaningful dialogue. Social support is needed to help the victim feel in control of their situation, which impacts the abuse pattern and related consequences of depression and anxiety (Zacarias et al., 2012). African American women in abusive relationships tend to feel more comfortable sharing personal information about themselves with individuals they know and trust, as opposed to individuals whom are strangers (Fraser et al., 2002; Valandra et al., 2016). Victims of abuse and the abusers need support to deal with substance use, poverty, and other problems that influence abuse, and they need support to change their behaviors (Aubuchon-Endsley et al., 2014). Valandra et al. (2016) noted that African American IPV victims may have difficulty locating a therapist or other professional who they feel is knowledgeable about their experience. Some African American women victims of IPV may prefer to seek the help of a professional who is of the same racial background, has experience with IPV issues, or is a survivor themselves (Fraser et al., 2002; Valandra et al., 2016).

Aubuchon-Endsley et al. (2014) reported that discrimination and fear or mistrust of providers due to racism impacts treatment seeking for minorities. Fraser et al., 2002 and Valandra et al. (2016) examined the experience of racism among African American women and noted that racism influences decision-making, and the African American women's reluctance to seek formal services. Fraser et al. (2002) also noted that living in a racist society creates stressors and stereotypes for African American women, which may affect their perception and response to abuse by an intimate partner.

Religion

The use of religion and spirituality has been documented as a traditional means of coping in the African American community (Assari, 2013; Lilly et al., 2015; Watlington & Murphy, 2006). Religion plays a major role in many African American households. Religious institutions have occupied an important position in the African American community throughout much of American history. Studies have reported that a majority of African Americans are associated with religious practices (Mengesha et al., 2012; Lilly et al., 2015; Watlington et al., 2006). Most African Americans view religion as hope, inspiration, a way of living, devotion, and happiness. The role of religion may mean something different to other ethnic groups, but in the lives of African Americans, religion has been a platform to speak to issues of oppression, quest for liberation, love, hope, and justice (Assari, 2013; Watlington et al., 2006). Religion within the church may provide individuals with a feeling of safety, solace, and a sense of community. Religion plays an important role in the lives of African American women, and is considered to be more likely used as a way to cope (Lilly et al., 2015; Sullivan et al., 2018; Watlington et al.,

2006). Religious variables may be critical for African American women in abusive relationships because religion may be relied upon as a means for coping more than seeking traditional mental health services.

Therapeutic Intervention

Literature findings support the effectiveness of therapeutic intervention to help IPV victims, which supports the need to understand barriers to accessing this treatment. For example, psychotherapy is an effective evidenced-based treatment that is utilized to treat women survivors of IPV. The utilization of individual, group therapy, and motivational interviewing can benefit women victims with IPV (Hegarty et al, 2013; Wahab et al., 2014). Group therapy may provide the individual with opportunities to feel connected to others with similar experiences. Group therapy also helps the individual to decrease feelings of isolation (Davis et al., 2009; Lothstein, 2013). Davis et al. (2009) reported that although psychotherapy is effective for treating IPV victims, African American abused women require professionals who are culturally competent and trained in treating IPV victims. Abused African American women desire culturally relevant interventions, and well-designed studies testing interventions for these women are nonexistent (Davis et al., 2009; Rizo, 2016). Davis et al. (2009) noted that no studies targeted only African Americans, describe a culturally competent program, or specifically address abuse from an intimate partner. Culturally informed interventions for abused African American women, such as the Grady Nia Project (GNP), are needed (Davis et al., 2009).

Davis et al. (2009) indicated that the GNP is triadic and culturally competent. The GNP is a treatment intervention that is tailored to the cultural background of its participants. GNP utilizes Afrocentric theory to empower women, in addition to being guided by Black feminism that addresses racial and gender dynamics (Davis et al., 2009). The GNP also has a group therapy component for African American women to share stories, promote positive health, and build emotional and spiritual support (Davis et al., 2009). Davis et al. (2009) noted that the GNP includes a preintervention assessment, post-intervention assessment, and two follow-up assessments from six months to one year after intervention. The GNP is also described as including 10-sessions (seven 90-minute and three 20-minute) with a group format in an outpatient setting that is facilitated by an African American and non-African American therapist (Davis et al., 2009).

According to Davis et al. (2009) data from an Intervention Satisfaction Survey show that participants in the GNP were extremely pleased. More than 80% of the women reported that participation helped facilitate their capacity to talk about IPV and cope more effectively. Lothstein (2013) reported that more information is needed to provide support for group therapy as an intervention for IPV victims.

Additional treatments for IPV include treatment of the victim, the perpetrator, and the couple (Hegarty et al., 2013; Heru, 2007). These treatments need to assess risk factors and comorbidity, especially alcohol misuse and dependence. Stover et al. (2009) reported findings from a review of 20 studies of treatment for IPV. Results showed that treatment dropout rates ranged from 14% to 50%. Interventions for perpetrators resulted in mixed outcomes. Group cognitive behavioral therapy/psycho-education resulted in a significant

reduction in recidivism rates and no differences in outcomes. Pretrial counseling was shown to be more helpful than probation counseling, but similar to mandatory sentencing for decreasing recidivism rates. Interventions for victims included providing support advocacy for women who left a domestic violence shelter; these resulted in lower rates of violence experienced compared to providing a shelter only. However, outcomes were not maintained three years. Counseling with mentorship for pregnant victims of IPV resulted in significant reductions in violence at two months, but outcomes did not remain by 12 to 18 months. Police and social services outreach programs to help victims did not result in significantly less recidivism rates. Interventions for couples included couple's therapy and individual or group perpetrator treatment. Outcomes were mixed but for the most part, behavioral couples therapy combined with individual substance misuse treatment was found to be more effective than substance misuse treatment for the reduction of recidivism rates. There are also treatments such as joint child and mother programs, which have been shown to be more effective than community case management for reducing child and parent psychological symptoms. Trauma-focused cognitive behavioral therapy was also found to be more helpful than child-centered therapy for PTSD symptoms (Beck et al., 2016; Stover et al., 2009).

Summary and Conclusions

African American women continue to experience IPV and barriers to treatment. There is a strong relationship between the treatment barriers African American women in abusive relationships confront and mental health issues. This review of the literature included a discussion of physical and mental effects of IPV, individual and social barriers

to treatment, mental health problems and symptoms, and social factors that contribute to the abusive relationship. The next chapter will provide an explanation of the methodology for this research study to include an introduction, research design procedures, role of the researcher, participant selection logic, instrumentation, procedures for recruitment, participation, data collection, data analysis plan, issues of trustworthiness, and ethical procedures.

Chapter 3: Research Method

Introduction

The purpose of this study was to explore treatment barriers and views of the healthcare system among African American women affected by IPV. This chapter is an explanation of the research design and rationale, role of the researcher, participant selection logic, instrumentation, procedures for recruitment, participation, data collection, data analysis plan, issues of trustworthiness, and ethical procedures.

Research Design and Rationale

Research Design

A phenomenological methodology was used for this qualitative research study. The intent of a phenomenological approach to qualitative research is to outline the life experiences of individuals (Creswell, 2007). The phenomenological approach helps identify phenomena and how these events are perceived by individuals in the situation (Creswell, 2007). Phenomenological approaches involve a paradigm of personal knowledge and subjectivity, which emphasizes the importance of personal interpretation and perspective. This approach is also used for understanding experiences that are subjective, gain insight into an individual's actions and motives, and eliminate assumptions and conventional beliefs. A qualitative research study may use semistructured interviews for gathering data by which participants can freely explain responses. Semistructured interviews can uncover more information and provide explanation from participants (Creswell, 2013; Vogt, Gardner, & Haeffele, 2012).

Though the population of African American women and the topic of IPV has been primarily explored through qualitative approaches, a gap still remains that supports the need for a more in-depth understanding of the problem of treatment barriers. Thus, the research questions that guided this study are as follows:

Research Question 1: What are the overall experiences of African American women survivors of IPV regarding the impact of IPV from an ecological perspective?

Research Question 2: What are the treatment barriers faced by this group of individuals from an ecological framework?

Research Question 3: From an ecological perspective, what are the views and experiences of African American women survivors of IPV with the health care system?

Research Question 4: What additional resources do survivors of IPV need in order to repair their traumas and thrive again?

Rationale

A qualitative research design was chosen as it is less formally constructed compared to a quantitative research design, and it has flexibility regarding data gathering and procedures (Creswell, 2013). For the qualitative study, the researcher is focused on meanings and themes related to the research questions (Creswell, 2013; Levitt et al., 2018). As this study was designed to gather detailed information and insights from participants, this less formal approach was desired. There are five major qualitative research designs: ethnography, phenomenology, grounded theory, content analysis, and the case study. Ethnography is used to understand how behaviors reflect the culture of a group, which was not chosen since this was not the study goal. Grounded theory was not

chosen as since the study goal was not to derive a theory from data collected in a natural setting. Content analysis was not chosen since the goal of the study was to explore more than to simply identify a specific characteristic from information (Creswell, 2013). Finally, the case study was not chosen since the study does not focus on one or a few cases in their natural setting. Phenomenology was chosen since the study purpose was to seek an understanding of the experiences from another person's point of view (Creswell, 2013).

Given the phenomenological design of this study, participants engaged in interviews to explore treatment barriers that African American women in abusive relationships confront. Phenomenology is a more appropriate approach for this study when compared to a quantitative approach because the study goal is to explore the lived experiences of African American women in abusive relationships regarding the experience in general, barriers to treatment, and views of the healthcare system. Data were gathered to explore the life experience of these women in general and related to the health care system and barriers to treatment.

For the phenomenology research design, there are stages and processes that I followed. Van Manen (1997) created a research methodology using the phenomenological approach for systematically gathering material from subjects. This methodology begins with the starting point of everyday lived experience, which helps to situate people in their world and provides an understanding of these individuals. A researcher seeks to identify and understand the life world of the individual. This process begins by identifying the nature of the lived experience with the formulation of the

phenomenological question. Next, the investigatory stage takes place, in which the researcher explores experience as it is lived. For this study, one-on-one semistructured interviews were used to gather data. During the reflection process, the researcher seeks to identify themes and meanings related to research questions (Van Manen, 1997).

Formulating the Phenomenological Questions

According to Van Manen (1997), phenomenological research begins with the formulation of the phenomenological question. This question regards what lived experience a researcher is attempting to explore. For this study, the phenomenological question was "What is the lived experience of African American women survivors of IPV?"

Investigatory Stage

The second stage of the phenomenological process is the investigatory stage. This involves researching the lived experience of the study participants in great depth. This stage can include different sources of data gathering such as writings, personal interviews, or observations. For this study, the one-on-one personal interviews were used to gather detailed data regarding the participants' lived experience. The investigatory stage and interview process involved consideration for the sample, setting, and unit of analysis.

Data Management Strategies

Data management strategies and procedures are used to ensure efficient management of the data. For this study, each interview was taped recorded and the recordings then transcribed fully by me. This enabled me to peruse the content in a

thorough manner, underlining material that seems thematic, and coding parts of the transcribed material that seem to form patterns. The goal was to find themes that are related to the research questions.

Role of the Researcher

I gathered the data, conducted the interviews with participants, and analyzed data. I had no personal or professional relationship with the participants. Any researcher bias was managed by returning all data analyses to participants for verification of accuracy and credibility. It is important to establish this credibility to ensure that study findings are believable from the perspective of the participants, as it is the participants who are able to legitimately judge the credibility of study findings (Trochim, 2008). In qualitative research, the researcher does bring a unique and personal perspective to the study, but any bias must be overcome with confirmability. This means that all findings must be confirmed by others to ensure that they are credible. Returning findings to participants for verification helps to make judgments and overcome any potential for bias or distortion (Trochim, 2008).

Methodology

The following sections present a discussion of methodological issues. These include participant selection, instrumentation, procedures for recruitment, participation, data collection, and data analysis plan. Then issues of trustworthiness and ethical considerations are presented.

Participant Selection

For qualitative research, the sample is chosen according to pre-established guidelines, but the sample size is not as important as in quantitative studies. For the phenomenological study, the sample size is dependent on the study goals. For a qualitative analysis, the smallest number to reach saturation is 15 participants (Mason, 2010). For this study, the criteria for selection were the following: African American women survivors of IPV, ages 18 years and older, having been or currently in treatment, and interested in sharing their experience regarding being a survivor of IPV and related issues. Following study approval, all subjects were recruited on a volunteer basis according to availability. This convenience sample was chosen locally, since there are appropriate subjects from which to choose. If 15 subjects were not gathered, I would have returned to the social service organization and redistributed flyers. If this method would not have yielded 15 participants, I would have contacted another organization and repeat the process.

Instrumentation

Interview Protocol

For this study, one-on-one interviews were conducted. The phenomenological approach includes the use of broad questions that are answered by the participants. The interview questions were presented to the participant during the interview protocol:

1. What is your experience regarding the impact of IPV, in general?
2. What is your experience regarding the impact of IPV on barriers to treatment?

3. What is your experience regarding your mental health service utilization patterns?

4. What is your experience with the health care system?

5. What is your experience with domestic violence intervention service providers?

Gender, age, ethnicity/race, education level, occupation, and marital status of the participant were also recorded, and any other questions were used to guide the interview only such as "Could you tell me more about that . . ..?"

Content validity is established for the interview protocol since all items are consistent with the study research questions. A panel of experts in qualitative research design reviewed the interview protocol items and be asked to review each question and indicate whether the question should be included. They were asked if the protocol lacked any question that should be included in the study. Modifications and adjustments were made to the protocol based on the responses of the panel. When constructing the interview protocol, efforts were made to ensure its reliability. A test-retest pilot study will be conducted with the panel members. Panel members responded to interview items once and then again a week later to ensure reliability of the items.

Procedures for Recruitment, Participation, and Data Collection

The researcher contacted the executive director of a social service agency regarding study participation. A letter of cooperation from the agency was obtained (Appendix A). Following approval from the director and Walden IRB, a flyer was posted on their public bulletin board, describing the study and requesting study participation. The researcher also posted the recruitment flyer (Appendix B) on two social media

outlets (Facebook and LinkedIn). Interested parties will contact the researcher directly. The researcher determined if the potential participant meets inclusion criteria (African American women survivors of IPV, ages 18 years and older, having been or currently in treatment, and interested in sharing their experience regarding being a survivor of IPV and related issues). If criteria was met, each participant was asked to meet via Zoom or Skype to participate in two one-on-one interviews.

A letter of consent was distributed and collected prior to the first interview (Appendix C). Subjects willing to participate were instructed to complete the consent form and meet via Zoom or Skype for a one-hour, one-on-one interview. The interview was guided by the research questions and the session will be audio-recorded for transcription and analysis. The researcher analyzed data using qualitative analysis (described below). Following this, participants met via Zoom or Skype for a second one-hour, one-on-one interview to discuss findings and conclusions for verification. On the flyer (Appendix B) and prior to the first interview, subjects were informed that their participation was voluntary and they may withdraw from the study or ask questions at any time, and that confidentiality regarding the participant was maintained with the use of identification numbers in place of names.

An initial sample size of 15 is targeted. The researcher conducted all interviews with selected participants. The focus of the first interview is the gathering of data about their lived experience as African American women survivors of IPV. Data was gathered about their lived experience regarding the impact of IPV on mental health outcomes, barriers to treatment, and experiences with the health care system. The focus of the

second interview was to provide the participants with an opportunity to read the data analysis, commenting on the themes and meanings that have emerged from the study. This feedback allowed for further refinement of the data. Each interview was approximately 60 minutes long. The data was collected primarily by recording both interview sessions. Secondary data was collected through notes taken by the researcher during each interview. These notes were used to identify body language and other points of emphasis to supplement the recorded data.

Before conducting the interviews, the researcher obtained permission from the IRB and will obtain signed letters of consent from the participants. If there are less than 15 volunteer participants, the researcher will contact the executive director regarding a second attempt to distribute the letter of introduction. To ensure that all participants are debriefed, each was asked if they had any questions at the end of the interview sessions. Each participant was provided with the researcher's email and telephone number in case additional questions should came up at a later time.

Data Analysis Plan

Descriptive statistics, including frequencies and distributions, derived from the use of SPSS software (version 21), will be used to describe sample. Tables also demonstrated results. Qualitative analysis will be used to describe narrative data. The researcher used qualitative analysis to analyze the interview data to address the research questions. Data analysis procedures included several steps involved in the process (Mills, 2010; Moustakas, 1994):

1. Transcribe all interview data.

2. Read all transcribed data carefully, clustering units to identify basic themes or meanings in each document as they relate to each research question (Moustakas, 1994).

3. Examine the documents as a group, hand coding any themes or meanings that seem to recur in several documents.

4. Examine coded data using qualitative analysis software, such as Nvivo, to search for patterns, or connections, between the themes and meanings.

5. Draw conclusions based on patterns of themes and meanings.

6. Return conclusions to participants who will be asked to look at the data analysis and indicate whether any of their thoughts or perceptions were recognized in the accumulated data. This feedback will allow the researcher to refine the data and conclusions, and establish validity for the analysis (Moustakas, 1994).

7. Relate the findings to pre-existing knowledge, including information in the literature review.

Issues of Trustworthiness

The following presents issues of trustworthiness. This included a discussion of verification of findings. The credibility, transferability, dependability, and confirmability issues are presented. This is followed by a discussion of ethical considerations.

Credibility (Internal Validity)

Trustworthiness as it applies to the qualitative methodology, involves the credibility, or trustworthiness of the study and findings. To establish this trustworthiness,

all findings were returned to participants for verification (Huberman & Miles, 2002; Lincoln & Guba, 1985; Trochim, 2008).

Transferability (External Validity)

While findings were specific to the study participant's lived experience, findings may be transferable to other like individuals. Data findings revealed how and in what ways the information could be transferred to other situations in a relevant way (Huberman & Miles, 2002; Lincoln & Guba, 1985; Trochim, 2008).

Dependability

To ensure reliability and validity of data and findings, following the researcher's analysis of qualitative interview data, conclusions were returned to the participant for verification of findings. Rigor will be established in this study with the use of a strictly phenomenological approach. The phenomenological theoretical background is provided by Merleau-Ponty (1962) and the application of this theory is based on methods presented by Van Manen (1997). This study included the use of established phenomenological procedures for data collection, management, and analysis, while validating the data analysis through participant feedback (Huberman & Miles, 2002; Lincoln & Guba, 1985; Trochim, 2008).

Confirmability

Trust and rapport was established between the researcher and participants with the use of interviewing techniques that emphasize interpersonal relationship and trust. This was achieved by the researcher thoroughly learning the interview protocol and then engaging in the interview process rather than simply reading the interview questions to

the respondent. This allowed the interview to take place in a more informal conversational manner. Note taking will be kept to a minimum, focusing on indications such as body language. The primary means of recording the interview will be with an audio recorder placed in an unobtrusive location. Reflexivity will be used to establish confirmability. Considering reflexivity, the researcher is aware of the potential influence she may have on data interpretation. To insure confirmability of findings, the researcher returned all data conclusions to participants for verification, which helped to overcome any researcher bias (Levitt et al., 2018; Trochim, 2008).

Ethical Procedures

All data collection took place following IRB approval and executive director approval. Ethical issues were addressed by providing full information to the potential participants and obtaining signed letters of consent from those wishing to participate in the study. The cover letter to the potential participants included information about the research project, the procedures involved, the interview method to be used, and the intended use of data obtained from the interviews. The letter of consent ensured that participants were fully informed about the research project and have given their voluntary consent to participation. There was no deception or methods designed to cause harm or pain to the participants, although emotions may be uncovered during the interview process.

The participants were informed that anonymity, confidentiality, and privacy of the participant will be maintained with the use of identification numbers instead of names on all documents. Informed consent was obtained from each participant to ensure that they

are voluntarily participating in the study. Participants were also be informed that they would withdraw from the study at any time without consequence. Only the researcher had access to the data, which will be kept in a secure place. The secure place where all files, audiotapes, transcripts will be stored in a locked cabinet at the researcher's home office. Participants were informed that they may ask questions at any time to avoid any confusion, risk, or harm. As the sample formed a potentially vulnerable population at-risk for re-traumatization, provisions for counseling in case any participant has traumatic memories triggered by the interviews, will be provided. The researcher provided each participant with the names, phone numbers, and locations of these resources (Appendix D). The researcher called the resource of choice if requested by the participant to help them establish contact. The safety and confidentiality of the participants was guarded by the researcher with the use of identification numbers in lieu of names on all data collected.

Summary

This chapter was an explanation of the methods for the study. The research design and rationale, role of the researcher, methodology (participant selection logic, instrumentation, procedures for recruitment, participation, data collection, data analysis plan, and issues of trustworthiness (ethical procedures) were presented. For this study, a qualitative phenomenological research design was used. This research design will allow the researcher to explore the phenomenological question regarding: What is the lived experience of African American women survivors of IPV with respect to treatment utilization? The intent is to recruit participants for personal interviews that would be

analyzed and coded using phenomenological methods in order to reveal common themes and meanings. These findings were used to answer the research questions. Findings were considered trustworthy, dependable, and credible since they were returned to participants for refinement and validation. Chapter 4 presented the results of the study and Chapter 5 the analysis and interpretation of those findings.

Chapter 4: Results

Introduction

The purpose of this qualitative, phenomenological study was to explore barriers to treatment for African American IPV victims and their views of the healthcare system. Four research questions were formulated to guide this study, which addressed the overall experiences of these women, their treatment barriers, their views of the health care system, and additional sources that are needed for survivors of IPV. This chapter includes a section describing the setting of data collection, followed by a description of the study sample. Next, this chapter proceeds with descriptions of the data collection process, the data analysis process, and the procedures used to strengthen the trustworthiness of the study findings. This chapter then includes a presentation of the study results, which are organized by research question, followed by a summary.

Setting

Data were collected through two one-to-one interviews with each participant. Interviews were conducted over Zoom to minimize health risks to the participants and me by complying with guidelines associated with the COVID-19 pandemic. Participants were asked to participate in the videoconference from a safe, comfortable, private location so they would be able to answer the interview questions candidly. The use of a private office was intended to further contribute to participants' comfort by allowing them to feel assured that they were safe and that they would not be overheard by others during the interview. The interviews were conducted at a time of the participants' choice to ensure they would have adequate time in their schedules to provide rich, relevant data.

I am unaware of any personal conditions that influenced participants or their experience at time of study that may influence interpretation of the results.

Demographics

The study participants were 15 African American women survivors of IPV, age 18 years or older, who had been or were in treatment at the time of study. All 15 participants (100%) reported their race as African American and their gender as female, in accordance with the inclusion criteria for the sample. To protect confidentiality, participants were assigned pseudonyms. The first 12 participants interviewed were designated with the months of the year (i.e., P1 = January, P2 = February, etc.). Participants 13 through 15 were designated with the names of seasons (i.e., P13 = Winter, P14 = Spring, and P15 = Summer). Table 1 indicates the relevant demographic characteristics of the participants.

Table 1

Participant Demographics

Participant	Age	Highest level of education	Occupation	Marital status
January	37	Some college	Shipping Manager	Married/separated
February	37	Some college	Self-employed	Single
March	38	Master's	Counselor	Single
April	41	Master's	Social Worker	Married/separated
May	44	Master's	IT Manager	Married
June	67	High school	Security Guard	Single
July	41	Associate's	Homemaker	Divorced
August	61	Master's	Project Manager	Single
September	31	Some college	Call Center Rep	Single
October	30	Bachelor's	Registered Nurse	Single
November	28	Bachelor's	Unemployed	Single
December	49	Master's	Manager	Married
Winter	44	Master's	Director	Single
Spring	42	Bachelor's	Instructional Aide	Marred
Summer	71	Bachelor's	Retired	Widowed

Note. All 15 participants were African American and female.

Data Collection

Data were collected from 15 participants. Two one-to-one, semistructured interviews were conducted with each participant, for a total of 30 interviews. The focus of the first interview was on gathering data about participants' lived experience as African American women survivors of IPV. The focus of the second interview was on giving the participants the opportunity to read and comment on the themes and meanings that emerged from their data. Each interview was approximately 60 minutes long. The only change from the data collection procedures described in Chapter 3 was that all interviews were conducted over the videoconference application Zoom to minimize health risks during the COVID-19 pandemic. Interviews were audio recorded using a digital audio-recording device.

Data Analysis

Data from close-ended demographic questions were compiled and reported in Table 1. In the first step of the qualitative analysis, data from open-ended questions were transcribed verbatim (see Moustakas, 1994). As discussed in Chapter 3, the second step of the analysis involved reading and rereading the data while making handwritten notes of themes and meanings that appeared relevant to answering a research question. In the third step, preliminary, hand-coded meanings and themes were clustered across the 15 transcripts to identify overarching themes.

The fourth step of the analysis involved coding the data in NVivo 12 computer-assisted qualitative data analysis software. The interview transcripts were imported into the software as source documents and the data were reread, with blocks of text being

assigned to nodes when they indicated meanings relevant to answering a research question. All transcripts were coded together, and different excerpts from the same transcript or from different transcript that indicated similar meanings were assigned to the same node. The handwritten notes made during Steps 2 and 3 of the analysis were referenced as part of the NVivo coding process, but I also used this opportunity to reconsider the meanings and data clusters I had created during hand-coding in order to verify that they accurately represented the data.

The clustering of 117 transcript excerpts during the fourth step of the analysis resulted in the creation of 21 NVivo nodes, which represented codes. Each code was labeled with a word or phrase describing the data included in it. The fifth step of the analysis consisted of searching for larger patterns of meaning from which conclusions to answer the research questions would be drawn. This step involved grouping together similar or related codes into a smaller number of emergent themes. The 21 codes were grouped into four themes. Table 2 indicates the codes formed in Step 4 and how they were grouped to form themes in Step 5.

Table 2

Data Analysis Codes and Themes

Theme Code grouped to form theme (listed alphabetically)	*n* of participants contributing (*N*=15)	*n* of transcript excerpts included
Theme 1. IPV and the Closure of the Microsystem	15	45
Absent or judgmental family contributes to isolation	5	6
Depression-PTSD	7	9
Dissociation	1	1
Feeling shame/not wanting to disclose	3	5
Negative coping methods	7	7
Positive coping methods	11	13
Reluctance to communicate with family	4	4
Theme 2. Cultural Inhibitions and Treatment Costs Are Macrosystem Barriers	15	29
Challenge to find connection with therapist	4	4
Communicating with law enforcement	2	2
Community disapproval of treatment	5	5
Cost barriers	5	9
Insurance requirements difficult to navigate	3	3
Shame as barrier to help seeking	4	6
Theme 3. Connecting with Providers Opens the Relationship Microsystem	15	27
Experiencing lack of validation and support	1	2
Feeling supported by providers	4	4
Importance of someone who understands	5	5
Lack of support from white doctors	5	5
Opening the door and making connections	7	7
Source of emotional support	4	4
Theme 4. The Need for Belief and Acceptance	12	16
Safety and validation essential to breaking the silence	10	12
Seeing the signs of IPV	3	4

Evidence of Trustworthiness

Credibility

Findings are credible when they accurately represent what they were intended to describe (Lincoln & Guba, 1985). Threats to credibility include inaccuracies in participants' responses, inaccurate recording of data, and inaccurate interpretations of the data. Assurances of confidentiality were used to allow participants to feel safer in giving open and accurate responses, thereby reducing the likelihood of intentional misrepresentation. Additionally, member checking, in which participants reviewed their transcript and the findings drawn from their responses in a second interview, gave participants the opportunity to verify the accuracy of their responses, thereby decreasing the likelihood of unintentional misrepresentations. Participants accepted my interpretations and recommended no modifications. The identification of themes that incorporated the experiences of all or most participants further minimized the likelihood that individual participants' errors or biases would diminish the credibility of the findings. Accurate recording of the data was ensured through audio recording and transcribing the interviews verbatim.

Transferability

Findings are transferable when they are true of other settings and populations (Lincoln & Guba, 1985). The small sample and restricted geographic scope in this study are expected to limit transferability. However, detailed descriptions of the sample and data are provided in this chapter to assist readers in assessing transferability.

Dependability

Findings are dependable to the extent that they would be replicable in the same research context at a different time (Lincoln & Guba, 1985). Member checking used in this study strengthened the dependability of the findings by allowing participants to review their responses at a different time and verify that their answers still represented their perceptions, indicating the stability of those perceptions over time. Dependability was also strengthened by providing detailed descriptions of the study procedures to assist future researchers in replicating this study if necessary. Discussions of study procedures can be found in this chapter and in Chapter 3.

Confirmability

Findings are confirmable to the extent that they represent participants' perceptions instead of the researcher's (Lincoln & Guba, 1985). Member checking contributed to confirmability in this study by allowing participants to verify that my interpretations of their responses accurately represented their perceptions rather than any biases. Confirmability was also strengthened through the presentation of direct quotes from the data as evidence for all themes in the Results section of this chapter. The presentation of evidence will allow the reader to independently assess the confirmability of the analysis.

Results

This presentation of results is organized by research question. The themes that emerged during data analysis are presented as answers to the questions. The description of each theme begins with a summary of the theme, followed by a more detailed discussion and presentation of evidence.

RQ1: What Are the Overall Experiences of African American women Survivors of IPV Regarding the Impact of IPV from an Ecological Perspective?

The theme of IPV and the closure of the microsystem emerged during data analysis to answer Research Question 1. The following subsection is a discussion of this theme. Evidence is provided for the finding in the form of quotations from participants' responses.

Theme 1: IPV and the Closure of the Microsystem

A central tenet of ecological systems theory, as described by Bronfenbrenner (1979), is the interdependence of the ecological systems and the continual circulation of influences between them. A theme that emerged repeatedly in all 15 participants' accounts of their IPV experience and its impacts may be interpreted through the lens of ecological systems theory as a self-amplifying disruption of the interchanges between ecological systems. Participants indicated that IPV tended to close the microsystem of the abusive relationship by cutting off influences and supports, such as those originating with family and friends. This closure of the relationship microsystem then fed back into the pattern of IPV by increasing the victim's vulnerability and dependence.

The IPV pattern all 15 participants described began with the partner becoming verbally and emotionally abusive. The immediate effect of this abuse was to isolate the victim by causing her to experience shame and a sense of inadequacy that deterred her from reaching outside of the relationship microsystem for support. Summer, for example, stated,

> My family would have been supportive if I chose to share [my IPV experiences], but I didn't choose to share it because of the shame factor. I felt ashamed . . . because I thought it was something that I was doing that caused this to happen.

March remembered her bewilderment over her tendency to internalize the negative messages she received through verbal and emotional abuse, even though she previously had high self-esteem: "I've always been confident . . . [but] when somebody is saying a lot of mean and hurtful things and then you're sitting and crying, and for what? Like they said these things, but you believe these things." Like Summer, April also reported that verbal and emotional abuse caused her to doubt and isolate herself instead of looking outside of the relationship microsystem for support:

> It was the verbal [abuse], you know, he would talk to me any kind of way he wanted. He would curse. He would use profanity. You know, he would tell me I was a loser, no one would ever want me . . . I questioned myself like, "Why is this happening, why, why me? You know, why? Like I'm so nice and so giving, you know, am I doing anything to provoke it? Like what am I doing wrong?" I started to question myself and my actions and what I was doing and how that was, in any way, related to how they were treating me.

Participants reported that their abusers also directly interfered with their ability to connect with people outside the relationship microsystem, such as by forbidding them to work or behaving jealously and aggressively toward anyone who was friendly toward her. July, for example, reported that her abuser kept her housebound and that her situation at that time was more isolated than during self-quarantine: "With [COVID-19], we're on

lockdown. Well, I was on lockdown 15 years. I was locked down! I felt more locked down in that situation than I did during the pandemic. That's how bad it was." August described her abusive partner as so jealous of any connection she might form with someone outside the relationship microsystem that he became accusatory even when restaurant servers were friendly to her: "When we were in a restaurant and the server said something to me that in [my abusive partner's] mind was flirting, he would accuse me of flirting with that person." Even after June left her abusive partner, he continued to interfere in her ability to connect with her friends by stalking and assaulting her when she socialized: "The violence kept going . . . I would go out with my girlfriends. He'd see me and he would still come up and try to push me around."

As participants' relationship microsystems became increasingly closed and isolating, many were subjected to escalating IPV, including physical battery resulting in emergency-room visits and rape. August, for example, said that after years of increasingly isolating verbal and emotional abuse, "Then it got physical, so he would be pulling on my hair, and kicking me in the stomach, and I was too afraid." Participants reported that their sense of shame and inadequacy persisted or increased as the IPV escalated, with the result that they felt they could not tell family or friends about the abuse, and they became more isolated within the relationship microsystem. October described the effect of her experience of IPV as isolating her in intense, negative feelings, saying, "[IPV] led to depression. It led to me internalizing. It led to anger, isolation." Summer had no one to go to for support or protection, so she would escape her abuser temporarily by going on aimless, solitary drives for hours: "I would just go and ride

around, just trying to stay out of the way. You want to be out of the [abuser's] radar, you don't want to be seen, you want to try to go invisible." January stated that when she was being victimized, she doubted herself and her value, and instead of reaching outside of the relationship microsystem for support, she began a pattern of alcohol abuse that further isolated her:

> I got to be a heavy, heavy drinker. That was my go-to. That was my peace. That was my sanity. That was to escape reality. Once the drunkenness came down, it was back to reality. It did not help but made the situation worse, because I was a dweller. I felt like I was not good enough. I had low self-esteem, feeling like I was not good enough, and I always questioned, "Well, why did this happen to me? Maybe I am not pretty enough. Maybe I am not sexy enough. Maybe my mother should have given me up, or maybe my mother should not have had me."

The self-amplifying cycle of IPV, shame, isolation, and increased vulnerability to further IPV was exacerbated when participants' prior relationships with their childhood families (i.e., participants' mesosystems) made potential sources of support seem unapproachable. July reported that a habit of self-suppression she learned during childhood intensified her isolation when she suffered IPV as an adult: "I felt like what I went through in my childhood, it wasn't just the abuse. It was like I wasn't allowed to speak up on it. I wasn't allowed to say, 'Oh, this is what was done to me.'" May said of being unable to avert the escalation of IPV by leaving her abuser early on: "Not being able to nip [IPV] in the bud, it comes with not being open, being secretive, and feeling like you don't have somewhere to go because you're feeling like, 'My family is very

judgmental.'" May also spoke of how the expectation that her family would rebuff her made her vulnerable to increasing isolation within the closed microsystem of her abusive relationship: "If you are not perfect or feel like something is not perfect, then you don't feel like you have a safe place. That whole judgment thing is there, and that's a breeding ground for someone to isolate you."

When participants escaped their abusers, all remained isolated at least temporarily as a result of an impairment of their ability to trust others, to accept intimacy, and to disclose the traumatic IPV experiences with which they were preoccupied. Participants also reported that their coping strategies, whether they perceived these in retrospect as healthy or unhealthy, were predominantly solitary. July described her solitary coping strategies as a result of feeling that people she might otherwise have sought support from were unavailable and uninterested:

> When I journal, I write about [my IPV experiences] . . . that's something that's helped me cope, especially when I don't have anybody to talk to, which I usually don't. And if I do, people really don't want to be bothered. I get it.

March stopped answering her phone and allowed her carrier plan to lapse as she became increasingly isolated after leaving her abuser. March began this pattern of self-isolation because she did not believe other people could understand the IPV experiences that were central to her emotional life at that time, she stated: "I didn't answer my phone. I think I just purposely let my phone go off . . . I haven't had anybody along the way in this journey to be with me. They didn't understand it." August expressed puzzlement about her ability to reach out to her family for support after leaving her abuser:

"Although my family knew, I just still couldn't talk to them for some reason. I just couldn't talk to them about it." Instead of opening up to her family, August turned to solitary coping strategies: "I did a lot of crying, unfortunately, just sobbing, crying, going for long walks. I would just spend most of the time just letting it all out, crying. Then I started journaling, and that helped a little bit."

Like January, June adopted a coping strategy of self-isolation and alcohol abuse: "For about a year, I had been in my bedroom, didn't come out, only to just go to the mini-store and buy me a box of wine and go back to my room." In reflecting on why she isolated herself and relied on solitary coping strategies after she left her abuser, May referred to her pre-existing pattern of isolation established during the abusive relationship, her fear of being harmed again, her embarrassment that she had been a victim of IPV, her distrust of potential supporters, and her resulting, self-imposed imperative of self-reliance:

> When you are being taken advantage of in all areas of your life, you find that you want to protect yourself. You want to protect your feelings because you're maybe isolated, and you feel like you are by yourself, and you're embarrassed, and you don't want to tell anyone, or no one is going to believe you, or they'll be like, "Oh, well, that's what [men] do anyway." So you're kind of like, "Well, I'm on my own, so let me protect myself."

RQ2: What Are the Treatment Barriers Faced by This Group of Individuals from an Ecological Framework?

The theme *cultural inhibitions and treatment costs are macrosystem barriers* emerged during data analysis to answer research question two. The following subsection is a discussion of this theme. Evidence is provided for the finding in the form of quotations from participants' responses.

Theme 2: Cultural Inhibitions and Treatment Costs are Macrosystem Barriers

Participants described two complementary sets of macrosystem barriers to treatment, including cultural barriers and treatment costs. Cultural barriers included disapproval within the African American community of seeking treatment, and the communication barriers participants encountered when they contacted law enforcement and treatment providers. The barrier of treatment affordability resulted from the high cost of treatment and a lack of insurance and public assistance.

Five out of 15 participants reported that disapproval of treatment-seeking in their African American communities was a barrier because it increased feelings of shame that deterred resource access. April said that in her childhood home and African American community, "it was always, 'Don't go telling anybody your business, you shouldn't be telling people your private business or talking to anyone,' as it relates to personal issue. I would say that would be one of my barriers." Winter reported a similar experience of an imperative toward silence in African American communities as a barrier, stating: "In the Black community, you just don't speak, you don't go--like for me, I wouldn't think about going to a doctor, my primary care doctor, and saying 'domestic violence.'" September

characterized cultural inhibitions about treatment-seeking in her African American family and community as a perception that therapy was not "for" African Americans: "A lot of people in the African American community think therapy isn't for us. Initially, that's how I thought, as well . . . I wasn't getting support from my family because they're like, 'Oh, that's for white people.'"

The result of macrosystem cultural inhibitions about treatment-seeking within African American communities was that the prospect of shame deterred participants from seeking help. Summer described the reasons for her fear of seeking help while living in a disapproving community: "It was a small community, and everybody knew everybody. So, I didn't feel I could get some help because it would be known . . . Once again, the shame, the shame factor." August expressed a similar experience of the expectation of being shamed or stigmatized in her community as a barrier: "To seek a counselor and get mental anxiety help, it's a stigma in most cases."

Distrust between victims and first responders were cultural treatment barriers for three participants. Rather than feeling protected and supported, February felt ridiculed by the police she called when her abuser struck her:

> I had no faith in the police in my neighborhood at all. They thought I was a joke. I was mocked a lot. I have heard them laughing at me when I was trying to talk to them about what was going on. So, it was like they were putting my life back into the hands of my abuser without even thinking.

December also encountered communication barriers when she spoke with frontline personnel. The first such barrier was the focus of emergency services personnel

on treating physical injuries rather than inquiring into causes: “I had a couple emergency room visits, it just wasn’t an environment where help is encouraged, where it was more like, oh, let’s treat the physical, let’s get an x-ray.” On one occasion, December mentioned to an emergency services worker that battery had caused her injury. Her disclosure triggered a mandatory reporting requirement, but December was afraid to communicate with the law enforcement officers when they arrived to take her report:

> The police came and they were like, “Oh, yeah, who hit you?” and it was two Caucasian male officers, and I was so scared I just said, “I don’t know, some guy just ran out.” I mean, I totally just fabricated a story so that they would leave me alone.

Communication barriers resulting from a shortage of female, African American counselors and distrust of male and non-African American counselors was a cultural barrier for four participants. December stated that she aborted her first attempt to obtain counseling because she did not connect with and did not feel supported by her white, female counselor: “I had one meeting . . . It was a Caucasian female in her 60s . . . I need somebody I can connect with, not who’s going to say you have to figure it out on your own.” April’s sense of disconnection from her white, male couples counselor resulted from her impression that he was siding with her abusive partner against her: “It was a white, male therapist, and I felt like he couldn’t relate to me. I almost didn’t feel comfortable. I felt like it was the guys against the girl, and he more understand my partner’s point of view.” May provided a representative response in stating that she wanted a black, female therapist and that such individuals were scarce:

The first thing I would think of [in seeking counseling] is finding someone that can relate to you. The first thing I'm going to be like is looking through their pictures. They black? I ain't want to talk to no white lady, 'cause she ain't gonna understand nothing I'm talking about. I'm definitely not talking to no man, so trying to find a black woman is like trying to find a unicorn.

Eight participants reported that cost was a macrosystem barrier to treatment. Losing health insurance made the cost of therapy prohibitive for October and resulted in her discontinuing her treatment: "I was going two to three times a week when [IPV] was bad. But then once my insurance got cut off and didn't renew, I didn't have my deductible. It completely stopped. I wasn't able to get services." March stated that even with health insurance, she was unable to afford the treatment she needed because the copays accumulated: "At times, financially, it was too much. Let's say you go into therapy twice a week, that's $20 or $30 for your copay, and . . . that can affect the finances." Excessively complicated insurance requirements were another barrier to affordable treatment, April reported: "Is [treatment] covered or is it not? Those are the challenges. [Coverage is] limited, basically, and I think that presents a challenge for getting whatever care that I need, navigating the system." Cultural and cost barriers to treatment became mutually reinforcing when they made culturally congruent providers inaccessible, November stated: "When I was looking for a therapist, I preferably wanted a black therapist, but those are not easy to find. Then, of course, insurance makes it harder, and you just take what you can get."

RQ3: From an Ecological Perspective, What Are the Views and Experiences of African American women Survivors of IPV with the Healthcare System?

The theme *connecting with providers opens the relationship microsystem* emerged during data analysis to answer research question three. The following subsection is a discussion of this theme. Evidence is provided for the finding in the form of quotations from participants' responses.

Theme 3: Connecting with Providers Opens the Relationship Microsystem

As discussed in relation to Theme 1, the impact of IPV on participants from an ecological systems theory perspective was the closure of the relationship microsystem, with the result that participants became increasingly isolated, dependent, and vulnerable to escalating abuse. Participants experiences with the healthcare system sorted into two broad categories, including positive and negative experiences. The distinction between the two kinds of experience was expressed in participants' perception that accessing healthcare was positive when they connected on a personal level with their providers and negative when this connection was not achieved. Participants connected with providers through shared experiences and through manifestations of the provider's empathy. Participants associated negative healthcare experiences with disconnection from an unrelatable or uncaring provider. When participants connected with providers, they alleviated the vulnerable, self-doubting isolation they experienced in the closed relationship microsystem.

In describing negative experiences with healthcare that resulted from provider disconnection, April expressed her sense that her couple's counselor could not understand

her perspective because as a white male, his experiences were too different from hers: “I feel like he just couldn’t relate to me. There was no like sympathy. I didn’t feel a connection. I just didn’t feel comfortable. I didn’t feel understood.” February attributed her negative experiences of disconnection from providers to their prejudice against her as an African American woman:

> I have not had the best experiences going to doctors as a black young woman. I have noticed that we are treated a lot differently. In some incidents, I have had to check doctors and put them in their places. Because of who I was and what I looked like, they thought [worse] of me and I had to explain to them, “I am a human being with common sense and education just like yourself,” and they tend to care less. They treat you differently. They kind of allow you to wither away and die.

September expressed herself adamantly in stating that she would insist on African American providers in the future because she perceived non-African American providers as unable to fully empathize with her: “I’m seeking out black doctors, black therapists . . . I want to be with doctors that look like me because only they’ll know the struggle I go through.” The shared experiences that facilitated a personal, empathetic connection between patient and provider did not have to be based solely on race, however. For January, the connection that made her provider so inspiring to her was based primarily on shared experiences of faith and IPV:

> She is a Christian woman . . . She was in a domestic violence situation, and that is one of the key things. You cannot tell someone that they can make it out of the

> situation that they never been in it. This woman spoke so profoundly, and she had been through a lot of things. So, she was able to help me heal. Just seeing her, if she made it through, I know that I was able to make it through.

Even the most well-meaning provider who could not connect to the patient through shared experiences was inadequate, July reported. July met for a period of time with a therapist who empathized with her and wanted to help, but the therapist had not been a victim of IPV. July admired the young woman's candor about the limitations of her own experience, and she found the therapist's efforts to research IPV and victims' experiences to be meaningful expressions of empathy and support. However, July indicated that the absence of significant, shared experiences prevented her work with this provider from being helpful by inhibiting a deep, empathetic connection:

> The DV counselor, she was very empathetic and supportive, and I think she really truly tried her best to help . . . I just felt like she didn't know a lot about DV . . . She really tried to encourage me. And I was like, "Oh, you know, I don't need encouragement. I need somebody to help me with my problems and understand." And, you know, it's like talking to a man about labor and being pregnant till the baby moves. And you're like, "Do you understand?" No, he doesn't, and he never will. And it's okay. I'll just talk to a woman about that experience, you know. So, that's what it felt like.

The effect of positive healthcare experiences based on connection with the provider was to reduce the patient's isolation within the relationship microsystem and begin to reconnect her to macrosystems. June's account of her positive experience of

connection with a caring psychiatrist illustrated how a therapeutic intervention could begin to free an IPV victim from her isolating sense that she depended on her abuser and his approval:

> I went to see a psychiatrist. And this psychiatrist was amazing, and the reason why I say he's amazing, he never had a pen and paper or anything like that, he sat and he listened to me. And each week that I'd come back, he knew exactly where we left off at, and I was like, he's really listening to me. And he gave me some advice as to not having to feel like I needed to prove anything to any man, and it really helped.

March also reported a positive experience of healthcare based on a connection to a provider. March added that the connection helped her overcome her vulnerable, self-doubting isolation, which was enforced in part by her family's (mesosystem) lack of understanding:

> I didn't feel like I had family support. They didn't understand what was going on . . . I was going to therapy [because] sometimes I need an extra voice . . . sometimes I get a little questioning about my thoughts, and I just need that extra support.

May reported that connecting with her provider, an objective but caring stranger, helped her escape isolation because it was a way to circumvent the negative judgments she encountered in the people she knew: "Just being able to have someone to talk to that doesn't know you is wonderful . . . I was like, 'Oh, I like this. You're just listening and you're not judging me.'"

RQ4: What Additional Resources Do Survivors of IPV Need in Order to Repair Their Traumas and Thrive?

The theme *the need for belief and acceptance* emerged during data analysis to answer research question four. The following subsection is a discussion of this theme. Evidence is provided for the finding in the form of quotations from participants' responses.

Theme 4: The Need for Belief and Acceptance

Twelve out of 15 participants reported that their greatest need as IPV survivors was for other people to believe their reports and accept them without judgment or shame. February stated in a representative response that the other resources IPV survivors needed existed but that they were not adequately accessible because IPV victims' accounts were too often doubted:

I believe the resource is there. My problem is how the resource is being handled when [IPV victims] come. What I need to see is them actually believe in the women . . . just believe them at their word and get them out of the situation.

Winter expressed that survivors' paramount need was for others to believe their reports of IPV: "The biggest thing would be to believe Black women. That is the biggest thing, if we tell family members, if we tell people outside of our family, we need help." January agreed that IPV victims' greatest need in order to thrive was to be believed and not shamed or judged: "Just to be able to speak freely and not feel ashamed. We need more programs where women can come in . . . where they can talk freely and feel comfortable and not feel judged."

April explained the perceived necessity of belief and acceptance from others in saying that the victim's isolation in an abusive relationship was enforced partly by the expectation of disbelief and judgment if she reached out for support: "I think there are a lot of us that are suffering in silence because we don't feel safe or comfortable sharing our stories." Summer expressed a similar perception in stating: "I think it would have saved me a lot of heartache if I felt safe to go and actually share what was going on, and not have any repercussions in doing that. But I didn't." October perceived survivors as isolated by the exclusion of IPV from acceptable discourse: "People don't talk about [IPV]. It's a very hush-hush type of thing. So I think that's why everybody mostly suffers in silence, and we don't know who's experiencing [IPV], because they're not gonna tell you. [Telling is] not normalized."

April stated that to lower the barriers to help-seeking that isolated IPV survivors, those survivors needed to be able to expect nonjudgmental acceptance of themselves and their stories: "I need to see that in a community where I live, people can feel comfortable and safe to disclose what it is that they're going through without judgment and without feeling shamed." Spring believed that accepting support groups for IPV survivors, particularly if they were age- and race-homogenous, would benefit survivors by providing them with an accepting, nonjudgmental network of social contacts: "I think support groups can be good . . . because you always think you're the only one . . . nobody seems to be talking about [IPV]."

To believe and accept IPV survivors, other people could believe and accept signs of IPV and take the initiative to reach out to the apparent victim. February suggested:

"For people who see any sign of domestic violence, do not just ignore it . . . Always reach out, always make it known that you are there to help where you can." December provided an example of a way to believe, accept, and reach out when noticing signs of IPV:

> I'm very cognizant now, because of the things that I went through, to recognize the signs in other people. I see somebody, and we're at a ballpark or a picnic, and I see the eye aversion, I recognize that, and I may just write my name and be like, "Hey, if you ever want to go for coffee or something . . ." which is something that I wish I'd had.

Summary

In Chapter 4, four research questions were used to guide this study. In the first question, the theme IPV and the microsystems' closure emerged to answer research question one. This theme that repeatedly appeared in all 15 participants' accounts of their IPV experience was the disruption of those interchanges between ecological systems. Participants indicated that IPV tended to close the abusive relationship's microsystem by cutting off influences and supports, such as those originating with family and friends. In the second research question, the theme of cultural inhibitions and treatment costs are macrosystem barriers that emerged to answer research question two. Participants described two complementary sets of macrosystem barriers to treatment, including cultural barriers and treatment costs. These barriers to treatment affordability resulted from the high cost of treatment and a lack of insurance and public assistance.

In the third research question, the theme connecting with providers opens the relationship microsystem answered this question. In line with this theme, participants' experience with the healthcare system was sorted into two broad categories: positive and negative experiences—the Participants of the study connected with providers through shared experiences and manifestations of the provider's empathy. Also, participants associated negative healthcare experiences with their disconnection with unrelatable or uncaring providers. In the fourth research question, the theme, the need for belief and acceptance from others emerged to answer research question four. Twelve out of 15 participants reported that their greatest need as IPV survivors was for other people to believe their reports and accept them without judgment or shame. The participants felt that other resources IPV survivors needed existed but were not adequately accessible because IPV victims' accounts were too often doubted. This chapter provided imperative results that will be discussed, interpreted, and the implications of findings further examined in Chapter 5.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

Chapter 5 presents an interpretation of study findings, limitations, recommendations, implications, and conclusions regarding the study results pertaining to treatment barriers confronted by African American women with backgrounds of IPV and their views regarding the healthcare system. IPV is widespread in the United States and affects close to 5.3 million women in the country annually (Arnette et al., 2007; Park, 2016; Modi et al., 2014). African American women are the most affected among all women who are impacted by IPV and often experience it at a 35% higher rate than that of White women and approximately 2.5 times more often than women belonging to other races (Jackson, 2016). Despite previous findings that women who experience IPV face treatment barriers for their mental health care needs such as stigma and socioeconomic status (Jones et al., 2001; Lilly et al., 2015; Miller et al., 2014; Nicholas et al., 2010; Rodriguez et al., 2009; Valandra et al., 2016), detailed information regarding IPV among African American women is lacking. Therefore, the purpose of this study was to investigate barriers to treatment for African American women whom are victims of IPV in addition to examining their respective views of the healthcare system.

This research adopted a qualitative phenomenological methodology to conduct this investigation. Participants of the study were interviewed to explore treatment barriers that women of African American communities often confront while in retrospective abusive relationships. The data collected from the interviewees was recorded for the data analysis process where these data were categorized to come up with themes that are

relative to the objectives of the study. The outcomes for this study are essential as they will enable policymakers in healthcare units and law enforcement agencies to create programs and policies that assist women in addressing treatment difficulties. Most importantly, the outcomes of this research will provide additional knowledge to future researchers seeking to explore different aspects of this field of study.

Interpretation of Findings

Research Question 1: What are the Overall Experiences of African American women Survivors of IPV Regarding the Impact of IPV from an Ecological Perspective?

IPV and the Closure of the Microsystem

Bronfenbrenner's (1979) ecological systems theory presents paradigms of environmental systems and implicative circulations that exists between them. These are the microsystem, the exosystem, the mesosystem, the chronosystem, and the macrosystem. During the development stages of an individual, they are affected by the five environmental systems that affect them, referred to as implicative circulations. This theory was used as a foundational platform for this study because it depicts how IPV victims react and interact with their environmental systems to a point where they seek for help or choose not to. Through the lens of ecological systems theory, themes that frequently emerged across all the 15 participants regarding their accounts of IPV and its impacts can be interpreted.

According to all 15 participants of this study, IPV closes the microsystems by terminating the influences and supports that originate from the victims' families and

friends. The termination of relationships in an individual's microsystems frequently fueled the IPV pattern by increasing women's vulnerability and dependence toward their abusive violent partners. This finding aligns with Rodriguez et al.'s (2009) sentiment that cultural beliefs within some African American communities reinforce nondisclosure of IPV issues and maintain violent relationships despite the negative implications that arise from stigma. Steven-Watkins et al. (2013) also asserted that it is part of African American culture that unprivileged and dependent African American women with limited economic resources and chronic psychological stressors believe that hard work and self-determination are required to overcome adversities like IPV. This narrative implies that African American women in abusive relationships would instead focus on hard work and determination in their livelihoods rather than seek support from their microsystems or relevant institutions for help.

Additionally, findings regarding IPV patterns among all 15 participants revealed that their abuse experiences often began with emotional and verbal abuse. This abuse was followed by tendencies of isolation and experiences of shame and inadequacy, thus discouraging them from reaching out for microsystem support. For instance, March frequently internalized the negativity she received through emotional and physical abuse, though she had high self-esteem. This finding is supported by Nicolaidis et al. (2010), who stated that victims of IPV are often described as having depression with symptoms such as social isolation, hopelessness, sadness, loss of energy, suicidal thoughts, and guilt. Ouellet-Morin et al. (2015) also illustrated that IPV leads to depression and exposes them to the risk of poor mental health due to emotional and physical abuse.

The findings revealed that all participants experienced interference with their interaction ability with individuals outside their relationship microsystem. Some of the participants reported that their partners forbade them from attending to work and confiding to friends who were supportive of them. They are forced to lockdown their experiences to themselves and are housebound. Further, the cultural emphasis on self-reliance among African American communities often assumes that reaching out and sharing personal traumatizing experiences is equivalent to announcing their weakness in society (Rodriguez et al., 2009). Therefore, many African American women with IPV do not confront unhealthy relationships lead to adverse effects on their relationships and mental health.

Findings from the research also revealed that as the relationship microsystems of all participants became more closed and isolated, a number of these participants were subjected to escalating IPV, which included physical abuse that resulted in frequent emergency room visits or even rape. The self-amplifying cycle of IPV, isolation, increased vulnerability, and shame to further IPV was increased when the prior relationships of participants with their childhood families made potential sources of support more unapproachable. If these participants escaped from the hands of their abusers, they remained isolated temporarily due to their ability to trust other individuals, disclose the IPV traumatic experiences, or even accept intimacy from others. This outcome is supported by Furlow (2010), who documented that if women affected by IPV do not confide about their situations, the effect is escalating IPV, which leads to trauma and other mental health conditions to the victims of domestic violence. The severity of

IPV attacks among African American women is more rigorous and when the victims experience frequent physical attacks, which leads to serious physical injuries on the body and the brain (Furlow, 2010).

Research Question 2: What are the Treatment Barriers Faced by This Group of Individuals from an Ecological Framework?

Cultural Inhibitions and Treatment Costs are Macrosystem Barriers

According to Bronfenbrenner (1979), a macrosystem refers to the cultural context in which individuals live. A macrosystem is the larger culture that incorporates an individual's socioeconomic status, ethnicity, wealth, poverty, parents, children, and the workplace (Bronfenbrenner, 1979). Under this theme, results from the findings revealed that the participants described two critical macrosystem barriers to treatment: cultural obstacles and treatment costs. Cultural barriers are disapprovals that prevail within the African American community of seeking treatment and the barriers for communication encountered in an attempt to contact health care providers and law enforcement officers. Treatment affordability results from high treatment costs and a lack of insurance and public assistance.

From the research findings, five out of 15 participants demonstrated that disapproval of treatment procedures in communities' health centers was a key barrier due to the increased feeling of shame that deters access to resources. The result of macrosystem cultural inhibitions with respect to treatment-seeking within their communities identified that the presence of shame discouraged IPV African American women from seeking help. Three participants reported the distrust between victims and

first responders as cultural barriers. Rather than feeling supported and protected, the participants reported feeling ridiculed by law enforcement officers. This finding aligns Sabri et al. (2015), who illustrated that IPV is a common occurrence among African American women, but they often fail to seek treatment for the fear of being perceived as weak in society. Bryant-Davis et al. (2009) also supported this sentiment by asserting that African American women in the United States are often faced with various social injustices such as sexist and racist behavior from law enforcement officers aimed against them when trying to hold the police accountable to protect their lives. Overstreet et al. (2013) also explained that the interaction of African American women with law enforcement officers exposes them to sexual and racial vulnerabilities, thus discouraging them from seeking help. Sabri et al. further added that these women often feel ashamed to confide to health care professionals due to distrust and the fear of being perceived as a disappointment to the African women fraternity. This aspect stands as one of the barriers that contribute women suffer in silence as their IPV continues to escalate.

From the findings, eight of the 15 participants also revealed that treatment costs were a significant barrier to their treatment. The participants mentioned various reasons why they could not afford the costs of treatment. Some of the reasons included lower standards of living, loss of health insurance, higher costs of health care, and complicated insurance requirements that raise the general price of health care. Aubuchon-Endsley et al. (2014) suggested that socioeconomic status is regarded as the most prevalent factor that is associated with IPV among African American women and often related to financial costs. Women in African American communities affected by IPV may be

unable to afford treatment thereby resulting in a lower enrollment in treatment programs (Aubuchon-Endsley et al., 2014; Bryant-Davis et al., 2009).

Research Question 3: From an Ecological Perspective, what are the Views and Experiences of African American Women Survivors of IPV with the Health Care System?

Connecting with Providers Opens the Relationship Microsystem

Under this theme, findings from the research indicate that the revelations of participant experiences with the health care system were distinguished into negative and positive experiences. These experiences were expressed in line with the perception of participants that accessing healthcare was positive when they connected with healthcare providers and negative when there was a disconnection with healthcare providers. The participants indicated that they often associated with healthcare providers through shared experiences and feelings of empathy from health care providers. At the same time, the associated negative experiences of African American women during treatment resulted to disconnection with uncaring or unrelatable providers of health. For instance, July stated that she met with a therapist for a period of time who often empathized with her and wanted to help, but the therapist had not been a victim of IPV. This finding aligns with studies by Overstreet et al. (2013) that argued that IPV victims might perceive their experience as delegitimized due to cultural stigma. In addition to shame, fear of retaliation and embarrassment are other factors that inhibit these women from seeking help. This argument implies that they may not conceal their experiences to individuals that they are not connected to psychologically. For instance, studies by Sabri et al. (2015)

demonstrate that African American women often perceive a negative stigma in seeking mental health services, and this stigmatization can further present as a barrier to initiating treatment. This perception arises from other life experiences that Black women encounter as they seek social services in communities such that they may profile health care bodies as racially inclined institutions (Overstreet et al., 2013).

According to the findings of this study, the majority of the participants indicated that they would elect being attended to by African American health care providers in the future since they would be more empathic to fellow African American patients. All 15 participants held the conviction that the effect of positive health experiences, resulting from positive connections with healthcare providers, reduced the isolation of patients with the microsystems and later connected to their macrosystem relationships. Studies by Zacarias et al. (2012) support this finding by stating that the comfort of connectedness, understanding, and meaningful dialogue is key to the social support of African American women in abusive relationships. African American women in abusive relationships often feel more comfortable sharing personal information about their ordeals with people they know and trust, as opposed to individuals who are strangers such as healthcare providers (Valandra et al., 2016). Valandra et al. (2016) also documented IPV victims may have difficulty locating a therapist or a health care provider whom they regard as knowledgeable about their experience. Also, a number of IPV victims often seek help from health practitioners from the same racial background, one that has had experiences with IPV issues in the past, or one who is a survivor of IPV (Valandra et al., 2016; Zacarias et al., 2012).

Research Question 4: What Additional Resources do Survivors of IPV need to Repair Their Traumas and Thrive Again?

The Need for Belief and Acceptance

Under this theme, findings from the research indicate that 12 out of 15 participants identified that the most significant need as survivors of IPV was for an individual to believe in the reports they presented and accept their situations without shame or judgment. Out of the 12 participants, the majority opined that resources needed by IPV survivors were available but were not accessible because their IPV accounts were often doubted by health care providers and law enforcement officials. On the other hand, a section of participants held the conviction that their expectation of judgment and disbelief in the community enforced the isolation of IPV victims in abusive relationships if they attempted to reach out for support. This finding is supported by Fraser et al. (2002) whom asserted that African American women affected by IPV in abusive marriages confide to people they know and trust because they believed they will get support from these confidants. African American women encounter various social injustice in their day-to-day undertakings in the U.S. These injustices include racism, white supremacism, distrust from law enforcement officers, intracommunal issues related to snitching resulting in conflicts, and social segregation (Fraser et al., 2002; Lewis & Szymanski, 2016). In the view of Fraser et al. (2002), African American women are often discriminated against for being black, and for being women, but they continue to exist in both identities at the same time. The virtue of being a Black woman, not only affects them when they are the place of work or in social gatherings, but also when seeking

social services (Fraser et al., 2002; Lewis & Szymanski, 2016). Lewis and Szymanski opined that the level of discomfort which Black women communicate with the law enforcement officers due to the fear and distrust they hold against the police reveals how the intersection of class, race, and privilege impacts the intersection between the police and Black women in the U.S. Aubuchon-Endsley et al. (2014) also added that discrimination and fear or mistrust of providers and law enforcement impacts treatment-seeking for African American abused women.

Recommendations to Eliminate Treatment Barriers Confronted by Women with IPV Experience

Watson et al. (2020) opined that to work inclusively with African American women victims of IPV, understanding why they opt to remain in abusive relationships is important since they may not seek help soon. Watson et al. add that some of the barriers that prevent IPV victims from seeking help result from the psychological and emotional impacts of domestic abuse, while others may be practical, cultural, or social. In the view of Watson et al. (2020), health care and law enforcement practitioners must take responsibility and keep a range of issues relevant to African American women affected by IPV at the front of their mind when identifying potential abuse, encouraging or enabling disclosure, evaluating assessments, and planning effective interventions. Health and law enforcement officers must acknowledge various laws associated with their legal obligations, to determine which action to take once abuse is reported.

Pickover et al. (2018) asserted that while some IPV victims have good and positive experiences with healthcare professionals and law enforcement officials, a

majority of them do not trust agencies mandated to deal with such atrocities. Although these victims may be reluctant to disclose their ordeals, they often have the hope that someone will give them a listening ear, and this makes a significant difference to them. Pickover et al. (2018) recommended that repeated inquiry to the victims of IPV increases the likelihood of their disclosure. It is the responsibility of health care providers, counselors, and law enforcement officials to make inquiries when IPV victims are safe to disclose and in circumstances that will not increase their risk in the future. This aspect implies that building-up trust regarding the approach of the organization and their representatives to IPV victims will make them comfortable to disclose.

Lastly, Ferrari et al. (2016) recommended the introduction of support groups in African American communities for victims of IPV. These support groups will offer them group therapy and a platform where they can disclose, given physical and emotional support, and be referred to relevant authorities in case they need specialized medical assistance. Such therapy groups often aid women impacted by IPV to build their self-esteem, belonging support, locus of control, less traditional attitudes towards marriage and the family, a reduction in perceived stress, and improved marital functioning (Ferrari et al., 2016). These groups also equip them with skills on how they can avoid physical and non-physical abuse and control their occurrence in the event they erupt. Besides, support groups for women affected by IPV tend to issue them with life skills on various life aspects, such as empowering women to be independent in thinking, finance, and improve life status (Ferrari et al., 2016).

Research Limitations and Recommendations

In various studies, limitations of study often exist due to methodological or research design constraints. This qualitative phenomenological study encountered some limitations, even as the researcher attempted to ensure that the outcomes of the research were entirely based on the research design and the adopted methodology. First, the use of interviews as a data collection method resulted in limited access to data that was required regarding the study. The questions administered to respondents by the researcher were personal from some of the participants' perspectives. Some respondents were not able to give detailed information regarding their experience with IPV, thus resulting in limited access to data.

Interview data collection methods are also vulnerable to subjectivity as the interview responses are based on the opinion, memory and understanding of participants. Subjectivity is described as a way that a research is influenced by the values, perspectives, social experiences, and viewpoints of the researchers (Creswell, 2013; Vogt et al., 2012). In this case, this research recommends that future researchers undertaking such an investigation embrace the use of a structured questionnaire to avoid subjectivity. Questionnaires are often used to elicit from the researchers' subjective information regarding their thoughts and perspectives (Creswell, 2013; Vogt et al., 2012). Besides, the interview method for data collection should be adopted alongside questionnaire used to obtain more focused answers and avoid irrelevant answers. For future researchers seeking to carry out studies in related fields, furthermore, they need to put reliance on

both secondary and primary data to enhance the relevance and accuracy of satisfactory results.

This qualitative study was limited to African American women who were in heterosexual relationships that were abusive. Besides, the participants' geographical location was a limitation going by the cultural considerations in the country's specific regions, which could affect the existing individual and social viewpoints.

Implications of the Study

This qualitative phenomenological research is significant to positive social change at different levels at an individual, family, societal, and policy levels. First, at the individual level, the outcomes of this research will identify the experiences that African American women affected by IPV undergo. These outcomes will also equip them with knowledge and skills on how to confront barriers when seeking mental health treatment, such as discrimination, negative stigma, distrust in the health care system, and other significant cultural factors. Through knowledge gathered by this research, these women will adopt new mindsets that will help them navigate the health care system as they seek mental health counseling and treatment for their conditions. The new mindsets of African American women will be adopted through policy makers and local authorities who are encouraged to embrace the recommendations proposed by this study. Proposed recommendations such as the introduction of therapy support groups will train women on how to handle IPV and report to relevant officials in the case of an occurrence. At the family level, this research will encourage women facing IPV to seek immediate help from

their microsystem. The study will expose women affected by IPV to the significance of their microsystem as an intervention to abuse.

The research also encourages women to focus on their families as an imperative microsystem of support if they experience IPV from their spouses. The outcomes of this research will save families that are yet to break up due to IPV. The recommendation of support issued to African American women will teach women how to deal with IPV so that other members of the family, such as children, are not affected. In the context of society, this investigation will positively impact the community by aiding women facing IPV through various support avenues after experiencing IPV. Through the recommendation of introducing support groups run by African Americans to empower women affected by IPV, they will be supported by making them resilient to discrimination and negative stigma. The presence of African American group administrators will encourage these women to invest their trust in the health care system to help them deal with the consequences of IPV. If they are not entirely run and administered by fellow African Americans, these support groups will be less effective since the distrust levels in society is deeply rooted and going by the social injustice that many African Americans encounter in a society that is manned by institutionalized racism (Bryant-Davis et al., 2009).

Lastly, this investigation will compel local authorities and health care administrators to come up with policies to aid African American women with IPV violence in communities. Some of the legal aspects that should be enforced include; taking legal action against abusers, formulating additional laws to punish health care and

law enforcement officers who are reluctant to take action once an abuse case is reported, and policies to empower women so that they do not become dependent to abusive partners.

Conclusion

This chapter provided an interpretation of findings, the limitations of study, recommendations, implication, and conclusions regarding the study that treatment barriers that are confronted by African American women with experiences of past abusive relationships. The purpose of this qualitative study was to explore the treatment barriers for African American women affected by intimate partner violence (IPV) and their views regarding the healthcare system. Women affected by IPV are characterized by mental health disorders, which include; PTSD and depression, among others. During the previous investigation, researchers concluded that studies on the symptoms revealed by battered women are consistent with PTSDs that would likely prevail due to multiples experiences of victimization. Going by the outcomes of this research, the researcher recommends that health care practitioners and law enforcement practitioners must take responsibility and make inquiries when IPV victims are safe to disclose their ordeals. The researcher also recommends some proposals to support African American women affected with IPV. These include the introduction of various support groups to offer them a platform where they can confide, issued with physical and emotional support, and be referred to relevant authorities in case they need specialized medical help.

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Appendix: Resource Information

Main Street Counseling Center
West Orange, New Jersey