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"Bruises heal by theyself": Experiences and perceptions of help-seeking among survivors of intimate partner violence in Metropolitan Atlanta

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University of Wisconsin-Madison

2019

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An abstract of

A thesis submitted to the Faculty of the

Rollins School of Public Health of Emory University

in partial fulfillment of the requirement for the degree of

Master of Public Health in

Global Health

2023

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Introduction: Intimate Partner Violence (IPV) is an endemic health issue that threatens populations' health and well-being across the world. In the United States, Black, Indigenous, and People of Color (BIPOC) experience disproportionate rates of IPV and are less likely to seek help compared to White populations. Within the racially and ethnically diverse geographic area of Metropolitan Atlanta, there is a dearth of evidence about how IPV survivors seek help to improve their well-being. The purpose of this study was to understand the experiences and perceptions of survivors of IPV seeking help in Metropolitan Atlanta.

Methods: Researchers conducted in-depth interviews with 12 IPV survivors who sought formal help services because of their experiences with violence between March 2020 and December 2022. Thematic analysis was conducted to describe the perceptions and experiences of IPV survivors' help-seeking in Metropolitan Atlanta.

Results: Survivors described the complex web of support services they navigated, including health services, social services, and informal help from loved ones. Notably, severe experiences of IPV—typically experiences of extreme physical violence—forced survivors to make quick help-seeking decisions. Participants also commonly sought out and experienced barriers to accessing mental health care. One's own perception of the severity of violence and mental health symptomology acted as key determinants for survivors to seek help.

Conclusions: This study provides a base of evidence for IPV help-seeking in the context of Metropolitan Atlanta. Findings suggest that help-seeking is complex and that the first connection survivors have with formal help is a critical point in time to support IPV survivors.

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Acknowledgments

First, I would like to recognize the 12 survivors who spoke with our research team. I extend a tremendous amount of gratitude to them for being courageous and open to sharing. I hope that their experiences can truly inform future IPV response in Metropolitan Atlanta and improve the lives of others.

Additionally, I want to acknowledge and express thanks to my thesis advisor and mentor, Dr. Dabney Evans. Her guidance, feedback, and passion for this work were immensely invaluable to me throughout this process. I am grateful for the opportunity to work with her on this important research while I am a student at the Rollins School of Public Health. I also want to especially recognize another member of the research team, Kathryn Wyckoff, who led the parent study and was a key contributor to this continued research. I thank her, Subasri Narasimhan, and Nicole Gonzalez for being empathetic and kind interviewers.

The support of my colleagues at the Rollins School of Public Health at Emory University was also critical for me. I thank my professors, especially those who taught me the foundations of qualitative research and working alongside communities, and peers for their encouragement and knowledge.

Lastly, thank you to my closest friends and family who provided unwavering support throughout my academic endeavors. I could not have gotten here today without you!

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Chapter 1: Introduction

Problem Statement

The World Health Organization (WHO) defines IPV as, "behaviour within an intimate relationship that causes physical, sexual or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse and controlling behaviours" (2022). This definition encompasses present or previous partners from one's intimate relationships and is not specific to a particular gender or sexuality. IPV occurs globally, with an estimate that approximately one in four women aged 15-49 have experienced physical and/or sexual IPV in their lifetime (Sardinha et al., 2022). This estimate comes from national-level data from 161 countries and demonstrates the extent to which IPV impacts women worldwide (Sardinha et al., 2022). The prevalence of IPV is accompanied by the vast number of negative health outcomes. Evidence of short- and long-term impacts on one's physical, mental, sexual, and reproductive health are well-documented (WHO, 2013).

Within the United States (US), the Centers for Disease Control and Prevention (CDC) has found that 41% of US women report experiencing IPV, defined as experiencing and reporting sexual violence, physical violence, and/or stalking perpetrated by an intimate partner, in their lifetime (2022). US women are more likely to report experiencing IPV than US men, with 26% of men reporting experiencing IPV in their lifetime (CDC, 2022). Differences in prevalence rates also exist across racial and ethnic groups. In the US, approximately 30% of White women experience IPV in their lifetime (Black et al., 2010). In comparison, 43.7% of Black women, 37.1% of Hispanic women, 46.0% of American Indian or Alaska Native women, and 53.8% of multiracial women experience IPV; data on Asian or Pacific Islander populations are limited but suggest that nearly 20% experience IPV in their lifetime (Black et al., 2010). These rates

demonstrate the disproportionate impact IPV has on Black, Indigenous, and People of Color (BIPOC).

Within the state of Georgia, the lifetime prevalence of IPV among women, 35.1%, is similar to the US average (Black et al., 2010). This percentage represents nearly 1.2 million women in Georgia. Data stratified by race, sexuality, and other factors are unavailable at the state level, but the nationwide disproportionate prevalence rates by race and ethnicity are essential to understand when considering that the Metropolitan Atlanta area has a population where nearly 50% of people identify as Black or African American (U.S. Census Bureau, 2021). The global endemic nature of IPV and the adverse health consequences survivors experience demonstrate the importance of this issue.

Purpose Statement

The purpose of this study was to better understand how IPV survivors seek help from IPV resources in Metropolitan Atlanta. For the various organizations and institutions that work to prevent and respond to IPV, listening to survivors' lived experiences and perceptions of resources are important for future programming and policies.

Research Objectives and Aims

The objective of this study was to understand the experiences and perceptions of survivors of IPV seeking help in Metropolitan Atlanta.

The aims of this study were to:

Aim 1: Understand survivors' attitudes and beliefs towards IPV-related help;

Aim 2: Examine help-seeking behaviors among IPV survivors; and

Aim 3: Identify key facilitators and barriers to help-seeking.

Significance Statement

It is essential to understand how IPV survivors seek help and navigate the current landscape of IPV-related services in Metropolitan Atlanta. The perspective of IPV survivors provides crucial data related to formal help services and systems-based barriers. The input of survivors may provide critical feedback to improve how existing services address survivors' needs. Further, survivors may inform the development of future interventions and policies that are most appropriate and acceptable to them.

Chapter 2: Comprehensive Review of the Literature

A review of existing literature about intimate partner violence (IPV) and survivors' help-seeking behaviors is necessary to understand IPV survivors' experiences, perceptions, and interactions with IPV services in Metropolitan Atlanta, Georgia.

Intimate Partner Violence

The World Health Organization (WHO) defines IPV as, "behaviour within an intimate relationship that causes physical, sexual or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse and controlling behaviours"(2022). This encompasses current or previous partners from one's intimate relationships and is not specific to a particular gender or sexuality. Yet, most of the existing IPV literature and indicators focus on heterosexual and cis-gendered women, with survivor and perpetrator data generally differentiated on a binary sex scale consisting of female or male. On a global scale, it is estimated that approximately one in four women aged 15-49 have experienced IPV, defined as physical or sexual, or both, violence perpetrated by an intimate partner (Sardinha et al., 2022). This estimate comes from national-level data from 161 countries and demonstrates the extent to which IPV impacts women worldwide (Sardinha et al., 2022).

Within the United States (US), the Centers for Disease Control and Prevention (CDC) finds that 41% of US women report experiencing IPV, as defined as experiencing and reporting sexual violence, physical violence, and/or stalking perpetrated by an intimate partner, in their lifetime (2022). US women are more likely to report experiencing IPV than US men, with 26% of men reporting experiencing IPV in their lifetime (CDC, 2022). Growing evidence about the experiences of IPV survivors with other sexual orientations and gender identities (e.g., lesbian, non-binary) find that they experience similar, if not higher, prevalence rates as compared to

heterosexual, cis-gendered people (Petzmeier, 2020; Rollè et al., 2018). Data on IPV in transgender populations especially highlights the unique experiences of those populations; a meta-analysis of 85 academic articles found that a transgender individual is nearly twice as likely to experience IPV than a cisgender individual (Petzmeier, 2020).

Differences in prevalence rates also exist across racial and ethnic groups. In the US, approximately 30% of White women experience IPV in their lifetime (Black et al., 2010). In comparison, 43.7% of Black women, 37.1% of Hispanic women, 46.0% of American Indian or Alaska Native women, and 53.8% of multiracial women experience IPV; data on Asian or Pacific Islander populations are limited but suggest that nearly 20% experience IPV in their lifetime (Black et al., 2010). These rates demonstrate the disproportionate impact IPV has on Black, indigenous and other people of color (BIPOC). Within the state of Georgia, the lifetime prevalence of IPV among women, 35.1%, is similar to the US average (Black et al., 2010). This percentage represents nearly 1.2 million women in Georgia. Data stratified by race, sexuality, and other factors are unavailable at the state level, but the nationwide disproportionate prevalence rates by race and ethnicity are essential to understand when considering that the Metropolitan Atlanta area has a population where nearly 50% of people identify as Black or African American (U.S. Census Bureau, 2021).

It crucial to note that reporting on IPV may use different definitions and indicators to measure violence perpetrated by an intimate partner. Additionally, reporting involves multiple organizations and institutions, including healthcare and law enforcement officials. This makes it difficult to make a comparative analysis of IPV globally, nationally, and by state. On top of these challenges, stigma surrounding disclosure impacts surveillance data. Existing literature documents how the fear of negative social reactions impacts survivors' willingness to disclose

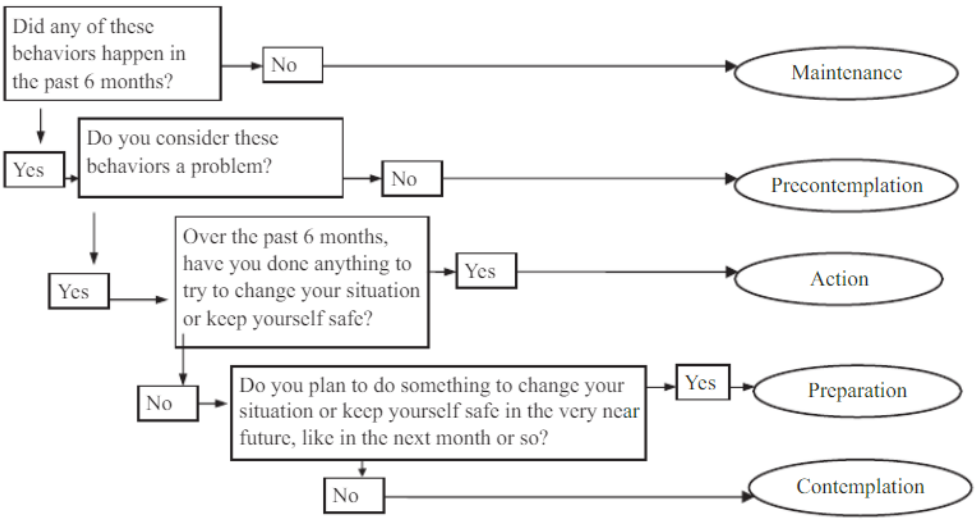
IPV (Kennedy & Prock, 2016; Ullman, 2021). This not only impacts reporting, but also a survivor's experience with seeking help.

Help-Seeking

Help-seeking theories

Conceptual frameworks and concepts of help-seeking have been derived from the field of psychology, often used to discuss mental health help-seeking (Mojtabai, 2016; Nagai, 2018; Rickwood & Thomas, 2012). The utility of help-seeking theory is evident as it continues to expand to different fields of study and topics, such as help-seeking for financial assistance (Lim et al., 2014) and health care seeking (Mahalik, 2003). A basic model that is adaptable to various contexts incorporates three stages: 1) recognizing and defining a problem, 2) deciding to act to seek help, and 3) selecting what type of support is desired (Cornally & McCarthy, 2011; Liang et al., 2005). This model has similarities to another useful framework for considering behavior change: the stages of change theory. In considering if the stages of change theory—pre-contemplation, contemplation, preparation, action and maintenance—was useful, researchers found that it was not helpful to define the stages in relation to IPV survivors' experiences (Burke et al., 2009). Though they created a model to follow (Figure 1), they found that defining "preparation" and "action" was difficult; survivors in the "preparation stage" were already engaged in behaviors to promote their safety while in an abusive relationship (Burke et al., 2009). Due to the challenges of defining stages and survivor's unique preferences for action, the stages of change model is not the most helpful approach when considering IPV. More broadly, help-seeking and behavior change are not always linear and may be cyclical.

Figure 1. IPV Stages of Change



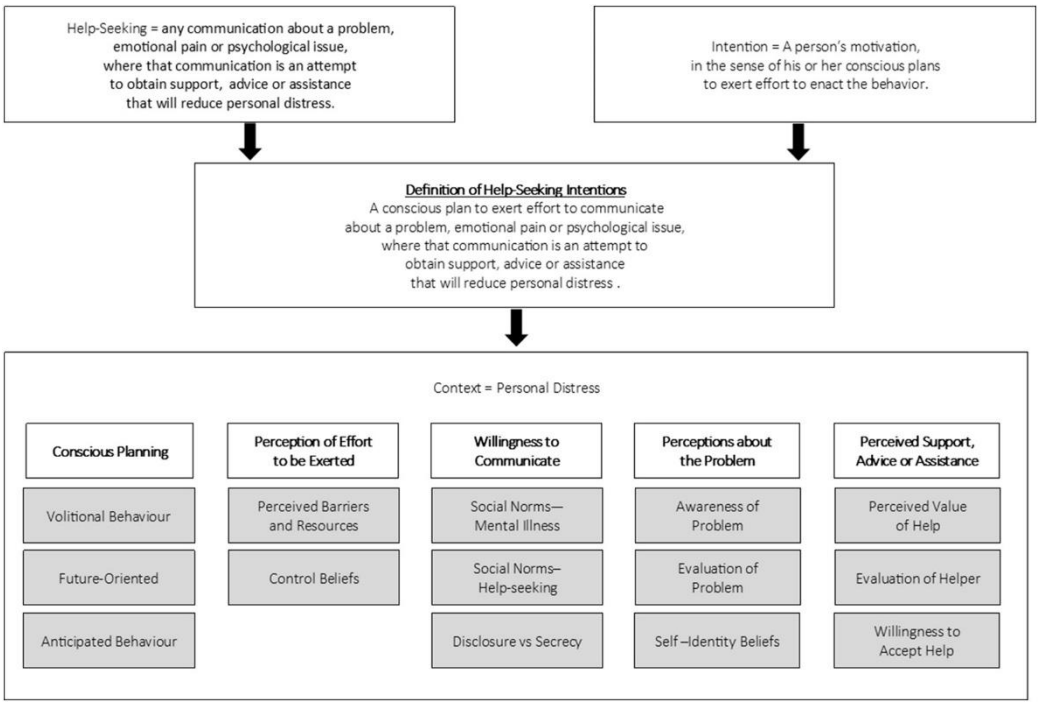
Note. From "Defining appropriate stages of change for intimate partner violence survivors," by J. G. Burke, P. Mahoney, A. Gielen, K. A McDonnell & P. O'Campo, 2009, *Violence and victims, 24*(1), 36-51, (https://doi.org/10.1891/0886-6708.24.1.36). Copyright 2009 by Violence and Victims.

Stage theories only make up one type of help-seeking theories. A comprehensive systematic review of help-seeking theory cited three other theory categories: Expectancy-value models, dual-process models, and series frameworks (White et al., 2018). Series frameworks relate to stage theories in that a person goes through a series of processes that impact their motivation to seek help (White et al., 2018). The expectancy-value models are commonly used in addition to stage or series frameworks to describe the cognitive and social factors that may interrupt the process of a person going through various stages; an often-cited example of this is the Theory of Planned Behavior (Rickwood & Thomas, 2012; Cornally & McCarthy, 2011; Liang et al., 2005). These theories focus on individual cognitive aspects and interacting social factors which are important when considering IPV survivors' help-seeking. Dual-process models, such as the Prototype Willingness Model (Hammer & Vogel, 2013), bring another

perspective to help-seeking that challenges how help-seeking theories assume people experience an intentional process of help-seeking. Instead, Hammer & Vogel argue that environments and social conditions can impact one's spontaneous willingness to seek help (2013).

White et al. found key overlapping elements which are conscious planning, perception of effort to be exerted, willingness to communicate, perceptions about the problem, and perceived support, advice or assistance (2018). The number of components and sub-components demonstrate how intricate this process is (Figure 2). While organized into these separately listed categories, the reality is that all factors contribute to the context and interact with each other. The strength of each component may differ among individuals and even change over time. Certain issues are not best addressed by focusing on a single component. This is crucial when considering interventions related to help-seeking. For example, a common intervention may seek to address knowledge of the problems (e.g., education and awareness of health issues), but this can only impact the help-seeking process to a certain degree (Cornally & McCarthy, 2011). Understanding the full context of people seeking help is of the upmost importance.

Figure 2. Help-Seeking Elements



Note. From "What do help-seeking measures assess? Building a conceptualization framework for help-seeking intentions through a systematic review of measure content," by M. M. White, B. A. Clough & L. M Casey, 2018, *Clinical psychology review*, *59*, p. 70 (https://doi.org/10.1016/j.cpr.2017.11.001). Copyright 2018 by Clinical Psychology Review.

IPV help-seeking approaches

In the study of IPV, general help-seeking theories may aid to better understand the process through which survivors seek support. This is especially true as IPV survivors may seek mental health help, which is the backbone of help-seeking research. However, studies about IPV help-seeking typically lack a theoretical approach, though aspects of help-seeking theories do inform a select few of IPV studies. Namely, studies have focused on concepts of person-centered and behavioral considerations, cognitive aspects, and social norms (Fleming & Resick, 2017; Nurius et al., 2011). These aspects align with expectancy-value theories. Person-centered

approaches are beneficial in the way they acknowledge people are multi-faceted and that even those with similar demographics (e.g., age and race) may differ in help-seeking actions. While it is useful to recognize the individuality of people, these current approaches risk investigating separate issues when an amalgamated model is more appropriate.

In a recent study, researchers wanted to apply two theoretical approaches—one emphasizing personal demographics and the other focusing on perceptions of survivors and norms—to analyze IPV help-seeking (Fleming & Resick, 2017). These approaches relate to previously mentioned concepts like "perceived support, advice or assistance" and "perception of effort to be exerted" (White et al., 2018). Fleming and Resick found variables that were related to a higher level of help-seeking; these variables included older age, having PTSD, experiencing high levels of psychological violence, experiencing lower levels of depression, perceived usefulness of potential resources, perceived control of situation, and having an active coping strategy were related to higher levels of help-seeking for female survivors of IPV (2017). The findings from this study are helpful in beginning to understand the complex realities of help-seeking among IPV survivors focused on individual perceptions and experiences. Still, there is an overall need for more data collection and exploration of help-seeking to deepen the understanding of how survivors make decisions regarding what type of help and when they seek, how that process is, and their perceptions of utility and helpfulness of resources (Ansara & Hindin, 2010; Fleming & Resick, 2017). Specifically, understanding community and societal-level factors—such as accessibility to programs, policies and laws— and the way they interact with individuals' perceptions and experiences of seeking help would be beneficial (Ansara & Hindin, 2010; Fleming & Resick, 2017).

Another strategy to analyze the help-seeking process is to first describe facilitators and barriers to care and then consider the theoretical frameworks in which they fit. A comprehensive systematic review of facilitators and barriers of 29 studies found six key barriers for survivors accessing formal resources: 1) lack of awareness of resources and identifying IPV, 2) challenges accessing resources (i.e., accessibility issues), 3) fear of disclosing abuse and those consequences, 4) lack of critical resources such as housing and finances, 5) individual-specific barriers, and 6) issues related to the system (Robinson et al., 2020). In contrast, Ravi et al. found seven facilitators for seeking help from formal resources: 1) provider knowledge, 2) accessibility, 3) support from informal networks (e.g., friends and family) and providers, 4) fear of and desire to prevent further violence, especially in relation to survivors' children, 5) policy factors, 6) personal factors related to the desire to improve wellbeing, and 7) knowledge about services and desire to access them (2021).

To connect these facilitators and barriers to the individual-level theories and approaches, one's awareness of what IPV is and related existing resources, perceived control of situation (e.g., vulnerabilities around disclosing abuse, existing informal networks that may offer support), and factors related to personal motivation and perceived utility of resources are found in multiple IPV help-seeking studies (Fleming & Resick, 2017; Ravi et al., 2021; Robinson et al., 2020). Help-seeking determinants on a community and societal level are those often not featured in help-seeking theories; however, evidence converges on how the lack of accessible IPV resources, systemic issues (e.g., available advocacy, 'slipping through the cracks', disparities in resources), and support of providers impact help-seeking (Fleming & Resick, 2017; Ravi et al., 2021; Robinson et al., 2020). Ultimately, differentiating barriers and facilitators to help by level allows researchers to understand where interventions are needed.

IPV help-seeking among people of color

One important facet of societal-level factors not specifically examined in these studies is racial, ethnic and cultural phenomena. Current IPV help-seeking literature largely focuses on White women. A review of 17 articles found that the differences between racial and ethnic groups in relation to IPV help-seeking were noteworthy (Sayten et al., 2017). Principally, they suggest that Black and Hispanic/Latina women are less likely to seek IPV-related services than White women (Satyen et al., 2019). These groups also have higher hospitalization and police reporting rates and are less likely to access mental health resources compared to White women (Cheng et al., 2022; Satyen et al., 2019). Though race and ethnicity are often considered to be individual demographic data, the varying social, cultural, and structural issues (e.g., structural racism) impact one's trust in the medical system and desire to access formal care that can be crucial to improved well-being (Stockman et al., 2014). Though there may be similarities in the experiences of survivors from minoritized racial and ethnic groups, these experiences are not homogenous. Research on Hispanic women's help-seeking has conflicting results in women's preferred support (i.e., whether formal or informal help is desired), but generally agree that they are less likely to access resources or speak with someone about their experiences, in part due to normative shame, language and sociopolitical factors such as immigration status (Lipsky et al., 2007; Mookerjee et al., 2015; Satyen et al., 2019). Research on Asian, especially South Asian, women experiencing IPV is limited, but several small studies have found that Asian women who sought help were more likely to seek informal support from family or friends but less likely to access mental health resources due to cultural norms and social stigma over mental health (Mahapatra & DiNitto, 2013; Satyen et al., 2019). There is also a lack of substantive data specifically about Black women's experiences with IPV help-seeking; a review of 21 studies

found that racism and racial discrimination were key barriers to seeking support (Waller et al., 2021). Smaller qualitative studies including in-depth interviews with Black women also suggest that internalized racial stereotypes and cultural norms, such as "strong Black women," are an aspect of structural racism that also impacts help-seeking (Monterrosa, 2019; Morrison et al., 2006). Despite the presence of research on racial, ethnic and cultural factors related to IPV help-seeking, the continued examination of factors is critical considering the disproportionate rates of IPV among non-white people.

Type of help-seeking

In the field of study of IPV, survivors access resources that are often categorized as formal or informal. Formal support encompasses, but is not limited to, healthcare, law enforcement (e.g., police), legal services and mental health care. Conversely, informal support includes support from family, friends, neighbors, coworkers and other people in one's network. In considering the different categories of help that survivors may seek, one's individual IPV experiences are important as well. It is also notable that many survivors may not seek support.

Research about informal support finds that most female survivors of IPV do talk about their experiences with at least one person in their network, most commonly with a family member, friend or neighbor—one large-scale study in Canada found that this occurs despite the classification (e.g., physical, sexual) and severity of violence (Ansara & Hindin, 2010; Sylaska & Edwards, 2014). Survivors report that shame is a reason why they may not talk with others and that emotional support from those they disclosed information to, as compared to disbelief and victim blaming, is highly important (Sylaska & Edwards, 2014). These factors are highly relevant to help-seeking theories and formal support itself. The connection is clear that social

support can be helpful for survivors to continue through to the “action phase” and access formal support (Zapor et al., 2015).

Among those who do seek help, accessing formal services is linked to an increase in violence severity among female survivors—especially regarding support from police and healthcare (Ansara & Hindin, 2010). In addition to severity, specific classifications of violence also impact formal help-seeking in complex ways. Women experiencing sexual or psychological abuse seek less medical help as compared to survivors of physical abuse (Cho et al., 2021; Duterte et al., 2008). There is conflicting evidence if survivors of sexual abuse sought legal help, specifically protection orders, at a different rate than survivors of physical abuse (Cho et al., 2021; Duterte et al., 2008; Wright et al., 2021). Regarding mental health resources, a cross-sectional study of 6,870 women aged 18 to 65 found that approximately one in three women accessed mental health resources (Ahmed & McCaw, 2010).

When considering the types of support that IPV survivors seek, it is important to note that these resources do not exist in a vacuum. Although resources may be siloed, female survivors may seek multiple services at the same or differing times, and they may avoid particular services. A study of 369 female IPV survivors found that nearly half of the women sought either formal or informal support, with a large percentage of those women primarily seeking formal services except for law enforcement and legal services (Cheng et al., 2022). This speaks to how nuanced the process of seeking help is for IPV survivors.

Chapter 3: Manuscript
Introduction

The World Health Organization (WHO) defines IPV as, "behaviour within an intimate relationship that causes physical, sexual or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse and controlling behaviours" (2022). This definition encompasses current or previous partners from one's intimate relationships and is not specific to a particular gender or sexuality. IPV occurs globally, with an estimate that approximately one in four women aged 15-49 have experienced physical and/or sexual IPV in their lifetime (Sardinha et al., 2022). This estimate comes from national-level data from 161 countries and demonstrates the extent to which IPV impacts women worldwide (Sardinha et al., 2022). The prevalence of IPV is accompanied by the vast number of negative health outcomes. Evidence of short- and long-term impacts on one's physical, mental, sexual, and reproductive health are well-documented (WHO, 2013).

Within the United States (US), the Centers for Disease Control and Prevention (CDC) finds that 41% of US women report experiencing IPV, as defined as experiencing and reporting sexual violence, physical violence, and/or stalking perpetrated by an intimate partner, in their lifetime (2022). US women are more likely to report experiencing IPV than US men, with 26% of men reporting experiencing IPV in their lifetime (CDC, 2022). Differences in prevalence rates also exist across racial and ethnic groups. In the US, approximately 30% of White women experience IPV in their lifetime (Black et al., 2010). In comparison, 43.7% of Black women, 37.1% of Hispanic women, 46.0% of American Indian or Alaska Native women, and 53.8% of multiracial women experience IPV; data on Asian or Pacific Islander populations are limited but suggest that nearly 20% experience IPV in their lifetime (Black et al., 2010). These rates demonstrate the disproportionate impact IPV has on Black, Indigenous, and People of Color

(BIPOC). Within the state of Georgia, the lifetime prevalence of IPV among women, 35.1%, is similar to the US average (Black et al., 2010). This percentage represents nearly 1.2 million women in Georgia. Data stratified by race, sexuality, and other factors are unavailable at the state level, but the nationwide disproportionate prevalence rates by race and ethnicity are essential to understand when considering that the Metropolitan Atlanta area has a population where nearly 50% of people identify as Black or African American (U.S. Census Bureau, 2021).

Methods

Design

In keeping with the parent study (Wyckoff et al., 2023), this study used a cross-sectional mixed-methods study design. The purpose of this study was to conduct an analysis of survivors' experiences and perceptions of IPV help-seeking. The research team chose to continue to use the qualitative technique of in-depth interviewing from the parent study. Creating safe spaces and building rapport with individuals who have experienced IPV are both characteristics of in-depth interviewing and are essential for this research.

Instrument

The in-depth interview (IDI) was modified from the instrument used in the parent study to broaden the domain of help-seeking. The other sections remained the same as the parent study's original IDI, aiming to explore survivors' perceptions and experiences of IPV help-seeking during the COVID-19 pandemic. The instrument included prompts for participants to reflect on their perceptions and experiences before the COVID-19 pandemic (i.e., before March 2020), during its acute peaks (i.e., 2021), and during the protracted phase of the pandemic (i.e., 2022). To mitigate recall bias, the IDI guide provided selected time frames mentioned previously; participants could use these time periods to frame their responses. Additionally, there

were questions related to participants' perceived facilitators and barriers to help-seeking (Wyckoff et al., 2023).

The research team translated the guide into Spanish. Pilot testing of the Spanish-language IDI guide occurred among Spanish-speaking members of the research team along with Spanish-speaking contacts of research team members. The research team took note of feedback from this process to finalize the Spanish-language IDI guide. Interviews with survivors conducted in the earlier phase of the study also contributed to continual updates to the Spanish-language guide. The research team added additional probes and adjusted questions for clarity. Semantic adjustments were also made to the Spanish version of the IDI guide so that the questions were understood linguistically and culturally among Spanish-speaking participants.

Participants

The eligibility requirements for this study similarly match those in the parent study. Eligible participants must have sought health or social services related to domestic violence between March 2020 and December 2022**.** While recruiting, there was an emphasis to diversify the existing sample from the parent study, especially among Spanish-speaking participants and across racial and ethnic identities.

Recruitment of participants for studies in this research area proved to be challenging. The research team recruited participants via multiple methods. The research team created and distributed a flier in English and Spanish with information about the study itself, the eligibility requirements, the contact information to reach a member of the research team, and a QR code that linked to a Qualtrics survey. This linked survey asked clarifying questions to confirm that potential participants were eligible for the study and had space to fill out their contact information. These fliers were spread widely among domestic violence organization networks in

the Atlanta and Georgia area, both virtually and in-person, and displayed in public places (e.g., grocery stores, laundromats, shopping malls), with an emphasis on the diverse Buford Highway area of Metropolitan Atlanta. Additionally, a select few domestic violence and family health organizations chose to share the flier with specific eligible clients in the case that they had an interest in participating. One domestic violence organization contacted the research team about opportunities to conduct interviews in other languages, but the team did not have the language capacity.

Procedures

Whether the participant contacted the research team directly or filled out the Qualtrics survey, a research team member connected with the individual via the participants' preferred contact method (e.g., text, email, phone call) to discuss the study and their eligibility. As a safety measure, the research team used an agreed upon safe phrase and passcode before each contact with potential participants. All eligible individuals who wanted to participate were included. After the individual confirmed their desire to participate, a Zoom interview was scheduled. Prior to the interview, the participant received a passcode to use during the scheduled Zoom interview—for safety purposes—and a copy of the study's informed consent document. The interviewer reviewed the informed consent form with the participant before the start of the interview and used trauma-informed approaches throughout. The interview was recorded with the permission of the participant. At the end of each in-depth interview, the interviewer provided various IPV resources and a $25 gift card to the participant.

Data Collection

The data collection period was between April 2021 and December 2022. While this period was after the initial outbreak of COVID-19, the instrument has questions for participants

to reflect on their perceptions and experiences before the COVID-19 pandemic (i.e., before March 2020), during its acute peaks (i.e., 2021), and during the protracted phase of the pandemic (i.e., 2022). During these 60 to 120-minute interviews, the safety and privacy of the participants were at the forefront. The interviews include the interviewer, a note-taker, and the participant. Reminding the participant that they could use the established safe phrase or end the interview when they felt unsafe was important.

Following the completion of the interview, the interviewer sent the survivor the same resources provided in the partner study: information about a secure safety planning app and access to a password-protected resource guide with information about local IPV organizations and resources. Following each interview, the research team utilized Happy Scribe to create verbatim transcripts of each interview. A member of the research team who spoke both English and Spanish conducted quality checks for the transcripts.

Data Analysis

For this analysis, all data collected from the parent study, between April 2021 and November 2021, and data collected between May 2022 and December 2022 directly for this portion of the study, were used resulting in a total of 12 in-depth interviews with IPV survivors in Metropolitan Atlanta. The graduate research assistant conducted a thematic analysis following the procedure of the parent study and per Braun and Clarke (2006). First, utilizing the parent study's developed codebook as a base, including both the deductive and inductive codes, the graduate research assistant identified newly developed and defined codes related to help-seeking that were added to the codebook. The graduate research assistant then familiarized themselves with the data, generated preliminary codes, and searched for, reviewed and defined themes

(Braun & Clark, 2006). Additional methods utilized during data analysis included memoing, summaries, and mapping.

Ethical Considerations

Emory University's Institutional Review Board approved this research and found this work to be exempt based on its nature as public health practice. To address potential ethical issues of consent, a member of the research team sent the informed consent document to the participants before the interviews, and the interviewer read the form out loud to the participant and received verbal consent from each participant before beginning the interview. Additionally, the interviewer sent each participant information about a secure safety planning app and access to a password-protected resource guide with information about local IPV organizations and resources – with these resources either in English or Spanish. The interviewer also was available to stay on Zoom after the completion of the interview to provide space for the survivor to process and reflect. These strategies aimed to minimize study harms and re-traumatization and provide support for potential ongoing IPV.

Results

Researchers conducted 12 interviews with IPV survivors, a majority of whom spoke English (n=11). The participants included ten female-identifying survivors, one male-identifying survivor, and one non-binary survivor. Over half of the survivors were Black (n=7); overall, participants who identified as Black, Indigenous People of Color (BIPOC) (n=10) made up most of the sample. The average age of participants was about 37 years old and ranged from 22 to 65 (Table 1).

Table 1. IPV Survivor Demographics

Characteristics	**Overall N=12**
Age in years, mean (SD)	37.08 (3.79)
Gender, n (%)	
Female	10 (83.33.00)
Male	1 (8.33)
Non-binary	1 (8.33)
Race, n (%)	
Black or African American	7 (58.33)
White	2 (16.67)
Mixed	2 (16.67)
Other	1 (8.33)
Ethnicity, n (%)	
Hispanic or Latinx	1 (8.33)
Not Hispanic or Latinx	11 (91.67)
Interview Language, n (%)	
English	11 (91.67)
Spanish	1 (8.33)
Children, n (%)	
Yes	6 (50.00)
No	6 (50.00)
Formal services sought following IPV, n (%)	
Health	11 (91.67)
Community/Social	6 (50.00)

To analyze the perceptions and experiences of the IPV survivors, four themes were established: (1) Severe cases of violence force survivors to make quick help-seeking decisions, (2) Survivors must navigate a complex web of support services, (3) Mental health support is a

critical resource for people experiencing IPV, though survivor satisfaction varied, (4) Informal and formal support networks are crucial resources for IPV survivors.

Theme 1: Severe cases of violence force survivors to make quick help-seeking decisions

The severity of the IPV experiences was an important factor in help-seeking. Survivors only engaged with help services because they felt they were necessary. All participants (n=8) who called the emergency phone number or visited an emergency room expressed fear for their life or grave bodily harm; it was a last resort for them to seek support. The participants who spoke of this detailed experiencing physical harm and how one specific incidence of severe violence led them to seek help. One survivor who spoke about their experiences stated:

> *"[I went to the emergency room] because I was afraid that I might lose my eye. I was bleeding profusely. I felt like I could die." (36-year-old Black/African American female survivor)*

This participant's experience was common across participants. Of the participants who sought emergency help, many (n=5) did so because of what they considered "first-time violence," though participants defined violence differently. One participant explained their partner had physically injured them on only one occasion which prompted them to seek emergency services. Most other participants defined it based on their perceived severity of the violence, such as stating they, "only broke a bone once" with many minimizing their overall experiences of abuse. When asked if they had previously sought emergency help, one survivor said:

> *"No, because none of [the injuries] were this serious. Well, a lot, most of it was just bruises, bruises heal by theyself." (65-year-old Black/African American male survivor)*

While most survivors who sought emergency help discussed first-time violence in terms of the severity of physical violence, they also spoke about experiencing IPV—including all classifications of violence —prior to the incidence that prompted them to seek emergency help.

Subtheme 1.1: Survivors' distrust and perceptions of support services impact decision-making

Participants reported a variety of experiences when seeking help in these emergency situations. Despite the perception that their life was in danger, some participants cited feeling hesitant to call the police or go to an emergency room because of potential consequences. These perceived consequences included fear of being arrested for defending themselves, being arrested for being under the influence, and not wanting to report their partner or get them in trouble. Survivors were emotional while recalling these experiences with two common emotions being fear and anger, both of which were associated with emergency rooms and emergency police. One survivor recalled feeling scared in the emergency room because she had to be in there alone and was not sure what would happen to them and their partner. All participants who visited hospital emergency departments spoke about being alone due to the COVID-19 restrictions at the time. Participants also expressed anger with emergency help. One survivor discussed her thoughts about police's involvement in handling violent situations:

> *"And they're just not honest people like… They'll put things on you… You'll turn around and be the one to go to jail and not the person that actually needed to go to jail. I just don't deal with them. So, no, they wasn't about to flip nothing back on me. Try to manipulate me and tell me why I didn't do this and what I should have done. And, you know, no, women go through domestic violence, you don't tell them what they should had did or how they shoulda did something or what they should have done or what they*

> *could've done. It's either you help them, or you don't help them, it's either or. I just don't deal with them. I just don't deal with them." (23-year-old Black female survivor)*

While participants shared common frustration and experiences of fear and anger engaging with hospital emergency rooms and emergency police, these emotions were not shared by all participants. A few (n=3) survivors mentioned that hospital emergency department staff were kind and attentive. Additionally, two participants, neither of whom identified as Black, shared at least one positive interaction with police. Despite this, these survivors also described having negative experiences with emergency rooms and emergency police, making their relationship with the services complicated. One survivor who had a positive experience spoke about a separate interaction with emergency police that was negative:

> *"The second time that the police got called, I ended up going to jail too. And all I was trying to do is keep him from strangling me and I scratched him. So, somehow, I know there's no way to really do it, but if there's a past history, they need to look at that and realize who the problem is." (44-year-old White female survivor)*

For this survivor, it did not change their willingness to seek help from the police in the future.

Theme 2: Survivors must navigate a complex web of support services

All participants reported that their IPV experiences led them to seek and access formal support. Survivors sought a range of help that includes various institutions and organizations in Metropolitan Atlanta. Participants accessed health resources—ambulances, emergency rooms, urgent care, individual counseling, couples counseling, and support groups; likewise, social services used by survivors included legal protection (i.e., restraining order), police, domestic violence shelters, transitional housing, recovery programs, and financial assistance. Nearly all survivors engaged with multiple formal resources during and after their experiences of

relationship violence. Overall, individual experiences and needs heavily dictated the number of resources a person interacted with and the type of help they sought.

Subtheme 2.1: Health services were often survivors' first interaction with formal help-seeking

Though each person's experience was unique to themselves, survivors commonly sought out health services prior to social services. In addition, apart from instances of emergency police involvement, people's first interactions with formal support were typically a health service, whether through a healthcare entity or a counseling organization. For survivors, health services acted as a potential first point of contact through which they could connect with further health or social service resources.

Half of participants (n=6) had experiences within hospital emergency rooms or interactions with medical personnel (e.g., medical doctors or nurses). Participants shared their stories of overloaded emergency rooms with staff that did not have the capacity to spend a lot of time with them, especially when help-seeking occurred during the COVID-19 pandemic. One participant shared:

> *"All the medical facilities were overflowed, understaffed and they was going through hell... so many people with COVID. So, the regular emergency, you know, their priority was COVID-related. Kinda put [IPV] on the back burner." (65-year-old Black/African American male survivor)*

Aside from legally reporting the incident, multiple survivors (n= 4) who sought health services did not recall being provided further information or referrals to social services and further health resources. In general, survivors' recollections of those conversations varied, and several participants only vaguely remembered the interactions. For example, one person could not recall if resources were provided but remembered that they had to have a short conversation with a

social worker because their injury was “domestic violence or whatever.” Ultimately, this survivor never sought additional resources based on the conversation with the staff member. Of the two participants who were provided resources via medical professionals, only one ultimately sought help from any of those resources.

More notably, survivors remembered interactions with medical professionals regarding reporting their specific incident of violence to the police. One survivor mentioned they assumed it would be an automatic process, but upon being asked had to consider if they wanted to file a police report. Another survivor reflected on being asked if they wanted to report their partner:

> *“They did not provide resources at all, but they were going to report it. And I was like, oh, no, I'm going to take care of it. But I was too scared to take care of it, ultimately. I mean, I wish I had. You know, hindsight is 2020.” (44-year-old White female survivor)*

Distinctly, survivors who first interacted with mental health support instead of other forms of health services shared different experiences. There were fewer survivors (n=4) whose first interaction with formal support was for mental health-related reasons, but those who did expressed mainly positive aspects of their experiences and interactions with providers upon their first visit and continued to regularly access mental health help. Most (n=3) of these participants exclusively sought mental health help rather than in combination with other health or social support services. For the participant who sought further sources, they described a positive experience with their provider:

> *“To seek help, to put it how they say it, I educated myself because I did not know all what violence was very well. Then I had to find a psychologist. The psychologist recommended me to a support group which continue to help me learn and educate myself to better my life.” (translated from Spanish; 28-year-old Hispanic female survivor)*

A survivor's first interaction with formal support sits in the complex web of services. The experiences of survivors collectively detail how these first interactions can vary, influencing their subsequent decisions about what other types of support to seek.

Theme 3: Mental health support is a critical resource for people experiencing IPV, though survivor satisfaction varied

Among all participants, the most sought-out form of help was counseling (n=8), with most of these survivors (n=7) accessing mental health help. This type of support differed from other types of support because people sought out mental health help regardless of the type or severity of the IPV they were experiencing.

Another aspect that distinguishes mental health support as a unique source of help among participants is the variability in when and why survivors sought support in relation to their relationship. The primary distinction was whether or not survivors were still in a relationship where violence was present.

Of the participants who sought mental health care, half of the survivors sought mental health help while in a relationship (n=4). Those who sought mental health help during their relationship described experiences of individual and couples therapy sessions. One of the reasons these survivors sought therapeutic services while in a relationship was because of an expressed desire to have a resolution in their relationship. A participant discussed their interactions with a counselor and the impact it had on their relationship at the time:

> *"[It] kind of like put things into perspective and, yeah, help talk through certain things...like maybe being able to advocate for myself. Um, 'cause I'm the one who, like, ended the relationship and like, um, told, said what I wanted of the relationship or what I wanted to change." (22-year-old mixed race female participant)*

Independent of survivors' relationship status at the time of seeking mental health care, participants generally described wanting to focus on and heal themselves as the motivation behind talking to a counselor. All participants who sought out mental health help noticed the negative impacts of violence on their mental health; they described wanting to focus on themselves and their healing as a major factor of seeking therapeutic services. Survivors' self-awareness of the effects of violence acted as a facilitator and motivator to seeking care.

For those who did seek mental health care, survivors also commonly spoke of how seeking help was not straightforward. Many survivors (n=5) who sought mental health support were unsatisfied with the process. Participants frequently mentioned barriers like insurance status and/or cost associated with mental health care. Having health insurance was not always a facilitator for seeking care. One participant stated:

> *"I mean, I sought therapy services, but my insurance is crappy, and so because my insurance is crappy, I don't... I don't want to have to pay as much money as I would have to pay, so I declined the services because of that." (39-year-old Native/White female survivor)*

Accessing care is an important aspect of seeking help; this similarly differed depending on the person's insurance status and which support they desired. Some found a provider through their insurance company, while others were referred to a provider by another service they sought, such as a violence prevention organization. The few (n=3) participants with positive experiences seeking mental health care cited a straightforward process where they found a provider they liked and stayed with them. One of the participants who had a positive experience mentioned how they found their provider because their child's school had sent home a flyer asking about any support that families needed at the time of COVID-19. Once participants met with their mental health

provider, multiple survivors (n=4) mentioned issues with providers no longer accepting their insurance as well as their experiences bouncing between providers or types of therapy, which elongated and complicated the experiences of receiving care. A survivor described their experience with this:

> *"I was with her, and I started to get comfortable with her. As soon as I started to get comfortable with her, she was like, well, [text], I won't be able to work with you anymore. I'm going to refer you to this next lady. And then I never heard from the next person." (36-year-old Black/African American female survivor)*

As mentioned by this survivor, provider availability and other healthcare system factors complicate help-seeking. Survivors did not commonly mention how they visited with their counselors, but two participants explicitly mentioned that having virtual visits with their providers made the visits more accessible to them. One of these participants also explained utilizing an app on their phone to receive free mental health help. This same participant mentioned seeking additional online mental health resources, such as 'Therapy for Black Girls,' that were more general and did not have a provider.

Overall, survivors' perceptions and experiences of seeking and accessing mental health care differed across participants. This was also true for the perceived quality and helpfulness of mental health help. For several survivors, therapeutic services were beneficial and even empowered them to end their relationships. Others were met with barriers and said they did not find the care helpful.

Theme 4: Informal and formal support networks are crucial resources for IPV survivors

Sub-theme 4.1: Loved ones can be critical support for survivors

Engaging with formal support was not the only support participants sought. Eight of the participants specifically mentioned receiving support from their friends and/or family. Survivors interacted with their loved ones in a variety of ways, including calling them during an event of violence, staying at their residence instead of with their partner following an act of violence, confiding in them, and asking them for advice. Few people mentioned having loved ones in their life who were very supportive of them. One survivor spoke about her sister and how she played a role in seeking help after an incidence of relationship violence:

> *"And, um, you know, that morning when she said they woke up lookin' for me and then when she didn't find me, she didn't see the truck outside, she got crazy. She told, um, the oldest girl, my oldest niece, she was like, get dressed, come go with me. And they went straight to my house lookin' for me. And he was like, open the door, she told me, she said he opened the door and said, you weren't here. And they was like, did you kill my sista? Kill her? What you mean kill her? Hell, I don't even see my truck. I'm tryin' to figure out where she at." (54-year-old Black/African American female survivor)*

It was evident that some survivors' loved ones were key in providing support and aiding them to seek further help, but this was not a universal experience. Some survivors described that while they did have people in their lives they could turn to for support and talk to, they perceived that their loved ones were not particularly helpful or empathetic. For these reasons, several survivors expressed hesitance reaching out to or talking with certain people in their lives. For example, participants mentioned not wanting to discuss their experiences with their parents, siblings, and friends, or only speaking with them in specific cases. One participant stated:

> *“But I just have, you know, the sister-in-law. She, she's there if I need her, so I only call her if I need her. If it's not an emergency, I don't wear her out, she's got enough on her plate." (37-year-old White female survivor)*

In general, survivors frequently discussed the connections to other people in their lives, whether it be how they sought support from their networks or the isolation they experienced. Isolation was a topic that nearly all participants touched on. A few people reflected on how isolation was part of the IPV they experienced; they discussed coercive control tactics their partner used to keep them isolated from others. Not all isolation was perceived to be purposely perpetrated by their partners. Several survivors claimed they were unaware they were isolated from others. A small number (n=2) mentioned that they naturally were more reserved and introverted, so they did not take notice or mind they had few other close loved ones besides their partner. Most survivors discussed isolation as something that was deliberate or, reflecting retrospectively, believe it was a part of their IPV experiences. One survivor stated:

> *"...it was just me and him all the time and I didn't have any exposure to anyone else, um, I didn't get that. So, and because this was, like, one of my first serious relationships, I didn't know any different. So, I think that impacted things a lot. So maybe for young women in, like, their first serious relationship to have someone to talk to, or like to know, like, what a, you know, adult relationship should look like or shouldn't look like.” (22-year-old mixed race female survivor)*

Sub-theme 4.2: IPV and social support organizations may fill support gaps for survivors

Seeking and accessing help from organizational programs was uncommon across all participants. These encompassed services from domestic violence housing programs, recovery programs, and family-based wellness programs. Though the participants who sought help from

programs (n=4) make up a small portion of the sample, their unique experiences were extraordinary in the reported support they described receiving. Those four survivors who sought out and accessed this type of support from organizations reported having a strong support system in place because of the programs' structures—whether formally through service provision or informally through connection with other survivors. Two of the participants discussed negative experiences living in close quarters with other people, such as in domestic violence housing, but they felt grateful for having a safe place to stay. One survivor described the variety of services available at the organization they sought help from:

> *"Well, part of [the organization's services] is that we meet with each other in the women's group, um, for violence. There also is a children's group that helps the children; also one for those who have experienced violence. How they help, it isn't therapy, but it helps the kids to learn things and educate themselves too. The part, well, let's say, anything that one needs advice or something. They are there to listen to you." (translated from Spanish; 28-year-old Hispanic female survivor*

Support groups were one aspect of help provided by the programs that survivors cited as useful. Other services noted by survivors included forms of financial assistance that could help with rent, food and gas, and assistance with seeking and maintaining a job. Education about IPV and healthy relationships was another topic that came up across survivors who participated in such programs. One survivor spoke of the importance of education about IPV provided by the program they were involved in:

> *"But I went to the domestic violence classes, and that's where I learned about the control tactics such as the financial abuse, controlling all of the money. Or, you know, like giving me impossible tasks, sending me to the store and telling me get 20 items and you only*

gave me $10. You know, setting me up to fail. I didn't know that those things were related to domestic violence, intimate partner violence at all until I went there, so that shows I learned that that's what it was." (39-year-old Native/White female survivor)

These programs provided a variety of resources that participants appreciated and accessed. Overall, participants positively noted the idea that they were around other people with similar lived experiences.

Discussion

The purpose of this study was to understand the experiences and perceptions of survivors of IPV seeking help in Metropolitan Atlanta. Survivors described a variety of experiences, with most participants seeking out and accessing multiple sources of help including health and social services. The findings largely agree with existing literature that suggests the process of seeking help is not straightforward for survivors. Specific facilitators and barriers were salient for participants. These findings are a critical resource to inform efforts to prevent and respond to IPV in Atlanta.

Perceived severity of violence was an important determinant for seeking help among participants. Similar studies have found that accessing formal services is related to violence severity (Ansara & Hindin, 2010), including those conducted in the southeastern United States (Coker et al., 2000) and those centered on the experiences of Black women (Bent-Goodley, 2007). When discussing why they eventually sought help, survivors downplayed other experiences of violence throughout their relationship—especially when the violence was not physical harm. In this way, survivors' perceived severity of their IPV experiences acted as a major barrier to seeking formal help. Physical violence, especially severe violence, may act as a tipping point for survivors.

Due to this concept of perception of severity and only accessing services when violence was severe, many survivors cited that their first interactions with formal help were with emergency police or medical personnel in hospital emergency departments. For those who accessed services from emergency rooms, survivors discussed numerous factors that contributed to negative experiences, including long wait times, limited staff, and going through the process of seeking and receiving care by themselves. The context of the COVID-19 pandemic likely played a large factor in how survivors experienced seeking care from overburdened hospitals responding to the COVID-19 pandemic (Wyckoff et al., 2023). Still, survivors noted positive experiences of kind and warm staff members, re-enforcing existing literature that argues IPV survivors value patient-centered care and provider engagement (Tarzia et al, 2020). A commonality among survivors was having difficulty remembering the totality of their experiences in the hospital; this was especially true when participants attempted to recall speaking with staff about IPV resources. It is likely that the survivors were under acute stress which negatively impacted their experiences in the emergency department (Olive, 2016). The reality is that few people received or remembered receiving referrals and even fewer connected with resources because of that interaction with staff.

Of those who interacted with emergency police, nearly all survivors discussed negative perceptions or experiences. Like participants who sought out hospital emergency departments, calling the police was seen as a last resort. Predominately Black survivors had strong reservations about contacting the police, even when they experienced physical harm. Whether through their own experiences or other knowledge, the idea that the police could “flip on you” and arrest the person experiencing violence was brought up by multiple participants. Whether the arrest was due to the survivor physically defending themselves or because of the presence of

alcohol and drugs, there was a concern about being arrested. These perceptions are consistent with literature that finds survivors are concerned police will arrest them when they call them to help (Wolf et al., 2003; Leisenring, 2012). While experiencing violence, survivors must consider if calling the police could potentially do more harm. More broadly, the legacy of police violence against BIPOC—especially Black people— in the US contributes to survivors' hesitancy to contact the police (DeAngelis, 2021). Existing literature about police violence additionally examines the vulnerabilities that Black women face being both Black and women in this country (Crenshaw et al., 2015; Jacobs, 2017). The proliferation of Black Lives Matter (BLM) protests in Atlanta and across the US may have further reinforced survivors' negative beliefs about police. The attitudes of and perceived helpfulness of emergency police were important in survivors' decision-making process.

Another commonly sought-out source of help among survivors was formal therapeutic services. Though mental health resources are not commonly sought out, especially for BIPOC (Satyen et al., 2019), it was frequent in this study's sample regardless of the classification of IPV. This is not especially surprising because all types of IPV are associated with poor mental health outcomes like depression, anxiety, and post-traumatic stress disorder (Lagdon et al., 2014). For survivors seeking mental health services, a contributing help-seeking facilitator was recognizing symptoms of worsening mental health. Symptoms of anxiety were frequently reported. Most survivors actively sought out individual therapy to focus on healing themselves rather than addressing their relationship.

A plethora of barriers to accessing mental health care was salient among survivors. Both health insurance and cost impacted survivors' decision-making. The cost of care was especially prominent, persisting even if survivors had health insurance. Provider availability was another

challenge, with providers no longer accepting specific insurance or not having the qualifications to deliver certain therapeutic services. This led participants to have to start the search for another provider that fits their needs. Survivors were predominately unsatisfied with therapeutic services because of the process of seeking and securing care, although few cited straightforward and easy experiences. In the context of the COVID-19 pandemic, some therapy providers began to offer virtual visits; a small number of survivors discussed how virtually meeting with their providers made the service more accessible to them. Despite the multitude of barriers associated with seeking mental health care, there were few survivors who felt that the care they received was beneficial.

Fewer survivors sought services from domestic violence, legal, and other IPV-related organizations. During the COVID-19 pandemic, domestic violence organizations and shelters were limited in capacity to serve IPV survivors which contributed to negative experiences (Wyckoff et al, 2023). Some in-person services continued during the pandemic after movement restrictions were lifted and survivors found utility in having support groups, IPV education, and financial assistance services. A small number of survivors felt satisfied with the organizations' services and described supportive environments; among these survivors, they appreciated how the organizations provided all-encompassing services. Having a central organization or place to receive multiple types of services was helpful for those survivors.

Consistent with the findings of other studies, most survivors also spoke about how they sought informal support from their loved ones (Ansara & Hindin, 2010; Sylaska & Edwards, 2014). Survivors' experiences and perceived helpfulness of seeking help from friends and family varied, suggesting that informal support can be a facilitator or barrier to further help-seeking.

The presence of loved ones in a survivor's life did not guarantee that they were satisfied with the support.

Isolation was frequently discussed among survivors. Participants had varying thoughts about whether the isolation occurred on their own accord (e.g., prefer to spend time alone), because of the COVID-19 movement restrictions, or that it was a control tactic their partner used. Isolating a survivor as a form of control is well established as a form of psychological IPV (Hamberger et al., 2017), and research suggests that COVID-19 movement restrictions may have further exacerbated this control tactic (Wyckoff et al., 2023).

Overall, the findings of this study provide information about IPV help-seeking facilitators and barriers in Metropolitan Atlanta. Key determinants include survivors' perceived severity of IPV, accessibility of support service (e.g., cost, wait time, provider availability, etc.), attitudes of and perceived helpfulness of the support service, recognizing their own mental health symptomology, and the existence or lack of informal support. Two of the most salient determinants among participants were the perceived severity of IPV and noticing mental health symptomology, suggesting that survivors generally seek care when they experience specific symptoms after already experiencing violence.

Limitations

There are various limitations to this study. At its onset, the study aimed to recruit 15 IPV survivors in Metropolitan Atlanta, with an emphasis on the area's Spanish-speaking Latinx populations. Recruitment efforts failed to reach this goal, likely due to social norms related to stigma and fear of speaking about IPV. The final sample included 12 participants with only one self-identified Hispanic and Latinx Spanish speaker. The limited diversity in the sample—comprised primarily of English-speaking, cis-gender, heterosexual Black or African American

women—makes the findings not thoroughly representative, although these findings may be transferable to comparable groups of survivors. Due to the incorporation of Spanish-language in-depth interviews, only one bilingual (English- and Spanish-speaking) member of the research team coded and analyzed the Spanish interview data.

Although this study describes the important perspectives of survivors who successfully accessed care, a positive behavior, the study's eligibility requirement that participants must have accessed care limits the findings to only hear from those who accessed formal care. Additional research to incorporate more diverse survivors' voices, including those who have not sought help related to their experiences of IPV, is necessary. Experiences of survivors who speak other languages are also missing due to the research team's limited language capacity.

Based on the identified help-seeking determinants, we recommend capitalizing on known facilitators and addressing key barriers. First, the findings suggest that people will access emergency police and emergency health services after an incident of physical violence resulting in injury requiring outside care. Both services must be fully equipped to address situations of IPV. For police, advocate services may aid in mediating interactions with survivors, especially for those who believe that the police pose potential harm to them. Emergency department staff must also be aware that despite the best intentions of conversations, survivors may not fully process their conversations, hindering further connection with resources. Current services must ensure that staff use proper trauma-informed care and seek alternative ways to communicate with survivors during their time at the hospital bearing in mind that survivors may be in shock. Second, mental health services were highly sought after, and many survivors are aware of how IPV impacted their mental health. IPV organizations, public health advocates, and local policymakers must ensure that mental health resources are available for people experiencing

IPV. Further funding and research are necessary to better understand the mental health resources that survivors prefer and how to improve the help-seeking process for mental health help.

Conclusion

IPV poses a serious threat to populations' wellbeing across the world. Though researchers have conducted studies to examine how IPV survivors seek help, certain factors are highly variable, and contexts are unique. This is especially true for BIPOC who are less likely to seek help and experience IPV at higher levels proportionate to White populations. This study adds to the current IPV help-seeking literature and specifically provides a base of evidence for IPV help-seeking in the context of Metropolitan Atlanta.

Findings suggest that help-seeking is complex and does not follow a pattern. Survivors will reach out for support at different points in time and navigate the web of available resources based on their individual needs. However, survivors in this sample typically sought help only when they perceived the violence was severe. Due to this finding, it is important to emphasize that the first connection survivors have with formal help is a critical point in time to support IPV survivors, and that current initiatives to further connect survivors with resources may not be occurring as intended. Furthermore, mental health help is an important aspect of care that survivors are seeking at all points in their lives. These findings can inform Atlanta's response to IPV to better support survivors.

Chapter 4: Public Health Implications and Recommendations

Based on the identified help-seeking determinants in this study, we recommend capitalizing on known facilitators and addressing key barriers to improve IPV efforts in Metropolitan Atlanta.

The findings suggest that people will access emergency services after an incidence of severe physical violence. Therefore, both emergency police and health services must fully equip staff to address situations of IPV. For police, advocate services may aid in mediating interactions with survivors, especially for those who believe that the police pose potential harm to them. Police already respond to a myriad of situations, so incorporating advocate service staff has the potential to better support survivors during these situations because of staff's opportunity to receive specialized trauma-informed training. Emergency department staff must also be aware that survivors who present in emergency rooms due to IPV can be experiencing acute stress and/or shock. Despite the best intentions of conversations between staff and survivors, survivors may not fully process these interactions, hindering further connection with resources. Current services must ensure that staff practice proper trauma-informed care and seek alternative ways to communicate with survivors during their time at the hospital.

Many survivors are aware of how IPV impacted their mental health, making mental health services highly sought after. Survivors experienced various barriers to accessing these services and were not always satisfied with the therapeutic care. IPV organizations, public health advocates, and local policymakers must ensure that quality mental health resources are available for people who experience IPV. Further funding and research are necessary to better understand the mental health resources that survivors prefer, how to improve the help-seeking process for

mental health help, particularly for BIPOC, and leveraging survivors' capacity to recognize mental health symptoms.

Appendices

Appendix I: In-depth Interview Guide (English Version)

Interview Guide 1: Patients

Good morning/afternoon and thank you for agreeing to speak with me today. Before we begin can you please confirm your name and study password? **<confirm that password matches scheduler; If they do not know their password give them the hint. If they still don't know their password confirm identity through X identifier on the chart.>**

My name is _____, and I am part of a team from Emory University. I'd also like to introduce _____ who is another member of our team. Is this a good time to have a private conversation? I'd like to review a verbal consent form with you as I introduce the study. **<Share screen of verbal consent version 11.17.20>** We are conducting research to examine the potential impacts of COVID-19, also known as Coronavirus, on relationships. Because you sought services related to your relationship, we would like to speak to you about your thoughts and perceptions about your experience during the COVID-19 period. Information from this conversation will be used to better meet the needs of others like you. At this point we would like to establish a safe phase. If you need to pause or end the call early or your situation becomes unsafe or insecure please say "I don't want any" and hang up. We will text you at another time to reschedule.

I'll begin by asking you a few questions about you and some other questions about COVID. After those questions we will shift into a conversation. During our conversation, we will be talking about your relationship experiences during the COVID-19 pandemic. I am particularly interested in hearing about your personal experiences and views, so please feel free to share openly. I have a set of topics I would like to discuss, but you are welcome to bring up other topics you think are important. After our conversation I will ask a few other survey style questions before we wrap up. Your participation today is completely voluntary. If you do not feel comfortable answering any question, just let me know and we can skip it. If you need a break at any time or would like to stop our discussion, please let me know and we can pause or end the conversation immediately. Remember you can also use our safe phrase "I don't want any" at any time. Your safety is important to us so if you believe that we can provide you with any resources, please let us know.

Since your responses are so valuable to us, I would like to record our conversation to ensure I capture everything we discussed. Only the research team and I will listen to the recording, your identity will be kept confidential, and your responses will only be used for this project. Are you in a space where you can speak freely without being overheard by others? Is it okay if I record our conversation? Is it OK if **<insert notetaker name>** stays on the call today to take notes?

Our interview will last 60-90 minutes. Do you have any questions before we get started? May I begin recording. **<Start recording>**

To begin our conversation, I'd like to ask some introductory questions.

<Transition to Qualtrics survey for Survivors Survey on Demographics and COVID. Read each question aloud and enter the response selected by each participant. If short open-ended, type their response verbatim. If the participant is phoning in read aloud the questions and each answer and types response to open-ended questions verbatim.>

Demographics

Now I'd like to ask some basic background questions about you.

<Enter Interviewer Initials>

1. What is your zip code of residence? <#####>

2. What is your gender?

2. What is your age? <##>

4. What is your race? <Check all that apply>

White

Black or African American

American Indian or Alaska Native

Asian/Pacific Islander

Other Race: _____ <Open-ended>

5. Do you identify as Hispanic or Latino? <Y/N>

6. What is your marital or relationship status? <Choose one>

Single, Not currently in a relationship (if selected skip to question 7)

Member of an unmarried couple

Married

Separated

Divorced

Widowed, not currently in a relationship (if selected skip to question 7)

7. Do you live with your partner: <Choose one>

All of the time

Some of the time

I don't live with my partner

8. What is the gender of your most recent partner? <Open-ended>

9. Do you have any children? <Y/N>

9a. If yes, do they live with you at least some of the time?

Yes, all of the time

Yes, some of the time

No, none of the time

9b. If yes, How old are each of your children? ##, ##, ##, ##, ##

9c. If yes, is your current partner the biological parent of all of your children ?

10. What is your current employment status? <Choose one>

Unemployed

Part-time

Full-time

10a. If unemployed, when did your last employment end? <enter MM/DD/YYYY>

11. Did you have health insurance during 2020? <y/n>

10a. If yes, what was your primary type of health insurance when you sought services?: <Choose one>

A plan purchased through your employer

A plan purchased through your partner's employer

A plan that you or another family member pays for on your own

Medicare

Medicaid or other state/county program

TRICARE (formerly CHAMPUS), VA, or Military

Alaska Native, Indian Health Service, or Tribal Health Services

Other health insurance or health coverage plan: <Open-ended>

COVID-19

The next set of questions is about COVID-19. There are no right or wrong answers. Please just tell me what you know.

12. Tell me what you know about COVID-19? <Open-ended>

a. How is it transmitted?
b. How do you prevent it?

13. Public health authorities are working to prevent COVID in our community. What are some of the public health measures you are aware of to prevent COVID transmission? <Open-ended>

c. In Atlanta?
d. Statewide?

14. Are you aware of any movement restrictions? <Y/N>

15. What are the movement restrictions you are aware of? <Open-ended>

16. If yes to Q15 above, Where did you hear/learn about these movement restrictions?

17. When did you hear/learn about these movement restrictions? (Approx date is fine) <enter MM/DD/YYYY>

18. How did you feel about the restrictions? <Open-ended>

19. Do you have any health conditions (i.e., Diabetes, Asthma, smoking, high blood pressure) that would make you at higher risk of complications if you got COVID? <Y/N>

20. Have you been diagnosed with COVID-19? <Y/N>

20a. If yes, when (an approximate date is fine)? <MM/DD/YYYY> If an approximate date enter month, day as 01 and year.

21. Has anyone you live with been diagnosed with COVID-19? <Y/N>

20a. If yes, what is your relationship to that person or those people? <open-ended>

20b. When were they diagnosed (an approximate date is fine)? <MM/DD/YYYY> If an approximate date enter month, day as 01 and year.

Opening Interview Question

Now we will begin the conversation portion of the interview. Do you have any questions before we begin? Remember if you need to stop the conversation you can use the safe word "I don't want any."

22. Think back to before COVID. Please describe a typical day for you.

    e. Tell me about you, your partner and children/family.
    f. What kinds of problems/challenges did you have in your life?

23. What has a typical day been like for you during the pandemic (March 2020 to Present).

    g. How has COVID affected your daily life?
        i. Movement restrictions
    h. What has changed with you, your partner and children/family?
    i. What kinds of problems/challenges did you have in your life as a result of COVID?
    2. Refer back to anything they have referenced before such as:
    3. Forced to be at home (shelter in place)
    4. Kids out of school/virtual schooling
    5. Unemployed
    6. Unstable housing or transportation
    7. Effect of police violence during this time; if relevant at all
    8. Changes in health insurance
    9. Disconnection (isolation and mortality in social network) from friends/family

Relationships

Now, I'd like to ask a few more questions about your current or most recent relationship. We prefer that you are by yourself when we ask these questions. Are you by yourself right now?

<If not alone, is there a time you will be by yourself so that we can continue our conversation. If you would prefer you can text me day or time?>

Remember if you need to stop the conversation you can use the safe word "I don't want any."

24. How would you describe your current or most recent relationship?

    j. Tell me about how you met
    k. What was your relationship like before COVID?
    l. What are some of the challenges you faced in this relationship before COVID?
    10. How do you feel your partner treated you?

25. People in relationships argue and fight at times. What happened in your relationship before COVID when you disagreed or faced problems?

    m. Communication, money, parenting, values
    n. How many arguments or fights were you having a week?

Now let's talk about how things have changed during the pandemic

26. What, if anything, has changed since COVID?

    I. Refer back to anything they have referenced before such as:

    Ii. Relationship problems

    iii. Threats of COVID infection

    iv. Increases in stress

    v. Disconnection from friends and family

    vi. How many arguments or fights were you having a week?

27. During COVID, what happened in your relationship when you disagreed or faced problems?

    o. Refer back to anything they have referenced before such as: Communication, money, parenting, values, COVID infection.
    p. Tell me more about that.

28. Sometimes in relationships people are insulted, hit, or threatened, among other things. Has anything like this ever happened to you in your current or most recent relationship?

    q. What kinds of things are said or done?
    r. How have these arguments or fights changed, if at all?

11. Over the course of your relationship?
12. During COVID period?

s. How does this make you feel?

29. In what ways have these arguments or fights impacted your health and well-being?

Health/Help Seeking Behaviors

Now I'd like you to think about the event(s) that led you to seek support services. I want to remind you that your answers will be kept confidential. If you need to take a break at any time, let me know. Just to reiterate we can always stop our conversation and you can use our safe phrase to stop the conversation.

30. Where did you seek services?

Tell me about the event that led you to seek services?

t. What was happening beforehand?
u. Did COVID or COVID (mentioned earlier) movement restrictions play a role in this event?

31. Was this the first time something like this happened to you in this relationship? <y/n>

32. What made you decide to go to seek services?

v. How, if at all did COVID influence your decision?

33. What was your experience at [insert resource/shelter]l like?

w. What did the [insert resource/shelter] staff do to help you address your needs? (eg. provided advice, taught skills, provided therapy or treatment, referred to specialist)

34. What resources, supports, or other sorts of things would have helped you then?

    x. To address your relationship problems or disagreements?
    y. To address your health needs?
    z. Is there anything specific to COVID?

35. What happened after you sought services at [insert resource/shelter]?

    aa. What if anything have you done since you sought services at [insert resource/shelter] to help you stay safe in your relationship?
    bb. How if at all has COVID changed your thinking about safety in your relationship?

Violence & Support

For these next questions, please think back again to the incident that led to you to seek support services and your experiences there. Again I will read aloud the questions.

<Transition to Qualtrics survey for Survivors Survey on Violence. DO NOT share screen. Read each question aloud and enter the response selected by each participant. If open-ended type in the participant response verbatim.>

36. Were you living with the person who led you to seek services? <Y/N>

37. Were other people present at the time of the event that led to you to seek services ? <Y/N>

38. If Yes, who was present (for example, children, other family members)? <open-ended>

39. Other than your most recent visit to , have you ever gone to the hospital or shelter or other support service agency after a similar event or fight with your current partner? <Y/N>

39a. When did that happen?

40. Have you experienced anything like what led you to seek services in any past relationships or with past partners? <Y/N>

40a. If yes, When did that happen (an estimated date is fine) <MM/DD/YYYY> If an estimate put month, day as 01 and year>

40b. What happened then? <Open-ended>

40c. How was it similar? <Open-ended>

40d. How was it different? <Open-ended>

41. Have you ever gone anywhere else after a similar event or fight with your past or current partner? <Y/N>

41a.If Yes, where? <Open-ended>

42. Have you ever tried to end the relationship with your current partner? <Y/N>

43. Are you aware of any resources or support services for things like what you experienced? <Open-ended>

43a.If yes, what are those resources? <open-ended>

44. What resources or supports would you need to help you currently?

<Turn off screen share, return to interview>

Wrap-up:

I just have a few final wrap up questions about your interview experience.

45. I have asked about many difficult things. How has talking about these things made you feel?

(eg. relaxed, relieved, nervous, uncomfortable)

46. Would you like more information about anything we've discussed today?

cc. If so, what?

47. Is there anything else you'd like to share based on what we've already discussed? <Make sure to be quiet for at least 30 seconds>.

Closing:

Thank you for sharing your time and experiences with me today. I would also like to assure you once more that all of your responses will be kept strictly confidential. From what you have told me, I can tell that you have had difficult experiences in your life. No one has the right to treat someone else this way. However, from what you have told me, I can also tell that you are strong and have survived through some difficult circumstances. If you would like to talk with someone about anything we've discussed today, please let me know me. Can I offer you some secure resources related to what we talked about?

dd. **MyPlan:** There is a secure app that I'd like to share. This app is free and designed to help people like you plan for their safety. Can I share this app with you in the chat, by email or text.
    i. Paste https://www.myplanapp.org into chat
    ii. Email https://www.myplanapp.org to participant
    iii. Text https://www.myplanapp.org to participant

ee. **IPV resource guide:** We have also developed a password protected one pager with local resources related to domestic violence. I can paste this info into the chat, email or text it to you. Would you like to receive this info?
    iv. Paste url into chat; paste password "help" into chat
    v. Email url and tell the password "help" verbally

vi. Text url and tell the password “help” verbally

Thank you.

<Don’t turn off recorder until they really stop talking. This is usually when informants give good info!>

Once they have really stopped talking then begin….

As a token of our appreciation for your time, we’d like to provide you with a $25 Walmart eCode. This code works just like a gift card and can be used either in person at any Walmart location or online at Walmart.com.

We can send this to you via email or text. How would you like to receive this code?

Okay, I’ll share this with you now via **[INSERT SELECTED METHOD HERE]**.

Could you please confirm that you’ve received the link?

[WAIT FOR CONFIRMATION]

Wonderful.

I’ll now send you the PIN associated with this code.

Could you please confirm that you’ve received the PIN?

[WAIT FOR CONFIRMATION]

Great. Again, thank you very much for your time today.

Appendix II: In-depth Interview Guide (Spanish Version)

Guía de entrevista 1: Pacientes

Buenos días/tardes y gracias por acceder a hablar conmigo hoy. Antes de comenzar, ¿puede confirmar su nombre y contraseña? <confirme que la contraseña coincida con el programador; Si no saben su contraseña, déles la pista. Si aún no conocen su contraseña, confirme la identidad a través del identificador X en el gráfico.>

Mi nombre es _____ y formo parte de un equipo de la Universidad de Emory. También me gustaría presentarles a _____, que es otro miembro de nuestro equipo. ¿Es un buen momento para tener una conversación privada? Me gustaría revisar un formulario de consentimiento verbal con usted mientras presento el estudio. Estamos realizando una investigación para examinar los impactos potenciales de COVID-19, también conocido como Coronavirus, en las relaciones. Debido a que buscó servicios relacionados con su relación, nos gustaría hablar con usted sobre sus pensamientos y percepciones sobre su experiencia durante el período de COVID-19. La información de esta conversación se utilizará para satisfacer mejor las necesidades de otras personas como usted. En este punto nos gustaría establecer una frase segura. Si necesita pausar o finalizar la llamada antes de tiempo o si su situación se vuelve insegura, diga "No quiero ninguna" y cuelgue. Le enviaremos un mensaje de texto en otro momento para reprogramar.

Comenzaré haciéndole algunas preguntas sobre usted y algunas otras preguntas sobre el COVID-19. Después de esas preguntas, pasaremos a una conversación. Durante nuestra conversación, hablaremos sobre sus experiencias de relación durante la pandemia de COVID-19. Estoy particularmente interesada en conocer sus experiencias y puntos de vista personales, así que siéntase libre de compartir abiertamente. Tengo una serie de temas que me gustaría discutir, pero le invitamos a mencionar otros temas que considere importantes. Después de nuestra conversación, haré algunas otras preguntas estilo encuesta antes de terminar. Su participación hoy es completamente voluntaria. Si no se siente cómodo respondiendo alguna pregunta, hágamelo saber y podemos omitirla. Si necesita un descanso en cualquier momento o desea detener nuestra conversación, hágamelo saber y podemos pausar o finalizar la conversación de inmediato. Recuerda que también puede usar nuestra frase segura “No quiero ninguna” en cualquier momento. Su seguridad es importante para nosotros, si cree que podemos brindarle algún recurso, háganoslo saber.

Dado que sus respuestas son tan valiosas para nosotros, me gustaría grabar nuestra conversación para asegurarme de capturar todo lo que discutimos. Solo el equipo de investigación y yo

escucharemos la grabación, su identidad se mantendrá confidencial y sus respuestas solo se utilizarán para este proyecto. ¿Estás en un espacio donde puedes hablar libremente sin que otros le escuchen? ¿Está bien si grabo nuestra conversación? ¿Está bien si <insertar el nombre del tomador de notas> permanece en la llamada hoy para tomar notas?

Nuestra entrevista tendrá una duración de 60-90 minutos. ¿Tiene alguna pregunta antes de que empecemos? Puedo comenzar a grabar. <TOMADOR DE NOTAS: Empezar a grabar>

Para comenzar nuestra conversación, me gustaría hacer algunas preguntas introductorias.

Datos Demográficos

Ahora me gustaría preguntarle unas preguntas básicas sobre sus antecedentes.

<Ingrese la identificación del participante>

13. ¿Cuál es su código postal de residencia? <#####>

14. ¿Cuál es su género?

15. ¿Cuál es su edad? <##>

16. ¿Cuál es su raza? <Marque todo lo que corresponda>

    blanco

    negro o afroamericano

    indio americano o nativo de Alaska

    asiático/Isleño del Pacífico

otra Raza: _____ <Abierto>

17. ¿Se identifica como hispano o latino? <S/N>

18. ¿Cuál es su estado civil o de relación? <Elija uno>

Soltero/a, actualmente no tiene una relación (si se selecciona, pase a la pregunta 7)

Miembro de una pareja no casada

Casado/a

Separado/a

Divorciado/a

Viudo/a, no tiene una relación actualmente (si se selecciona, pase a la pregunta 7)

19. ¿Vive con su pareja?: <Elegir uno>

todo el tiempo

algo de tiempo

no vivo con mi pareja

20. ¿Cuál es el género de su pareja más reciente? <Abierto>

21. ¿Tiene hijos? <S/N>

9a. En caso afirmativo, ¿viven con usted al menos parte del tiempo?

Si, todo el tiempo

Si, algunas veces

No, nada de tiempo

9b. En caso afirmativo, ¿qué edad tiene cada uno de sus hijos?

##, ##, ##, ##, ##

9c. En caso afirmativo, ¿su pareja actual es el padre biológico de todos sus hijos?

22. ¿Cuál es su situación laboral actual? <Elija uno>

Desempleado

Medio tiempo

Tiempo completo

23. ¿Tuvo seguro médico durante el año 2020? <s/n>

11a. En caso afirmativo, ¿cuál era su principal tipo de seguro de salud cuando buscó los servicios?: <Elija uno>

Un plan comprado a través de su empleador

Un plan comprado a través del empleador de su pareja

Un plan que usted u otro miembro de la familia paga por su cuenta

Seguro médico del estado

Medicaid u otro programa estatal/del condado

TRICARE (anteriormente CHAMPUS), VA (asuntos de veteranos) o Militar

Nativo de Alaska, Servicio de salud indígena o Servicios de salud tribales

Otro seguro de salud o plan de cobertura de salud: <Abierto>

<u>COVID-19</u>

Las siguientes preguntas son sobre COVID-19. No hay respuestas correctas o incorrectas. Por favor, dígame lo que sabe.

24. Cuéntame, ¿qué sabe sobre el COVID-19? <Abierto>
    a. ¿Cómo se transmite?

b. ¿Cómo lo previene?

25. Las autoridades de salud pública están trabajando para prevenir el COVID en nuestra comunidad. ¿Cuáles son algunas de las medidas de salud pública que conoce para prevenir la transmisión del COVID? <Abierto>
    c. ¿En Atlanta?
    d. ¿En todo el estado?

26. ¿Conoce alguna restricción de movimiento? <S/N>

27. ¿Cuáles son las restricciones de movimiento que conoce? <Abierto>

28. En caso afirmativo a la pregunta 15 anterior, ¿dónde escuchó o se enteró de estas restricciones de movimiento?

29. ¿Cuándo escuchó/aprendió acerca de estas restricciones de movimiento? (La fecha aproximada está bien) <ingrese MM/DD/AAAA>

30. ¿Cómo se sintió acerca de las restricciones? <Abierto>

31. ¿Tiene alguna condición de salud (es decir, diabetes, asma, tabaquismo, presión arterial alta) que le pondría en mayor riesgo de complicaciones si tiene COVID? <S/N>

32. ¿Ha sido diagnosticado/a con COVID-19? <S/N>

20a. En caso afirmativo, ¿cuándo (una fecha aproximada está bien)? <DD/MM/AAAA> Si es una fecha aproximada ingrese mes, día como 01 y año.

33. ¿Alguien con quien vive ha sido diagnosticado con COVID-19? <S/N>

21a. En caso afirmativo, ¿cuál es su relación con esa persona o esas personas? <abierto>

21b. ¿Cuándo fueron diagnosticados (una fecha aproximada está bien)? <DD/MM/AAAA> Si es una fecha aproximada ingrese mes, día como 01 y año.

<Transición a la guía IDI>

Pregunta de apertura de la entrevista

Ahora comenzaremos la parte de conversación de la entrevista. ¿Tiene algunas preguntas antes de que comencemos? Recuerda que si necesita detener la conversación, puede usar la palabra segura "No quiero ninguna".

34. Piense en antes de COVID. Describa un día típico para usted.
    e. Cuéntame sobre ti, tu pareja e hijos/familia.
    f. ¿Qué tipo de problemas/desafíos tuvo en su vida?

35. ¿Cómo ha sido un día típico para usted durante la pandemia (marzo de 2020 al presente)?
    g. ¿Cómo ha afectado el COVID a su vida diaria?
        i. Restricciones de movimiento
    h. ¿Qué ha cambiado con usted, su pareja e hijos/familia?
    i. ¿Qué tipo de problemas/desafíos tuvo en su vida como resultado de COVID?

Haga referencia a cualquier cosa a la que hayan hecho referencia antes, como:

36. Obligado a estar en casa (refugio en el lugar)
37. Niños fuera de la escuela/ educación virtual
38. Desempleados
39. Vivienda o transporte inestable
40. Efecto de la violencia policial durante este tiempo (si es relevante)
41. Cambios en el seguro de salud
42. Desconexión (aislamiento y mortalidad en la red social) de amigos/familiares

Relaciones

Ahora, me gustaría hacerle algunas preguntas más sobre su relación actual o más reciente. Preferimos que esté solo cuando le hagamos estas preguntas. ¿Estás solo ahora?

<Si no está solo, hay un momento en el que estará solo para que podamos continuar nuestra conversación. Si prefieres, ¿puedes enviarme un mensaje de texto con el día o la hora?>

Recuerda que si necesita detener la conversación, puedes usar la palabra segura "No quiero ninguna".

43. ¿Cómo describiría su relación actual o más reciente?
    j. Cuéntame ¿cómo se conocieron?
    k. ¿Cómo era su relación antes del COVID?
    l. ¿Cuáles son algunos de los desafíos que enfrentó en esta relación antes del COVID?
        i. ¿Cómo siente que le trató su pareja?

44. Las personas en relaciones discuten y pelean a veces. ¿Qué sucedió en su relación **antes de COVID** cuando no estaban de acuerdo o enfrentaban problemas?
    m. Comunicación, dinero, paternidad, valores
    n. ¿Cuántas discusiones o peleas tuvieron a la semana?

Ahora hablemos de cómo han cambiado las cosas durante la pandemia.

45. ¿Qué ha cambiado, si es que ha cambiado algo, desde COVID?

Hacer referencia a cualquier cosa a la que hayan hecho referencia antes, como por ejemplo:

46. Problemas de pareja
47. Amenaza de infección por COVID
48. Aumentos en el estrés
49. Desconexión de amigos y familiares
50. ¿Cuántas discusiones o peleas tuvieron a la semana?

51. **Durante COVID**, ¿qué sucedió en su relación cuando no estuvieron de acuerdo o enfrentaron problemas?

Haga referencia a cualquier cosa a la que hayan hecho referencia antes, como: comunicación, dinero, crianza de los hijos, valores, infección por COVID.

Cuéntame más sobre eso.

52. A veces en las relaciones las personas son insultadas, golpeadas o amenazadas, entre otras cosas. ¿Alguna vez le ha pasado algo así en su relación actual o más reciente?
    o. ¿Qué tipo de cosas se dicen o se hacen?
    p. ¿Cómo han cambiado estos argumentos o peleas, si es que han cambiado?
        i. ¿En el transcurso de su relación?
        ii. ¿Durante el período COVID?
    q. ¿Cómo le hace sentir esto?

53. ¿De qué manera han afectado su salud y bienestar estas discusiones o peleas?

<u>Comportamientos de búsqueda de ayuda/salud</u>

Ahora me gustaría que pensara en los eventos que lo/a llevaron a buscar servicios de apoyo. Quiero recordarle que sus respuestas se mantendrán confidenciales. Si necesita tomar un descanso en algún momento, hágamelo saber. Solo para reiterar que siempre podemos detener nuestra conversación y puede usar nuestra frase segura para detener la conversación.

54. ¿Dónde buscó servicios?

    Cuénteme sobre el evento que lo/a llevó a buscar servicios.

ff. ¿Qué estaba pasando durante ese evento?
gg. ¿Las restricciones de movimiento de COVID-19 o COVID (mencionado anteriormente) jugaron un papel en este evento?

55. ¿Fue la primera vez que le pasó algo así en esta relación? <s/n>

56. ¿Qué le hizo decidir ir a buscar servicios?

a. ¿Cómo, en todo caso, COVID influyó en su decisión?

57. ¿Cómo fue su experiencia en [insertar recurso/refugio]?
    b. ¿Qué hizo el personal de [insertar recurso/refugio] para ayudarle a abordar sus necesidades? (p. ej., proporcionó asesoramiento, enseñó habilidades, brindó terapia o tratamiento, refirió a un especialista)

58. ¿Qué recursos, apoyos u otras cosas de ese tipo le hubieran ayudado en ese momento?
    c. ¿Para abordar sus problemas de relación o desacuerdos?
    d. ¿Para abordar sus necesidades de salud?
    e. ¿Hay algo específico para COVID?

59. ¿Qué sucedió después de que buscó servicios en [insertar recurso/refugio]?
    f. ¿Qué ha hecho, si ha hecho algo, desde que buscó servicios en [insertar recurso/refugio] para ayudarle a mantenerse seguro/a en su relación?
    g. ¿Cómo ha cambiado COVID, si es que ha cambiado, su forma de pensar sobre la seguridad en su relación?

Violencia y apoyo

Para las siguientes preguntas, por favor piense nuevamente en el incidente que le llevó a buscar servicios de apoyo y sus experiencias ahí. Nuevamente, leeré las preguntas en voz alta.

60. ¿Vivió usted con la persona que le llevó a buscar servicios? <S/N>

61. ¿Había otras personas presentes en el momento del evento que le llevó a buscar servicios? <S/N>

62. En caso afirmativo, ¿quién estuvo presente (por ejemplo, niños, otros miembros de la familia)? <abierto>

63. Además de su visita más reciente a [ingrese nombre de hospital], ¿alguna vez ha ido al hospital, refugio u otra agencia de servicios de apoyo después de un evento similar a una pelea con su pareja actual/más reciente? <S/N>
    h. ¿Cuándo pasó eso?

64. ¿Ha experimentado algo parecido a lo que lo/a llevó a buscar servicios en relaciones pasadas o con parejas anteriores? <S/N>
    i. En caso afirmativo, ¿cuándo sucedió? (una fecha estimada está bien) <DD/MM/AAAA> Si es una estimación, ponga mes, día como 01 y año>
    j. ¿Qué pasó después? <Abierto>
    k. ¿Cómo fue similar? <Abierto>
    l. ¿Cómo fue diferente? <Abierto>

65. ¿Alguna vez ha ido a otro lugar después de un evento similar o una pelea con su pareja anterior o actual? <S/N>
    m. En caso afirmativo, ¿dónde? <Abierto>

66. Solo si tienen una pareja actual, ¿Alguna vez has tratado de terminar la relación con su pareja actual? <S/N>

67. ¿Conoce algún recurso o servicio de apoyo para cosas como lo que experimentó? <Abierto>
    n. En caso afirmativo, ¿cuáles son esos recursos? <abierto>

68. ¿Qué recursos o apoyos necesitaría para ayudarle actualmente?

<Volver a la entrevista>

Terminar:

Solo tengo algunas preguntas finales sobre su experiencia en la entrevista.

69. Le he preguntado bastantes cosas difíciles. ¿Cómo le ha hecho sentir hablar de estas cosas? (ejemplos: relajado/a, aliviado/a, nervioso/a, incómodo/a)

70. ¿Le gustaría más información sobre algo que hemos discutido ahora?

hh. Si si, ¿qué?

71. ¿Hay otra cosa que quisiera compartir basado en lo que hemos discutido? <Asegurar de estar callado por 30 segundos>

Cerrar:

Gracias por compartir su tiempo y experiencias con nosotros hoy. También me gustaría asegurarle una vez más que todas sus respuestas se mantendrán estrictamente confidenciales. Por lo que me ha dicho, puedo decir que ha tenido experiencias difíciles en su vida. Nadie tiene derecho a tratar a otra persona de esta manera. Sin embargo, por lo que me ha dicho, también puedo decir que es fuerte y ha sobrevivido a algunas circunstancias difíciles. Si desea hablar con alguien sobre cualquier cosa que hayamos discutido hoy, hágamelo saber. ¿Puedo ofrecerle algunos recursos seguros relacionados con lo que hablamos?

ii. **MyPlan** (mi plan): Hay una aplicación segura que me gustaría compartir con usted. Esta aplicación es gratuita y está diseñada para ayudar a personas como usted para planificar su seguridad. ¿Puedo compartir esta aplicación con usted en el chat, por correo electrónico o mensaje de texto?

a. Pegue https://www.myplanapp.org/es/inicio en el chat.
b. Mande por correo electrónico: https://www.myplanapp.org/es/inicio al participante.
c. Mandar por mensaje: https://www.myplanapp.org/es/inicio al participante.

jj. **Guía de recursos de violencia de pareja íntima**. Hemos desarrollado un folleto con contraseña con recursos locales relacionados con violencia doméstica. Puedo mandarle esta información por medio del chat, correo electrónico, y por mensaje. ¿Le gustaría recibir esta información?
    a. Pegue este enlace: en el chat. Pegue la contraseña "ayuda" en el chat.
    b. Mande el enlace por correo electrónico y dígale que la contraseña es "ayuda" verbalmente
    c. Mande el enlace por mensaje de texto y dígale que la contraseña es "ayuda" verbalmente.

Gracias

<No pare de grabar hasta que hayan parado de hablar. ¡Por lo regular pasa cuando informantes dan buena información! Ya que han parado de hablar puede empezar…>

Como un signo de nuestro aprecio por su tiempo, quisiéramos proveer con un código electrónico de Walmart de $25 dólares. Este código funciona como una tarjeta de regalo y se puede usar en persona en cualquier ubicación de Walmart o en línea en Walmart.com.

Podemos enviárselo por correo electrónico o mensaje de texto. ¿Cómo le gustaría recibir este código?

Muy bien, compartiré esto con usted ahora a través de **[INSERTAR EL METODO SELECCIONADO AQUÍ].**

¿Puede confirmar que ha recibido el enlace?

[ESPERAR LA CONFIRMACIÓN]

Maravilloso.

Ahora le compartiré el PIN asociado con el código.

¿Podría confirmar que ha recibido el PIN?

[ESPERAR CONFIRMACIÓN]

Muy bien. Nuevamente, muchas gracias por su tiempo ahora.

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