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Abstract

Barriers to assessing and treating mental health problems with intimate partner violence (IPV) survivors were identified with qualitative responses from 62 IPV helping professionals who participated in an online survey question. Data were analyzed using a concept mapping approach, which resulted in following eight distinct clusters: (a) unsure, (b) limited IPV specific resources, (c) barriers to access, (d) systems-taboos, (e) immediate crisis needs, (f) fear-stigma, (g) offender's control and (h) cultural concerns. The opinions expressed in these clusters help to better explain logistic, relational, and intrapersonal obstacles that can limit women IPV survivors' ability to receive care for mental health conditions. Extending previous quantitative work by the authors (Simmons, Whalley, & Beck, 2014), the current portion of this project generates new ways of looking at barriers to service delivery, which can be used to develop theory and guide further research.

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Defined as the actual or threatened physical, sexual, emotional, and/or psychological abuse by an intimate (romantic) partner (Saltzman, Fanslow, McMahon, & Shelley, 1999, 2002), intimate partner violence (IPV) is a global, social, and public health concern. All too often, the abuse suffered within a romantic relationship occurs in the larger context of other lifetime trauma (e.g., childhood abuse, witnessing parent abuse, surviving other crimes, cultural victimization; Kimerling, Alvarez, Pavao, Kaminski, & Baumrind, 2007; Lang, Stein, Kennedy, & Foy, 2004; Stermac, Reist, Addison, & Millar, 2002; Warshaw, Brashler, & Gil, 2009; Wenzel, Tucker, Elliott, Marshall, & Williamson, 2004; Wenzel, Tucker, Hambarsoomian, & Elliott, 2006). In light of the range of traumatic experiences that most IPV survivors have likely experienced, their risk for developing mental health symptoms is increased. Indeed, posttraumatic stress disorder (PTSD), generalized anxiety, depression, and substance abuse/dependence have been well documented among this vulnerable population (e.g., Beck et al., in press; Golding, 1999; Nathanson, Shorey, Tirone, & Rhatigan, 2012; Warshaw et al., 2009; Zlotnick, Johnson, & Kohn, 2006). Despite significant evidence noting such concerns, not all IPV survivors receive treatment/care for mental health symptoms they may experience.

A number of real-world barriers can preclude IPV survivors from being evaluated and if necessary, treated for mental health-related issues that occur. Salient among these reasons are potential repercussions that diagnostic labels can have on the survivor/victim. IPV offenders (e.g., the abuser) can use the stigma associated with mental health-related diagnostic labels as a mechanism to discredit the survivor to others including friends, co-workers, family, police, and the courts; undermine the survivor in custody battles; and otherwise control the IPV survivor across a range of life domains. Diagnostic labels can also be used to manipulate through threats to commit the IPV survivor to a psychiatric facility (i.e., because you are “crazy” they’ll commit you if you do or don’t do . . . *fill in the blank*). Further, labeling the IPV survivor has the potential to reinforce their abuser’s ability to rationalize their own abusive behaviors (i.e., I had no choice because she’s “crazy”). Thus, many professionals recognize the possible negative implications that accompany diagnostic labels with this highly vulnerable population (Simmons, Whalley, & Beck, 2014).

On the other hand, equally real problems exist given that exposure to ongoing trauma (such as prolonged abuse) increases the likelihood of mental

health symptoms (e.g., Dutton, Kaltman, Goodman, Weinfurt, & Vankos, 2005; Golding, 1999; Nathanson et al., 2012; Warshaw et al., 2009; Zlotnick et al., 2006). Meta-analytic work identified considerably large weighted mean prevalences for numerous mental health conditions in samples of IPV survivors including PTSD (63.8% across 11 studies), depression (47.8% across 18 studies), alcohol abuse (18.5% across 10 studies), suicidality (17.9% across 13 studies), and drug abuse (8.9% across 4 studies; Golding, 1999). Even though all forms and degrees of IPV are related to mental health conditions, evidence indicates the highest prevalence of PTSD and depression are associated with the more severe patterns of violence (i.e., high levels of physical violence, psychological abuse, stalking, and sexual violence; Dutton et al., 2005). Further, recent findings suggest it is not unusual for women IPV survivors to experience multiple, co-morbid mental health conditions (Beck et al., in press)

In addition to the link between IPV and an increased likelihood of mental health concerns, it also appears that having a mental health condition (or conditions) increases a women's risk of being abused (e.g., Briere, Woo, McRae, Foltz, & Sitzman, 1997; Goodman, Dutton, & Harris, 1997; Goodman, Johnson, Dutton, & Harris, 1997; Messing, La Flair, Cavanaugh, Kanga, & Campbell, 2012; Oram, Trevillion, Feder, & Howard, 2013). To illustrate, a recent systematic review examined the prevalence of IPV reported among psychiatric patients (inpatient and outpatient), finding the median prevalence of lifetime IPV reported in high quality studies was 30% (interquartile range [IQR] = 26-39, range = 26-56) among women psychiatric inpatients and 33% (IQR = 21-53, range = 15-81) among women psychiatric out-patients (Oram et al., 2013). Similarly, Messing et al. (2012) found PTSD mediated the relationship between childhood sexual abuse and two different forms of IPV (psychological and sexual). Indeed, mental health conditions appear to be a risk factor for IPV victimization and revictimization. Thus, a conundrum exists in that, when appropriate, mental health diagnosis and treatment has the potential to greatly benefit women exposed to IPV (for systematic review please see Warshaw, Sullivan, & Rivera, 2013) while having the potential to put them at greater risk.

In addition to this conundrum, a number of logistical and practical obstacles affect and effect the decision about whether or not to assess and treat mental health conditions that women IPV survivors sometimes experience. Logistically, some individuals who work to prevent, treat, and otherwise end family violence may not have the training or financial resources needed to access, administer, score, and interpret standardized instruments. Practically, a number of "real-world" obstacles preclude women IPV survivors from receiving treatment/care for mental health symptoms (e.g., time, financial resources, other pressing problems/concerns). Professionals working in the

field discuss these realities in practice discussions, conceptual works, and training materials. Interestingly however, a literature search using PsychInfo and Google Scholar identified no empirical articles that address barriers to assessing and treating mental health problems with IPV survivors.

Study Purpose

Recently, the authors of the current study reported quantitative findings from a survey exploring the opinions, experiences, and needs of IPV helping professionals in relation to this topic (Simmons et al., 2014). In our study, most of the participants ($n = 325$) noted (a) a high prevalence of mental health symptoms/concerns among their IPV survivor clients, (b) a low prevalence of programs that routinely/systematically screen IPV survivor clients for mental health problems, and (c) a desire for resources to improve screening and referral options for IPV survivor clients who have mental health–related concerns (Simmons et al., 2014). The quantitative portion of this study also found that a majority of the participants had a positive attitude about mental health screening for IPV survivors despite the reality that most do not conduct such screenings (Simmons et al., 2014).

One of the quantitative questions included in this study asked why the respondent believed women IPV survivors do not receive care for mental health conditions. In addition to the seven reasons presented (discussed below), respondents were also presented with an open-ended “other” response option. Remarkably, almost a fifth of the participants ($n = 62$, 19.1%) chose to provide a detailed answer to this “other” option. These responses add depth and meaning to the discussion by providing different ways to view the realities that arise in the field than the authors anticipated when the survey was initially designed. To this end, the current study furthers this quantitative work by descriptively exploring the qualitative opinions that IPV helping professionals expressed when identifying obstacles their IPV survivor clients face when seeking treatment/care for mental health–related concerns. Specifically, the current work explores the following research question: When women IPV survivors also experience mental health symptoms/concerns, what are the obstacles that preclude them from receiving treatment/care for these symptoms/concerns?

Method

The current study used an online Internet survey of helping professionals working in programs/organizations whose work focuses on women IPV survivors (e.g., social service, advocacy, legal assistance, and faith-based). No

direct incentive was provided and participation was anonymous. Informed consent was obtained online by electronically requiring individuals to indicate whether or not they consented to participate after reading the Institutional Review Board (IRB)-approved consent document. Those who did not consent were directed to a thank you screen and out of the survey site. Those who did consent were directed to the survey instrument. The University of Memphis IRB approved the procedures for this study (Approval #2266).

Survey Design

The instrument designed for this study consisted of demographic information and a needs assessment. Demographic questions elicited information about the participant, their place of employment, and the capacity in which they work with IPV survivors. The needs assessment portion was written to specifically address the research questions and included a variety of question types (e.g., yes/no, multiple-choice, multiple response, and open-ended). Descriptive analyses for all of the quantitative questions are detailed in a previous report (Simmons et al., 2014). In an effort to better understand the realities that arise in the field, the current project focuses on one of the qualitative response options included in this survey.

Administration of the survey utilized a for-profit online survey software program (Qualtrics) that is licensed by the institution that employs two of the authors. The program provides state-of-the-art features to build and distribute surveys online. Among these is the ability to build panels to electronically e-mail potential participants. It also has security features that far exceed those of other survey programs including an anonymous survey function that was activated for data collection.

Participant Recruitment

Participants were recruited through a mixture of invitation and snowball sampling. First, professionals who work with IPV survivors were invited to complete the needs assessment via email addresses found on publically available websites and listservs of various professional organizations. From these original invitations, snowball sampling was used to broaden the sample. Snowball sampling is a form of chain sampling where study participants recruit additional participants from among their acquaintances (Rubin & Babbie, 2010). To accomplish the second step, participants were asked at the end of the survey to forward the link to their colleagues. This sampling method was selected to ensure anonymity of respondents while also achieving representation from a wide range of professionals working across the United States and the U.S.

protectorates. To prevent duplication of responses, the survey program did not allow multiple surveys to be completed from the same IP address. The survey instrument was open for 35 days and received 325 completed responses, all of which met criteria for inclusion.

Participants

Participants for the original study included 325 professionals working in organizations that provide support for IPV survivors across the United States (including Washington, D.C.) and the U.S. protectorates. The subsample in the current report included the 62 respondents who gave narrative answers to the “*other*” option presented with one of the questions. Demographic differences between the original 325 respondent sample and the 62 respondent subsample did not meet significance for any of the reported characteristics.

Ages ranged from 24 years to 67 years with a mean age of 42.89 years ($SD = 12.32$). Demographic makeup of the sample was predominantly female ($n = 59, 95.2\%$) and Caucasian/White (non-Hispanic; $n = 52, 83.9\%$). As expected for a study targeting professionals, the sample was very well educated. All of the participants were high school graduates with some college ($n = 62, 100\%$) and most indicated they have a bachelor’s degree or higher ($n = 55, 88.7\%$). A significant proportion of the participants received formal training in mental health assessment and diagnosis ($n = 25, 40.3\%$) as either a part of their education program ($n = 20, 32.2\%$) or through other means ($n = 23, 8.1\%$). Participants also had considerable experience working with IPV survivors, with an average of 12.11 years ($SD = 9.525$) and a range from 0 to 35 years. See Table 1 for further demographic characteristics.

Qualitative Data Analysis

A variation of the concept mapping approach to data analysis was selected for this project because it synthesizes qualitative data into a quantitatively structured diagram. Based on the work of Trochim and colleagues (Jackson & Trochim, 2002; Kane & Trochim, 2007; Trochim, 1989a, 1989b), concept mapping is a mixed method approach that integrates qualitative individual data with multivariate statistical analyses to help describe and represent ideas visually using two-dimensional maps (Rosas & Kane, 2012). Concept mapping variations have been used in more than 69 studies to generate new ways to look at familiar problems across multiple areas (Rosas & Kane, 2012) including mental health (Johnsen, Biegel, & Shafran, 2000), program evaluation (Kane & Trochim, 2007), public health (Burke et al., 2005; Trochim, Cabrera, Milstein, Gallagher, & Leischow, 2006), study abroad programs

Table 1. Sample Characteristics.

	<i>n</i>	%
Gender		
Male	3	4.8
Female	59	95.2
Race/ethnicity		
African American	2	3.2
Asian American	2	3.2
Caucasian	52	83.9
Hispanic	3	4.8
Other	3	4.8
Education level		
High school graduate some college	2	3.2
Associates degree	4	6.5
Undergraduate degree	17	27.4
Master's degree	31	50.0
Doctoral degree	5	8.1
Other	3	4.8
Professional affiliation		
Social work	21	33.9
Administrator	13	22.0
Psychologist or other professional counselor	10	16.1
Advocate or activist	10	16.1
Health profession	2	3.2
Legal profession	3	4.8
Para-professional	2	3.2
Pastor, rabbi, or other spiritual leader	1	1.6
Agency type		
Not-for-profit organizations	57	91.9
Government	5	8.1
Community type		
Rural	19	30.6
Urban	22	35.5
Suburban	10	16.2
Mix urban/suburban/rural	11	17.7

(Poole & Davis, 2006), help seeking of IPV survivors (Simmons, Farrar, Frazer, & Thompson, 2011), and social work ethics (Simmons & Rycraft, 2010). The concept mapping variation used for this study consists of the following five distinctive stages where qualitative data were reduced and sorted into meaningful categories.

Stage 1. In the first stage, participants' responses to the selected survey questions were divided into units of analysis with each unit consisting "of a sentence or phrase containing only one concept" (Jackson & Trochim, 2002, p. 313). These units of analysis were then printed on cards so that each card contained only one concept.

Stage 2. In the second stage, eight coders representing a variety of backgrounds independently sorted the cards containing participant responses (i.e., units of analysis) into meaningful groups/clusters. The coders included five graduate students (social work and psychology) and three graduate trained professionals working in the area of IPV prevention and intervention. Each coder was asked to sort the cards containing participant responses (i.e., units of analysis) into groups of similar concepts and advised that there were no predetermined grouping patterns or wrong answers. As such, each coder independently determined which concepts/cards (units of analysis) went together, how many groups/clusters to form, and the number of concepts/cards each group/cluster contained. After the card sort was complete, the coder identified the central theme for each group/cluster, which was considered in the labeling process described in Stage 5 below.

The resulting sort for each coder was entered into a matrix (spreadsheet) using a binary code grid with cell values representing "whether (1) or not (0) a pair of statements was sorted by that coder into the same pile" (Jackson & Trochim, 2002, p. 315). The individual grids were then combined into a larger matrix with cell values representing the number of coders who combined the respective concepts (e.g., units of analysis).

Stage 3. In the third stage, the computer program SPSS was used to conduct a multidimensional scaling analysis (ALSCAL procedure) on the larger matrix. Multidimensional scaling graphically shows how different objects of comparison do or do not cluster based on a series of similarity or distance judgments made by the sorters in Step 2 of the concept mapping process. During multidimensional scaling, a type of perceptual mapping takes the form of a scatter plot (or perceptual map) using an Euclidean distance model. The circles on the scatter plot represent data-point markers while the letters label the data-points and represent the unit of analysis. The stability of these scatter plots is reported using the stress value which ranges from 0.0 to 1.0 with 0.0 indicating a perfect goodness of fit and the stress and squared correlation (RSQ) (e.g., correlation between factors) which ranges from 0.0 to 1.0 with 1.0 indicating a perfect solution.

Stage 4. In the fourth stage, individual data-points on the scatter plots (the units of analysis) were grouped together into final cluster solutions using

hierarchical cluster analysis of the data-points identified by multidimensional scaling. Hierarchical cluster analysis uses agglomerative methods to arrange the elements (unit of analysis) into clusters using a hierarchical tree structure. The process begins with each individual element/unit in its own cluster then iteratively merges them in successive intervals until there is only one cluster. Thus, using this method, the researcher must decide the number of clusters based on the degree of detail desired. For purposes of the current study, the number of clusters was based on the degree of similarity of the included constructs and the number of times coders grouped the ideas together with connections being made by at least 50% ($n = 4$) of the coders.

Stage 5. In the fifth stage, clusters were named based on the central idea of the group cluster, coder recommendations, and discussion by the research team.

Results

To address the research question, participants were asked the question “Significant research indicates women who experience IPV do not receive care for mental health conditions. In your experience, what do you think causes this?” and were given seven multiple response answer choices and an open-ended “other” option. Analyses of the multiple response answer choices were detailed previously (Simmons et al., 2014). Summary for the 62 participants of this study are as follows: the system is designed in such a way that women who experience IPV are discouraged from getting help ($n = 9$; 14.5%); women who have experienced IPV have more pressing needs (e.g., safety, housing, employment; $n = 39$; 62.9%); women who have experienced IPV undergo enough negative reaction from others; assessing for mental health would stigmatize them further ($n = 16$; 25.8%); most of what women experience following IPV is not a mental health problem, it is a normal reaction to a highly stressful situation ($n = 12$; 19.4%); service providers are not familiar with the information that is needed ($n = 17$; 27.4%); the mental health screening tools that are currently available are not designed in a way that is appropriate for use with women who experience IPV ($n = 17$; 27.4%); women who are experiencing IPV are oftentimes not ready to receive help ($n = 23$; 37.1%).

Qualitative responses to the “other” option were provided by 62 participants and analyzed using the concept mapping variation previously described. Of the responses provided, 12 contained multiple concepts and were divided into 2 answers resulting in 74 distinct units of analysis. The Euclidean distance model revealed a stress value of .001 and an RSQ value of 1 after 1 rotation, indicating a stable solution using the Kruskal’s stress formula. Illustrated in Figure 1, the answer clusters include (1) *unsure*, (2) *limited IPV-specific*

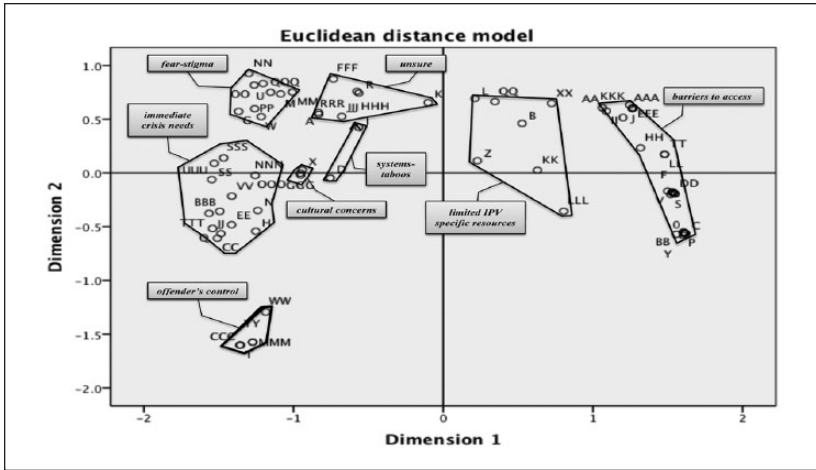


Figure 1. A concept mapping representing participants' answers to the open ended "other" option of the question "Significant research indicates women who experience IPV do not receive care for mental health conditions. In your experience, what do you think causes this?"

Note. Each cluster is labeled with the identified concept. The data-points are marked with circles, labeled with letters, and correspond to individual unit of analysis. IPV = intimate partner violence.

resources, (3) barriers to access, (4) systems-taboos, (5) immediate crisis needs, (6), fear-stigma, (7) offender's control, and (8) cultural concerns.

Cluster 1

Labeled, *unsure*, the first cluster includes 7 statements, which map as a distinct geographically unique cluster compared with the other clusters. Each of the statements highlight the uncertainty about the reasons women IPV survivors do not receive care. Two participants wrote, "I don't know." Another participant wrote, "This would entail a huge shift in thinking in IPV service providers—not saying this is bad or good, but [it is] a big shift." Responses included in this cluster identify an overarching uncertainty about the reasons IPV survivors do not receive care for mental health concerns.

Cluster 2

Labeled, *limited IPV-specific resources*, the second cluster includes 6 statements specifying concerns about limited availability of resources designed to

help IPV survivors. To illustrate, one participant wrote, “There are not enough available/accessible mental health service providers who understand the dynamics of IPV.” A second participant wrote, “System not providing long-term assistance or support.” A third participant wrote, “The organizations that receive IPV survivors first are often under resourced to ensure ample time, skill, and staff to do this effectively.” Responses included in this cluster illustrate the concerns about limited availability of IPV-specific resources that can make service delivery difficult for this population.

Cluster 3

Labeled *barriers to access*, the third cluster includes 29 statements explaining that costs and financial limitations reduce the ability of IPV survivors to access mental health resources. To illustrate, one participant wrote, “There are few mental health resources available in the community for those living in poverty.” A second wrote, “There are also affordability issues, as well as restriction to the access to those services in our area, which is a big problem for our community.” A third wrote, “Mental health care is costly and many of my clients cannot afford it.” Indeed, a number of participants indicated that “limited financial funding for mental health services” precludes access. Responses that clustered in this category reflect concerns about how IPV survivors who could benefit from care for mental health-related problems would be able to afford and otherwise access them.

Cluster 5

Labeled *immediate crisis needs*, the fifth cluster includes 11 statements denoting the importance of first addressing the immediate concerns of IPV survivor clients and the difficulties that occur after the immediate crisis is resolved. To illustrate, one participant wrote, “Once the immediate needs have been met, it can be difficult to get the woman to invest in working on her mental health.” A second wrote, “Women experiencing IPV often do have more immediate needs, i.e., safety, housing, childcare, etc.” A third wrote, “Only if [the] survivor has additional mental health issues then counseling is recommended or referring to mental health therapist, but it is not their priority at the time of crisis.” The constructs included in this cluster also address long-standing beliefs that ending the abusive relationship is sufficient. To illustrate, one participant wrote, “I think that survivors and agencies feel that if the individual can be removed from the abusive situation, that everything will be okay.” Similarly, another professional wrote, “Some of what women experience following IPV is not a mental health problem. Also, some

professionals who work with IPV victims do not agree that clients can suffer from both a mental health illness and IPV at the same time.” Responses that clustered in this category reflect how the urgency of addressing immediate crisis needs takes precedence over addressing mental health concerns.

Cluster 6

Labeled *fear-stigma*, the sixth cluster includes 11 statements highlighting fears about possible repercussions associated with mental health labels/diagnoses and the stigma related to mental health problems. For example, one participant wrote, “They fear their children will be taken by the Department of Children and Families; they fear or don’t like/trust their social worker.” A second wrote, “Victims are skeptical and lack trust in the system, many have had negative experiences with mental health care providers in the past.” A third wrote, “Concerned that mental health screening would lead to screening individuals for program & shelter participation.” Responses that clustered into this category reflect the fears and stigma that can oftentimes be associated with receiving a mental health diagnosis and subsequent care.

Cluster 7

Labeled *offender’s control*, the seventh cluster includes 5 statements highlighting the very real concerns that diagnostic labels will be used by the offender/abuser to control or otherwise harm the IPV survivor. To illustrate, one participant wrote, “Abusers will often use or threaten to use the victim’s MH records against her, specifically in custody cases.” A second wrote, “A violent partner often controls a woman’s life and limits her access to supports and resources.” A third wrote, “Women who are experiencing IPV may not be allowed to receive mental or physical health services due to the power and control exerted by the abuser.” Responses that clustered into this category reflect how the abuser can use mental health diagnosis and treatment to further the overarching power, control, and abuse they exert over the victim/survivor.

Clusters 4 and 8

The final two clusters are very small ($n = 2$ and 5 respectively). Cluster 4 includes two different concepts related to *systems-taboos*. To illustrate, one participant wrote, “They have attempted to get help at times and the systems have caused more trauma due to lack of understanding the dynamics of DV.” The other participant wrote, “The lack of information provided to victims and

the taboos behind mental health services specially in the Latino Community.” Cluster 8, *cultural concerns*, includes ideas related to potential cultural barriers associated with accepting help for mental health–related concerns. To illustrate, one participant wrote, “Cultural dynamics around ‘mental health’ issues.” Another wrote, “In some cultural communities it is not widely accepted to seek professional help for mental health concerns.” Although both of these final clusters are small, the ideas included represent important things to consider when conceptualizing possible reasons IPV survivors do not receive care for mental health conditions.

Discussion

Extending previous quantitative work by the authors (Simmons et al., 2014), the current study reports qualitative data identifying obstacles that can preclude IPV survivors from receiving treatment/care for mental health–related symptoms/concerns. The current portion of this project generates new ways of looking at barriers to service delivery by integrating responses front-line IPV helping professionals provided to the “*other*” option from one of the survey questions. Using a modified concept mapping approach, eight distinct clusters emerged from the analysis. As discussed below, the opinions expressed in these clusters help to better explain logistic, relational, and intra-personal obstacles that can limit women IPV survivors’ ability to receive care for mental health conditions.

Factors to Consider

The eight clusters that emerged point to important factors that can be considered in future research, theory development, and practice situations. First among these is the importance of addressing physical and safety needs of women who have experienced IPV. The cluster *immediate crisis needs* was identified by 11 participants and highlights this very real and urgent concern. Even though focusing on mental health has the potential to improve positive outcomes (Warshaw et al., 2013), taking a safety focus should (and always will) be the highest priority (e.g., Campbell, 2001; Campbell et al., 2003). Other immediate crisis needs include helping the IPV survivor meet basic life requirements, such as food, shelter, and childcare. The opinions expressed in this cluster also indicate that IPV helping professionals believe addressing immediate crisis needs may not be enough. Although crisis intervention is a good place to start, it is likely that long-term recovery will be predicated on going beyond the immediate crisis needs to address mental health issues that may result from or otherwise be associated with the abuse suffered.

A second factor to consider emphasizes the *barriers to access* IPV survivors oftentimes face when seeking care for mental health–related conditions and also concerns about *limited IPV-specific resources*. With 29 participants reporting concerns that clustered together, *barriers to access* was the largest cluster to emerge from data analysis. Concerns expressed in this cluster relate to the price/cost of mental health services, how these services would be paid for should they be available, and how appropriate the current mental health intervention models are for IPV survivors. Emerging as a distinct cluster, opinions about *limited IPV-specific resources* available to organizations and systems designed to help IPV survivors represent related yet different concerns. Identified by 6 participants, the viewpoints include limited availability of resources that many programs face when working with IPV survivors. Despite both a growing awareness about the impact of IPV on mental health (Warshaw et al., 2013) and increased federal funding for mental health care (The Patient Protection and Affordable Care Act, 2010), there appears to be a concern about limited IPV-specific resources available to serve the needs of this vulnerable population. As professional discourse in relation to funding trends and trauma informed service delivery evolve, perhaps access and availability concerns will be considered and addressed.

A third factor to consider encompasses areas salient to the IPV survivor's ability to seek and accept help, which is a common concern when working with women in abusive relationships (i.e., Montalvo-Liendo, 2009; Simmons et al., 2011). As such, although the four clusters, *fear-stigma*, *offender's control*, *cultural concerns*, and *systems-taboos*, emerged as four separate groups, they share conceptual similarities. Specifically, the opinions expressed in these clusters point to valuable areas that thwart the IPV survivors' help seeking and help accepting abilities. The *fear-stigma* cluster included 11 responses identifying concerns about stigma and possible repercussions associated with mental health labels/diagnoses. Among the concerns noted include fear about losing custody of their children, distrust of the system and helping professionals, prior bad experiences, and concerns about losing eligibility for resources. The *offender's control* cluster included 5 responses pointing to the very real and complex underlying problems associated with violent intimate partner relationships. In this cluster, respondents identified a range of concerns including the abuser's ability to use mental health records against the victim and an overarching control the abuser has over the victim (i.e., daily activities, access to health care). The cluster *cultural concerns* included 5 responses that illustrate potential cultural barriers associated with seeking and accepting help for mental health–related concerns. From this, the importance of culturally appropriate interventions is highlighted. Finally, the cluster *systems-taboos* included 2 responses that illustrate the importance of

providing the reliable, respectful, and appropriate care at all system levels. The 2 responses included in this cluster indicate that doing otherwise has potential adverse repercussions. In sum, when taken together, these four clusters represent real-world barriers that can preclude IPV survivors from seeking and accepting help for mental health concerns they may experience.

A fourth theme to emerge illustrates an uncertainty about how to best help IPV survivors who have mental health–related symptoms/problems. Issues inherent to the intersection between IPV and mental health are complex, with multiple levels of complications. The cluster *unsure* included 7 responses illustrating the uncertainty some professionals working in the field have about how to best address this topic. Yet, despite this uncertainty and when appropriate, mental health assessment, diagnosis, and treatment can greatly benefit this vulnerable population (e.g., Warshaw et al., 2013). From this, the opinions expressed throughout all eight clusters highlight a need for agencies to implement best practices that do not increase client risk through stigma and labels. Further discussion is needed to develop, assess, and implement service delivery models that balance the consequences that arise with diagnostic labels and the equally real difficulties related to mental health symptoms/problems when working with IPV survivors.

Relevance to Practice and Future Research

The current findings help identify ways to help women who experience IPV receive care for mental health conditions. Findings emphasize the importance of providing balance in service delivery models that address crisis needs, limited IPV-specific resources, and other barriers to access. Further discussion about how agencies can implement best practices that do not increase client risk through stigma and labels is encouraged. The significance of these findings for practice with IPV survivors is inherent in the worldwide prevalence of IPV. With the advent of the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-V*; American Psychiatric Association [APA], 2013), the diagnoses of PTSD and Adjustment Disorder are being moved away from the anxiety classification to the separate classification of Trauma- and Stressor-Related Disorders. It follows then that trauma-related symptoms/reactions are normal responses to abnormal situations. Whether working with a particular client or making programmatic changes, professionals should ask the question “is this a way to break the cycle of violence?” Findings from this research team and others (e.g., Beck et al., in press; Golding, 1999; Nathanson et al., 2012; Warshaw et al., 2009; Zlotnick et al., 2006) indicate that mental health symptoms and diagnoses are certainly problems within this population. Thus, a question that may need to be addressed

is whether programmatic and research funding sources should target mental health problems that IPV helping professionals see in their clients but do not always have the time, knowledge, and/or resources to address.

Findings can also help professionals to better understand the need to balance the very real concerns that arise when vulnerable clients receive diagnostic labels with the equally real difficulties related to mental health symptoms/problems. From this, future research should aim to incorporate client engagement in the identification of themes related to mental health needs with a focus on survivor mental health education to allow for informed decision making. Similarly, further research of ways to optimally integrate mental health assessment and referral into service delivery for this vulnerable population is also suggested.

Limitations and Closing

In closing, it is important to note a number of limitations inherent to the current study. First, the study is a qualitative exploration designed to inductively broaden theoretical understanding in a manner that can be used to guide future research. The qualitative questions used to address research question is broad and subjective in nature. Generalizability and objectivity is neither assumed nor expected. Thus, by design, further research is needed to determine if the findings are generalizable to the greater population of professionals working with IPV survivors and, subsequently, to the survivors themselves. Second, the two-part sampling method used for this study makes it impossible to know how many people received the survey or to directly follow-up with respondents. However, because participants represented a range of professional affiliations and demographic backgrounds, the diversity of the sample provides support for representativeness appropriate to the purpose of this study. Additional research exploring issues of generalizability could be useful. For example, are there differences between regions with respect to the acceptability of mental health screening within social service environments?

Despite the limitations of the current report, findings provide valuable insight into factors that may limit the ability of IPV survivors to receive care for mental health conditions. The study also highlights the need for more information that explains ways that mental health screening, assessment, and treatment can be applicable to work with IPV survivors. From this, a great deal of additional research is needed to better understand how to incorporate mental health assessment and treatment into service delivery models and effectively respond to the diverse array of experiences and needs IPV survivors often present.

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