Article

Violence Against Women
Volume 15 Number 7
July 2009 852-868
© 2009 The Author(s)
10.1177/1077801209334445
http://vaw.sagepub.com

Women's Experiences of Violence and Seeking Help

Judy L. Postmus
Center on Violence Against Women & Children, Rutgers University
Margaret Severson
Marianne Berry
University of Kansas
Jeong Ah Yoo
Rutgers University

Every day, women survive physical or sexual violence. Some survive as a result of services they receive in the aftermath of the abuse. The study presented here explored women's experiences of victimization and their use of and perceptions about the services they received. It is learned that what providers usually prioritize and what the women in this study used—namely emotional, psychological, and legal support—are not what these women identified as the most helpful. Instead, tangible supports, such as food, housing, and financial assistance, were viewed as the most helpful, along with religious or spiritual counseling.

Keywords: *help seeking; victim services; violent victimization; women*

Researchers have been studying for years the prevalence and impact of physical, sexual, and other forms of violence on women throughout their lifetime and conclude that millions of women experience and survive these experiences—sometimes with the help of others or in spite of that help. Indeed, we have learned that survivors struggle with physical, emotional, and financial conditions and, hence, to address those conditions community services have been created, including emergency shelter, support groups, individual counseling, and other services usually focused on improving the emotional and psychological health of survivors (Sanders & Schnabel, 2006).

In fact, most researchers agree that disclosing abuse and seeking help from informal and formal support networks will lessen the long-term impact of abuse (Coker et al., 2002; Thompson et al., 2000). Unfortunately, because of the methods and

Authors' Note: This project was supported by Grant #2003-IJ-CX-1037 awarded by the National Institute of Justice, Office of Justice Programs, U.S. Department of Justice. Points of view in this article are those of the authors and do not necessarily represent the official position or policies of the U.S. Department of Justice.

Downloaded from vaw.sagepub.com at PENNSYLVANIA STATE UNIV on September 18, 2016

sampling strategies used, the existing research is unclear and inconsistent on why and how women seek help (Hutchison & Hirschel, 1998). Indeed, some research challenges lie with the knowledge that survivors experience abuse differently with seeking help as a process, which evolves and fluctuates over time (Brown, 1997; Cattaneo, Stuewig, Goodman, Kaltman, & Dutton, 2007). In addition, there is limited research detailing the kinds of services sought and received and women's perceptions of the helpfulness of these services. Consequently, the purpose here is to address this limitation by presenting the results of a study that yields information on the types of formal and informal services survivors received, their appraisal of the helpfulness of the services, and the types of barriers survivors encountered in the process of seeking services.

Women's Experiences of Getting Help

Battered women often seek help from many informal and formal networks without necessarily disclosing their victimization (Henning & Klesges, 2002; Macy, Nurius, Kernic, & Holt, 2005). However, disclosing intimate partner violence (IPV) is often the first step to helping the victim realize she is abused and in limiting the resulting distress (Coker et al., 2002; Thompson et al., 2000). For services specifically developed for victims, research indicates that shelters and advocacy organizations are well equipped to enhance survivors' internal resources and improve their social support through counseling, support groups, advocacy, and shelter services (Berk, Newton, & Berk, 1986; Cox & Stoltenberg, 1991; Mancoske, Standifer, & Cauley, 1994; Sullivan & Bybee, 1999; Tutty, Bidgood, & Rothery, 1993). For example, support groups have been shown to increase women's self-esteem, sense of belonging, and locus of control (Tutty et al., 1993). Shelters and advocacy organizations are also equipped to enhance battered women's material and institutional resources through advocacy, referral, collaboration, and education (Hart, 1993; Sullivan, Campbell, Angelique, Eby, & Davidson, 1994; Sullivan, Tan, Basta, Rumptz, & Davidson, 1992; Weisz, 1999; Weisz, Tolman, & Bennett, 1998). Participation in community-based advocacy services resulted in a higher quality of life and greater social support for women. In addition, battered women had less difficulty obtaining community resources over time compared to battered women who did not participate in the same advocacy services (Bybee & Sullivan, 2005; Sullivan & Bybee, 1999; Sullivan et al., 1992). In other words, advocacy organizations are well equipped to address the stress of battered women and connect them with other helping systems.

However, not all battered women turn to shelters and advocacy organizations for help; in fact, most abused women seek help first from family and friends (Coker, Smith, Bethea, King, & McKeown, 2000; Davis & Srinivasan, 1995; Horton &

Downloaded from vaw.sagepub.com at PENNSYLVANIA STATE UNIV on September 18, 2016

Johnson, 1993) and then eventually from formal supports (Hutchison & Hirschel, 1998; Macy et al., 2005). Gordon's (1996) earlier review of the research on battered women's use of services suggested that the most commonly used social service systems were, in descending order of frequency, the criminal justice system (i.e., law enforcement and lawyers), social service agencies, medical services, crisis counseling, mental health services, clergy, and women's groups. However, while seeking services within the various systems, abused women did not necessarily view the services they received as helpful (Gordon, 1996).

More recent studies support Gordon's earlier research, finding that although abuse victims turned to services for help, they did not necessarily view them as helpful (Humphreys & Thiara, 2003; Zweig & Burt, 2007). Indeed, women reported that mental health providers focused on their mental health instead of abuse experiences, offered medication instead of support, and did not fully comprehend the trauma experienced as evidenced by their disbelief and blaming attitudes (Humphreys & Thiara, 2003). In Zweig and Burt's (2007) study, women found services more helpful when they experienced positive staff behavior, when women felt in control in their interactions with staff, and when agencies collaborated with other agencies.

Survivors may turn to many other helping systems to specifically address their needs. These systems may include mental health, substance abuse, and health systems for emotional and physical help, welfare systems for financial help and other concrete services, and criminal justice systems for legal help. Unfortunately, these same systems may unwittingly set up barriers that discourage victims from seeking help. Researchers have used terms such as *secondary rape* or *secondary victimization* to describe the impact of these institutional barriers that result in additional trauma and problems for victims (Campbell, 1998; Campbell & Raja, 1999; Campbell et al., 1999; Ullman, 1996).

In sum, we know that all women are at risk for experiencing physical or sexual victimization during their lifetimes, and we know that battered women turn to many formal and informal networks to get emotional and physical support to survive. What we do not know are the details of women's opportunities to access social supports and interventions after their victimization. Hence, several research questions frame our study and include the following: (a) Which type of services or supports do women use as a result of their victimization experiences? (b) Of the services used, which ones do women find helpful? (c) What barriers do women encounter while trying to seek such services? The study outlined below seeks to answer these questions by interviewing a varied and diverse group of women, recruited from sexual assault and domestic violence agencies as well as from a women's prison and several communities, asking them about their lifetime experiences of victimization, their postvictimization use of services, their perceptions of the helpfulness of these services, and the barriers they encountered in accessing those services.

Downloaded from vaw.sagepub.com at PENNSYLVANIA STATE UNIV on September 18, 2016

Method

Data for this research were collected as part of an exploratory study supported by the National Institute of Justice (NIJ). The overall goal of the larger study was to examine the consequences (i.e., health, mental health, substance use, incarceration, and suicidality) of IPV, sexual violence, and youth maltreatment and victimization to identify at-risk populations, modifiable risk and protective factors, and optimal times and settings for intervention (Postmus & Severson, 2006). The methods reported here have been reported in other published and unpublished works (Postmus & Severson, 2006; Severson, Berry, & Postmus, 2007; Severson, Postmus, & Berry, 2005). For this article, we specifically focus on women's postvictimization use of interventions, the helpfulness of those interventions, and the service barriers encountered.

Sample

Using convenience and snowball sampling procedures, we recruited women from three urban communities, one rural community, and the only women's correctional facility (CF) in a midwestern state. Flyers printed in English and Spanish were posted in the prison and in a range of sites in the four communities, including domestic violence and sexual assault agencies, community service sites, and other locations women frequent (e.g., laundromats, grocery stores, day care centers). Each woman participant from the community received a cash incentive of US$25 for her participation in the study; the prison system does not allow cash or in-kind incentives to be provided to participants. Each of the women consented to one face-to-face interview, with interviews occurring over a continuous 12-month period. The 1-hr interviews were held in private and conducted in English or Spanish by trained graduate and undergraduate students.

The total study sample of 423 women includes 157 women in the prison, 157 women living in one of four communities where they were receiving services from a domestic violence and/or sexual assault program, and 109 women living in one of the four communities and who had not received such services in the 12 months prior to the interview. For purposes of this analysis, all of these sample groups are combined into the total study sample of women reporting histories of childhood and/or adulthood victimization.

Measures

The interview questions were developed from a combination of existing and modified standardized instruments and reviewed by the State Department of Corrections and the statewide Coalition Against Sexual and Domestic Violence. The instrument

Downloaded from vaw.sagepub.com at PENNSYLVANIA STATE UNIV on September 18, 2016

was piloted with eight survivors of violence recruited from the CF and a local community not included in the study, and modifications were made consistent with the feedback received from that process.

Victimization

Women were asked about four different types of victimization: physical child abuse, sexual child abuse, IPV, and sexual assault. Women were asked to report any experience in their lives but were not asked to specify the number of perpetrators or the time frame within which the abuse occurred. The rate of victimization reported may relate to a single perpetrator or multiple perpetrators and may or may not reflect abuse experiences that occurred over time.

Child maltreatment. Sexual and physical abuse during childhood were measured using the Childhood Maltreatment Interview Schedule (Briere, 1992). The analysis relied on two summary questions: "To the best of your knowledge, before age 17, were you ever sexually assaulted . . . physically assaulted?" (Briere, 1992).

IPV. IPV, including physical, sexual, and psychological abuse from an intimate partner, was measured using the Abusive Behavior Inventory (ABI; Shepard & Campbell, 1992), which has 30 Likert-type questions divided into two subscales measuring psychological IPV (20 items) and physical IPV (10 items). For this study, the alpha coefficients show strong internal consistency in this sample with .92 for physical IPV and .96 for psychological IPV.

Sexual assault. Sexual assault in adulthood by an intimate partner, family member, or stranger was measured using the Sexual Experiences Survey (SES; Koss & Oros, 1982). The SES asks Yes/No questions about sexual experiences, ranging from sexual coercion to attempted rape and ending with rape. The alpha coefficient (.90) indicates high internal consistency for this sample.

Support From Agencies

Support from agencies included any support received from health, mental health, or community agencies. Support from agencies was measured using adapted questions from the National Comorbidity Survey (1992). After asking women about all of their specific victimization experiences, we then asked them about which services or resources they used, giving them a list of 24 different types of possible services. Participants were asked which services they received in the aftermath of their abuse experiences and, for each one received, to what degree, using a 5-point Likert-type scale, the service was helpful. Participants were then asked to identify possible barriers or challenges that prevented them from getting help for their abuse experiences.

Downloaded from vaw.sagepub.com at PENNSYLVANIA STATE UNIV on September 18, 2016

Results

Overall, 87% of the study sample is between ages 21 and 50, with the largest cluster of participants in the 31 to 40 age range (see Table 1). The total sample is ethnically diverse with 56% identifying as White; the remaining 41% include African American (25%), Latina (13%), and Native American (3%) women. Almost 70% of the participants have received welfare at least once.

Victimization

The women in this study report high levels of childhood and adult victimization (see Table 1). Violence between intimates is very common; almost all of the women report physical IPV (91.5%). Sexual violence in adulthood is also common; two thirds of the sample (67%) report being raped. Childhood maltreatment is the least reported form of victimization but is acknowledged by more than half of the women.

Co-occurrence of types of victimization is common in the three sample groups. More than 37% of the total sample report experiencing all four primary types of victimization (physical child abuse, sexual child abuse, physical IPV, and rape). The entire sample has experienced a mean number of 2.7 of these four different victimization experiences. Fewer than 5% of the women report no victimization, almost 18% report only one type of victimization, almost 21% report 2 types of victimization, and nearly 20% report 3 types.

When examining experiences of childhood sexual abuse and physical IPV, there are significant differences across age, welfare receipt, and sample source (see Table 2). When examining the largest ethnic groups represented in this sample (White, African American, and Latina), Whites are most likely to experience physical IPV followed by African Americans. Latina women consistently report the lowest levels of victimization in this sample.

Women who have received welfare are significantly more likely than those who have not received welfare to experience childhood sexual abuse, adult IPV, and rape. Women recruited from the prison are more likely to report childhood sexual abuse and adult rape, whereas women from the domestic violence/sexual assault agencies report higher rates of physical IPV. There are no significant differences between demographic groups in the incidence of childhood physical abuse. In addition, there are no significant differences in education levels for those reporting any of the four types of victimization.

Seeking Help in the Aftermath of Violence

Women were asked about the services they used, choosing from a list of 24 different types of services or resources that women might have sought after their

Downloaded from vaw.sagepub.com at PENNSYLVANIA STATE UNIV on September 18, 2016

Table 1
Demographics

	n	%
Age		
18-20	17	4.0
21-30	119	28.3
31-40	152	36.1
41-50	94	22.3
51+	39	9.3
Ethnicity		
White	235	55.6
African American	106	25.1
Latina	54	12.8
Asian/Pacific Islander	6	1.4
American Indian	12	2.8
Other	10	2.4
Education		
High school or less	243	57.4
Some college	166	39.2
Graduate level	11	2.6
Received welfare		
Yes	294	69.7
No	128	30.3
Recruited from		
DV/SA program	157	37.1
Community	109	25.8
Correctional facility	157	37.1
Victimization experienced		
Child physical abuse	214	48.4
Child sexual abuse	246	59.3
Physical IPV	387	91.5
Rape	281	67.4
Number of victim experiences		
0 Experiences	20	4.7
1 Experience	74	17.5
2 Experiences	89	20.9
3 Experiences	83	19.7
4 Experiences	157	37.2

Note: DV/SA = domestic violence and/or sexual assault; IPV = intimate partner violence.

victimization, presented here by decreasing frequency of use (see Table 3). Women were asked to indicate which services or resources they received at any time in the past as a result of their abuse experiences and to give an indication of the helpfulness of each service received based on a scale of 1 (*not helpful*) to 5 (*extremely helpful*). The top 10 most common services or resources used are as follows: (a) emotional support from friends or family (76%), (b) professional counseling (64%), (c) medication

Downloaded from vaw.sagepub.com at PENNSYLVANIA STATE UNIV on September 18, 2016

Table 2
Demographics and Types of Victimizations

	Childhood Physical Abuse	Childhood Sexual Abuse	Physical IPV	Rape
Age				
18-20	41.2	23.5	70.6	35.3
21-30	50.4	56.4	89.1	63.0
31-40	49.3	62.7	94.1	73.8
41-50	57.4	64.9	93.6	69.1
51+	52.8	55.6	92.3	64.9
χ^2	2.4	11.5*	12.3*	12.0*
Ethnicity				
White	54.1	60.9	95.3	70.5
African American	45.6	56.3	90.6	63.8
Latina	43.1	45.1	74.1	54.0
χ^2	3.3	4.4	24.6***	5.5
Education				
High School or less	51.9	61.1	90.5	70.2
Some college	50.0	55.6	92.2	63.0
Graduate level	63.6	63.6	100	63.6
χ^2	0.8	1.3	1.4	2.3
Received welfare				
Yes	53.1	63.4	93.5	71.5
No	47.6	49.2	86.7	57.6
χ^2	1.1	7.3**	5.3*	7.7**
Recruited from				
DV/SA program	56.1	58.7	96.8	70.6
Community	41.5	47.2	78.0	55.1
CF	53.9	68.2	95.5	72.6
χ^2	5.9	11.5**	34.6***	10.0**

Note: IPV = intimate partner violence; DV/SA = domestic violence and/or sexual assault; CF = correctional facility.
*$p < .05$. **$p < .01$. ***$p < .001$.

for emotional problems (53%), (d) welfare (51%), (e) support or self-help groups (50%), (f) visits to medical providers (48%), (g) legal services for divorce or restraining orders (46%), (h) psychotropic medication (44%), (i) food banks (41%), and (j) religious or spiritual counseling (40%). Many tangible services, such as subsidized housing, subsidized day care, unemployment benefits, vocational rehabilitation, reproductive services, and worker's compensation, are among the services received the least, used by no more than 20% of victims.

If a woman indicated that she received a particular service or resource, she was then asked to indicate how helpful she found that service, on a scale of 1 to 5. The

Downloaded from vaw.sagepub.com at PENNSYLVANIA STATE UNIV on September 18, 2016

Table 3
Services or Resources Used and Perceived Helpfulness (N = 423)

	Total			
Services or Resources Used	*n* (%)	Rank of Use	Helpfulness Score	Rank of Helpfulness
Emotional support from friends or family	320 (76.0)	1	3.8	12
Professional counseling	271 (64.4)	2	3.7	13
Medication for emotional problems	223 (53.0)	3	3.7	15
Welfare	214 (50.8)	4	4.3	4
Support group or self-help group	212 (50.2)	5	3.6	16
Visit to a medical provider	203 (48.2)	6	3.6	17
Legal services for divorce or restraining order	193 (45.8)	7	3.3	22
Prescribed psychotropic medication	185 (43.9)	8	3.5	18
Food bank	171 (40.7)	9	4.2	6
Religious or spiritual counseling	169 (40.1)	10	4.3	2
Domestic violence shelter	165 (39.2)	11	3.9	10
Hospital stay for emotional problems	125 (29.7)	12	3.3	21
Educational support (GED, vocational)	114 (27.1)	13	4.3	5
Job training/employment counseling	107 (25.4)	14	4.2	7
Subsidized housing	85 (20.2)	15	4.3	3
Homeless shelter	79 (18.8)	16	3.4	20
Rape crisis or other sexual assault services	78 (18.5)	17	3.9	9
Child protection services	71 (16.9)	18	3.0	24
Subsidized day care support	67 (15.9)	19	4.6	1
Unemployment compensation	66 (15.7)	20	4.0	8
Vocational rehabilitation	37 (8.8)	21	3.7	14
Reproductive services	33 (7.8)	22	3.9	11
Worker's compensation	28 (6.7)	23	3.4	19
Internet support group or chat room	17 (4.0)	24	3.2	23
Mean number of supports used	7.7			
Mean score of helpfulness			3.8	

Note: GED = general educational development.

Downloaded from vaw.sagepub.com at PENNSYLVANIA STATE UNIV on September 18, 2016

top 10 services reported as being most helpful are subsidized day care, religious or spiritual counseling, subsidized housing, welfare benefits, educational services, food banks, job training, unemployment benefits, rape crisis or sexual assault services, and domestic violence shelters. When compared to the top 10 services used, only welfare benefits, food bank, and religious or spiritual counseling remain as being both received and helpful in the aftermath of victimization. Notably, the common services and resources used (emotional support from friends and family, professional counseling, medication for emotional problems, support or self-help groups, visits to medical providers, psychotropic medication, legal services) are ranked in the bottom half of services appraised as helpful. In fact, the rank of helpfulness of legal services was 22, with only Internet support groups and child protective services being perceived as less helpful.

Women were also asked if certain barriers or challenges prevented them from getting help after their abuse experiences. Of the 15 possible barriers listed, 2 stand out as common to the women in this sample (see Table 4). The first is the desire of the women to handle the problem on their own, reported by 82% of the total sample. The second barrier, thinking that the problem would get better by itself, is reported by 70% of the sample. In addition, more than half of the participants (59%) report being unsure about where to go or whom to see; women also commonly report thinking that treatment would not work for them (54%).

Discussion and Implications

This study provides a glimpse into women's experiences with violence and seeking help to survive those experiences. As noted earlier, victimization rates are higher for this sample when compared to other studies, especially with regard to physical IPV rates (92% reporting) and rape (67%). In addition, these high rates of victimization are made even more striking because of these women's reports of having experienced multiple types of violence during their lifetimes. These high levels may be explained by participant self-selection; namely, women who had experienced violent victimization chose to participate. Alternatively, the use of trained and sensitive interviewers who conducted the face-to-face interviews using detailed survey questions to capture all forms of violence and victimization may have increased reports of victimization further (Browne, Miller, & Maguin, 1999; Russell & Bolen, 2000). Because this sample was recruited to talk about experiences of violence, the rates of violence in this study are clearly higher than that reported in the general population. Therefore, the reader is reminded that the purpose of this study is not to provide incidence levels but rather to examine the experiences of violence by women and the formal and informal help they used as a result of those experiences.

That significantly more welfare recipients experience sexual abuse, physical IPV, or rape is similar to the findings of other studies (Browne, 1999). Indeed, the

Downloaded from vaw.sagepub.com at PENNSYLVANIA STATE UNIV on September 18, 2016

Table 4
Barriers to Using Services and Supports

Barriers Named	*n*	%
I wanted to handle the problem on my own	344	82.1
I thought problem would get better by itself	293	69.9
I was unsure about where to go or whom to see	249	59.4
I didn't think treatment would work	224	53.5
I was concerned about how much money it would cost	202	48.2
I had problems with things like transportation or scheduling	193	46.1
The problem didn't bother me very much at first	188	45.0
I was concerned about what people would think if they found out I was in treatment	185	44.2
I thought it would take too much time or would be inconvenient	159	38.0
I was scared about being put in hospital against my will	143	34.2
My health insurance would not cover services	132	31.6
I received services before, and it didn't work	128	30.5
My parents did not take me to get help	106	25.4
I was not satisfied with available services	89	1.3
I could not get an appointment	43	0.3
Mean number of barriers named	6.2	

number of survivors of domestic violence receiving welfare benefits prompted the passage of the Family Violence Option (FVO) as an amendment to the Personal Responsibility and Work Reconciliation Act in 1996 (Postmus, 2000). The FVO, however, is implemented so that the focus is generally only on survivors of IPV without taking into consideration survivors of other forms of violent victimization, such as sexual violence or childhood violence. More research is needed to better understand the victimization backgrounds of women on welfare for the purpose of providing more responsive services and for improving policy responses such as that advanced by the FVO.

As to their use of service interventions and their appraisal of the helpfulness of these interventions, our findings indicate that the services and supports perceived as the most helpful were those that were material. Ironically, these were also the services and supports least received. Recall that the most commonly received services of emotional support from family and friends, professional counseling, medication, support or self-help groups, and medical providers were reported to be less helpful when compared to tangible interventions, such as day care, housing, education, food bank, and job training. These findings are important to every service provider's assessment protocol and to intervention planning. Victimization has its emotional repercussions that must be addressed, and these repercussions are perhaps most effectively addressed only after one's physical and environmental needs are acknowledged and managed. Indeed, it is important that advocates listen to women as they

Downloaded from vaw.sagepub.com at PENNSYLVANIA STATE UNIV on September 18, 2016

identify their needs and wants and then offer rather than prescribe the appropriate and responsive services (Postmus, 2003).

In recent years, the domestic violence field has attempted to incorporate services that address women's financial and economic security yet have received few tools or policy support for these services (Sanders & Schnabel, 2006). Indeed, advocates, who may be struggling with their own economic security concerns, struggle with balancing financial services with safety and emotional support services. We know that economics and financial concerns play a large role in women's lives when struggling with the decision to leave or not (Sanders & Schnabel, 2006; Strube, 1988; Zorza, 1991). We also know how abusers sabotage work or efforts to become self-sufficient (Curcio, 1998; Lloyd, 1997; Raphael, 1999; Riger, Ahrens, & Blickenstaff, 2000; Tolman & Rosen, 2001). Finally, we know that financial difficulties are related to depression, exacerbate trauma, and decrease survivors' self-efficacy (Adams, Sullivan, Bybee, & Greeson, 2008; Ham-Rowbottom, Gordon, Jarvis, & Novaco, 2005). (For an excellent review of the linkage between economic abuse and its consequences, see Adams et al., 2008.)

However, more attention is still needed to understand the scope and impact of economic abuse (Adams et al., 2008) and help survivors become economically self-sufficient. For example, The Allstate Foundation, in collaboration with the National Network to End Domestic Violence, created and tested its Moving Ahead Through Financial Management curriculum, which offers support to advocacy organizations to provide economic advocacy and promote financial stability for survivors. More policy, research, and financial support are needed to provide service providers the tools and resources to understand and address economic justice.

In addition, in the study presented here, helpfulness of legal services for divorce or restraining orders was ranked 22 out of 24 possible services, just above Internet support groups or child protection services. Research has repeatedly talked about revictimization by the criminal system, but these legal services, used by 46% of the women in this study, were of the civil nature of divorce and restraining orders, processes often recommended to survivors by advocates and other human service professionals. The debate about the effectiveness of restraining orders has resulted in mixed conclusions (Postmus, 2007). The importance of restraining orders and other civil processes is that these are options that should be made available to provide some measure of relief or safety, but they may not be helpful or even safe for every woman.

In this study, only three services were used often and found to be helpful: welfare benefits, food banks, and religious or spiritual counseling. These results point to the need for more cross-training and collaboration between state agencies and advocacy organizations. At present, these agencies are guided by different philosophies, often making collaboration difficult between welfare offices and advocacy organizations. Indeed, we know that some battered women turn to the welfare system for financial assistance (Yoshihama, Hammock, & Horrocks, 2006). Research indicates that 20% to 32% of welfare recipients report current domestic violence (Allard, 1997; Browne

Downloaded from vaw.sagepub.com at PENNSYLVANIA STATE UNIV on September 18, 2016

& Bassuk, 1997; Lloyd, 1997; Tolman & Raphael, 2000). In addition, between 55% and 65% of welfare recipients report lifetime prevalence rates of IPV (Allard, 1997; Lidman, 1995; Tolman & Raphael, 2000). Hence, more research is needed to better understand how to encourage collaboration so that the desired results—to offer user friendly services and to positively impact women's self-sufficiency—are achieved.

Finally, religious or spiritual counseling was reported as being used and found helpful to survivors in this study. Advocates have worked closely with religious providers in recent years (Fortune, 2001; Gillum, Sullivan, & Bybee, 2006); research is needed to understand how religious services help and ways to incorporate spirituality into services without trying to influence survivors' values and beliefs.

Of course, the words *used* and *received* services in the survey question imply the availability of the service or support. In fact, some of these services (e.g., day care, subsidized housing, food, job training, and educational supports) may not be available in all communities, or the women in this sample may not have qualified to receive such services. It may be that nontangible services are much more available than the more concrete supports of independence from the perpetrator, but the women's reports in this study raise the difficult question of whether women are using more therapeutic-type services because it is those they seek or because it is those that are available or recommended to victims.

A high percentage of women in this study turned to professional counseling for support following their victimization. Unfortunately, we did not specify what we meant by professional counseling but rather left it up to the individual participant to determine her own definition. Regardless, one can assume that participants identified "professional" as a wide range of service providers including those who may or may not work in organizations specifically designed to meet survivors' needs. Several researchers have reported that women who have experienced IPV or rape have encountered negative or unhelpful service providers, who may in turn unwittingly revictimize women (Campbell & Raja, 1999; Campbell et al., 1999; Humphreys & Thiara, 2003). More training and collaborations must occur with service providers to be helpful to victims' efforts to survive.

When asked about potential barriers to receiving services, the women in this sample overwhelmingly reported that they wanted to take care of the problem themselves (82%) or that they believed that the problem would resolve itself without intervention (70%), with the problem defined as the aftermath of experiencing the victimization. These findings may be related to the difficulty in disclosing one's experience of victimization, the fear of revictimization, or not wanting to be viewed as weak for seeking help. Policy statements that affirm the reality and undesirability of stigma and the appropriateness of seeking help for the tangible and emotional needs that emerge following victimization are the precursors to the public policies that will diminish these fears. Those policies must include universal access to quality health and mental health care and to unbiased and respectful systems of social and criminal justice.

Downloaded from vaw.sagepub.com at PENNSYLVANIA STATE UNIV on September 18, 2016

The findings from this study yield new and useful information that may be helpful for policy makers and social service practitioners alike. These findings, however, must be viewed in light of the limitations of this study. Convenience sampling methods limit our ability to generalize the findings to a broader population of women. Convenience sampling was used in part because of the at-risk nature of the population under study: women who have histories of victimization. The institutional review board overseeing our research methods required that the recruitment and consent strategies include the intent of the study to study women's victimization experiences; hence, certain women may have self-selected to participate in this study. In addition, we relied on self-report and so are limited by our subjects' willingness to disclose their experiences to us and limited by their memories of the experiences as well. These are common challenges faced in all retrospective studies.

Conclusion

The results from this study shed light on the types and helpfulness of formal and informal services women use as a result of their victimization experiences as well as barriers women encountered as they sought those services. We learned that what we as providers usually prioritize and what the women in this study used—namely emotional, psychological, and legal support—are not what these women identified as the most helpful. Instead, tangible supports, such as food, housing, and financial assistance, were viewed as the most helpful along with religious or spiritual counseling.

Our intervention strategies must go beyond offering emotional support; we must offer survivors help locating and securing the types of tangible services (financial assistance, child care, transportation, housing, and educational assistance) that will support their survival and the termination of abuse. Perhaps, as some advocates are doing, it is time to bring greater emphasis and awareness to economic justice and the self-sufficiency of survivors.

More empirical investigation is needed that examines service utilization and its effectiveness in helping support women to not only survive violence but also to progress in spite of violence. This knowledge would translate into more responsive service planning and more effective interventions, meeting the needs of all survivors of violence whether physical, sexual, or emotional, whether one incident or many, and whether one perpetrator or many.

As a society, we must ensure that services and social supports are available to victims of physical and sexual violence. As professionals, we must learn and be willing to appropriately assess all forms of victimization early on with our clients. Training and education of practitioners in the use of assessment strategies and intervention skills are crucial. Asking sensitive questions in a safe environment may help victims disclose these deeply personal and life-changing experiences.

Downloaded from vaw.sagepub.com at PENNSYLVANIA STATE UNIV on September 18, 2016

Finally, as policy advisors and makers, we must strive to eliminate the barriers erected at all levels of service provision so that survivors receive the interventions needed and perpetrators are held accountable for the havoc they created. Women survive abuse, but they are more likely to do so when we are equipped with the knowledge of what is helpful to them—personally and organizationally—in the aftermath of the violence.

References

Adams, A. E., Sullivan, C. M., Bybee, D., & Greeson, M. R. (2008). Development of the Scale of Economic Abuse. *Violence Against Women, 14*, 563-588.

Allard, M. A. (1997). *In harm's way? Domestic violence, AFDC receipt, and welfare reform in Massachusetts*. Boston: University of Massachusetts at Boston.

Berk, R. A., Newton, P. J., & Berk, S. F. (1986). What a difference a day makes: An empirical study of the impact of shelters for battered women. *Journal of Marriage and the Family, 48*, 481-490.

Briere, J. (1992). *Child abuse trauma: Theory and treatment of the lasting effects*. Newbury Park, CA: Sage.

Brown, J. (1997). Working toward freedom from violence. *Violence Against Women, 3*, 5-26.

Browne, A. (1999). The impact of recent partner violence on poor women's capacity to maintain work. *Violence Against Women, 5*, 393-426.

Browne, A., & Bassuk, S. (1997). Intimate violence in the lives of homeless and poor housed women: Prevalence and patterns in an ethnically diverse sample. *American Journal of Orthopsychiatry, 67*, 261-278.

Browne, A., Miller, B., & Maguin, E. (1999). Prevalence and severity of lifetime physical and sexual victimization among incarcerated women. *International Journal of Law and Psychiatry, 22*, 301-322.

Bybee, D., & Sullivan, C. M. (2005). Predicting re-victimization of battered women 3 years after exiting a shelter program. *American Journal of Community Psychology, 36*, 85-96.

Campbell, R. (1998). The community response to rape: Victims' experiences with the legal, medical, and mental health systems. *American Journal of Community Psychology, 26*, 355-379.

Campbell, R., & Raja, S. (1999). Secondary victimization of rape victims: Insights from mental health professionals who treat survivors of violence. *Violence and Victims, 14*, 261-275.

Campbell, R., Sefl, T., Barnes, H. E., Ahrens, C., Wasco, S. M., & Zaragoza-Diesfeld, Y. (1999). Community services for rape survivors: Enhancing psychological well-being or increasing trauma? *Journal of Consulting and Clinical Psychology, 67*, 847-858.

Cattaneo, L. B., Stuewig, J., Goodman, L., Kaltman, S., & Dutton, M. A. (2007). Longitudinal helpseeking patterns among victims of intimate partner violence: The relationship between legal and extralegal services. *American Journal of Orthopsychiatry, 77*, 467-477.

Coker, A. L., Smith, P. H., Bethea, L., King, M. L., & McKeown, R. E. (2000). Physical health consequences of physical and psychological intimate partner violence. *Archives of Family Medicine, 9*, 451-457.

Coker, A. L., Smith, P. H., Thompson, M. P., McKeown, R. E., Bethea, L., & Davis, K. E. (2002). Social support protects against the negative effects of partner violence on mental health. *Journal of Women's Health & Gender-based Medicine, 11*, 465-476.

Cox, J. W., & Stoltenberg, C. D. (1991). Evaluation of a treatment program for battered wives. *Journal of Family Violence, 6*, 395-413.

Curcio, W. (1998, October 26). *Planning research from the inside: Domestic violence in a welfare-to-work program*. Retrieved March 25, 1999, from http://www.ssw.umich.edu/trapped/curcio.html

Downloaded from vaw.sagepub.com at PENNSYLVANIA STATE UNIV on September 18, 2016

Davis, L. V., & Srinivasan, M. (1995). Listening to the voices of battered women: What helps them escape violence. *Affilia, 10*, 49-69.

Fortune, M. (2001). Religious issues and violence against women. In C. M. Renzetti, J. L. Edleson, & R. K. Bergen (Eds.), *Sourcebook on violence against women* (pp. 371-385). Thousand Oaks, CA: Sage.

Gillum, T. L., Sullivan, C. M., & Bybee, D. I. (2006). The importance of spirituality in the lives of domestic violence survivors. *Violence Against Women, 12*, 240-250.

Gordon, J. S. (1996). Community services for abused women: A review of perceived usefulness and efficacy. *Journal of Family Violence, 11*, 315-329.

Ham-Rowbottom, K. A., Gordon, E. E., Jarvis, K. L., & Novaco, R. W. (2005). Life constraints and psychological well-being of domestic violence shelter graduates. *Journal of Family Violence, 20*, 109-121.

Hart, B. (1993). The legal road to freedom. In M. Hansen & M. Harway (Eds.), *Battering and family therapy* (pp. 13-28). Newbury Park, CA: Sage.

Henning, K. R., & Klesges, L. M. (2002). Utilization of counseling and supportive services by female victims of domestic abuse. *Violence and Victims, 17*, 623-636.

Horton, A. L., & Johnson, B. L. (1993). Profile and strategies of women who have ended abuse. *Families in Society, 74*, 481-492.

Humphreys, C., & Thiara, R. (2003). Mental health and domestic violence: "I call it symptoms of abuse." *British Journal of Social Work, 33*, 209-226.

Hutchison, I. W., & Hirschel, J. D. (1998). Abused women: Help-seeking strategies and police utilization. *Violence Against Women, 4*, 436-456.

Koss, M. P., & Oros, C. J. (1982). Sexual experiences survey: A research instrument investigating sexual aggression and victimization. *Journal of Counseling and Clinical Psychology, 50*, 455-457.

Lidman, R. M. (1995). *The family income study and Washington's welfare population: A comprehensive review* (*Executive summary*). Washington, DC: Institute for Public Policy.

Lloyd, S. (1997). *Domestic violence and women's employment*. Retrieved January 24, 2000, from http://www.nwu.edu/IPR/publications

Macy, R. J., Nurius, P. S., Kernic, M. A., & Holt, V. L. (2005). Battered women's profiles associated with service help-seeking efforts: Illuminating opportunities for intervention. *Social Work Research, 29*, 137-150.

Mancoske, R. J., Standifer, D., & Cauley, C. (1994). The effectiveness of brief counseling services for battered women. *Research on Social Work Practice, 4*, 53-63.

National Comorbidity Survey. (1992). Retrieved February 16, 2003, from www.hcp.med.harvard.edu/ncs

Postmus, J. L. (2000). Analysis of the family violence option: A strengths perspective. *Affilia, 15*, 244-258.

Postmus, J. L. (2003). Valuable assistance or missed opportunities? Shelters and the family violence option. *Violence Against Women, 9*, 1278-1288.

Postmus, J. L. (2007). Challenging the negative assumptions surrounding civil protection orders: A guide for advocates. *Affilia, 22,* 347-356.

Postmus, J. L., & Severson, M. (2006). *Violence and victimization: Exploring women's histories of survival*. Washington, DC: U.S. Department of Justice, Office of Justice Programs, National Crime Justice Reference Service.

Raphael, J. (1999). Keeping women poor: How domestic violence prevents women from leaving welfare and entering the world of work. In R. A. Brandwein (Ed.), *Battered women, children and welfare reform: The ties that bind* (pp. 31-43). Thousand Oaks, CA: Sage.

Riger, S., Ahrens, C., & Blickenstaff, A. (2000). Measuring interference with employment and education reported by women with abusive partners: Preliminary data. *Violence and Victims, 15*, 161-172.

Russell, D. E. H., & Bolen, R. M. (2000). *The epidemic of rape and child sexual abuse in the United States*. Thousand Oaks, CA: Sage.

Sanders, C. K., & Schnabel, M. (2006). Organizing for economic empowerment of battered women: Women's savings accounts. *Journal of Community Practice, 14*(3), 47-68.

Downloaded from vaw.sagepub.com at PENNSYLVANIA STATE UNIV on September 18, 2016

Severson, M., Berry, M., & Postmus, J. L. (2007). Risks and needs: Factors that predict women's incarceration and inform service planning. In R. Sheehan (Ed.), *What works with women offenders* (pp. 355-374). Devon, UK: Willan.
Severson, M., Postmus, J. L., & Berry, M. (2005). Incarcerated women: Consequences and contributions of victimization, risk, and resiliency. *International Journal of Prisoner Health, 1*, 223-240.
Shepard, M. F., & Campbell, J. A. (1992). The Abusive Behavior Inventory: A measure of psychological and physical abuse. *Journal of Interpersonal Violence, 7*, 291-305.
Strube, M. J. (1988). The decision to leave an abusive relationship: Empirical evidence and theoretical issues. *Psychological Bulletin, 104*, 236-250.
Sullivan, C. M., & Bybee, D. I. (1999). Reducing violence using community-based advocacy for women with abusive partners. *Journal of Consulting and Clinical Psychology, 67*, 43-53.
Sullivan, C. M., Campbell, R., Angelique, H., Eby, K. K., & Davidson, W. S. (1994). An advocacy intervention program for women with abusive partners: Six-month follow-up. *American Journal of Community Psychology, 22*, 101-122.
Sullivan, C. M., Tan, C., Basta, J., Rumptz, M., & Davidson, W. S. (1992). An advocacy intervention program for women with abusive partners: Initial evaluation. *American Journal of Community Psychology, 20*, 309-332.
Thompson, M. P., Kaslow, N. J., Kingree, J. B., Rashid, A., Puett, R., Jacobs, D., et al. (2000). Partner violence, social support, and distress among inner-city African American women. *American Journal of Community Psychology, 28*, 127-143.
Tolman, R. M., & Raphael, J. (2000). A review of research on welfare and domestic violence. *Journal of Social Issues, 56*, 655-682.
Tolman, R. M., & Rosen, D. (2001). Domestic violence in the lives of women receiving welfare: Mental health, substance dependency and economic well-being. *Violence Against Women, 7*, 141-158.
Tutty, L. M., Bidgood, B. A., & Rothery, M. A. (1993). Support groups for battered women: Research on their efficacy. *Journal of Family Violence, 8*, 325-343.
Ullman, S. E. (1996). Social reactions, coping strategies, and self-blame attributions in adjustment to sexual assault. *Psychology of Women Quarterly, 20*, 505-526.
Weisz, A. N. (1999). Legal advocacy for domestic violence survivors: The power of an informative relationship. *Families in Society, 80*, 138-147.
Weisz, A. N., Tolman, R. M., & Bennett, L. (1998). An ecological study of nonresidential services for battered women within a comprehensive community protocol for domestic violence. *Journal of Family Violence, 13*, 395-415.
Yoshihama, M., Hammock, A. C., & Horrocks, J. (2006). Intimate partner violence, welfare receipt, and health status of low-income African American women: A lifecourse analysis. *American Journal of Community Psychology, 37*, 95-109.
Zorza, J. (1991). Woman battering: A major cause of homelessness. *Clearinghouse Review, 25*, 421-429.
Zweig, J. M., & Burt, M. R. (2007). Predicting women's perceptions of domestic violence and sexual assault agency helpfulness: What matters to program clients? *Violence Against Women, 13*, 1149-1178.

Judy L. Postmus, PhD, ACSW, is an assistant professor and director of the Center on Violence Against Women & Children at Rutgers University School of Social Work, New Brunswick, New Jersey.

Margaret Severson, JD, MSW, is an associate professor in the School of Social Welfare at the University of Kansas, Lawrence.

Marianne Berry, PhD, ACSW, is a professor in the School of Social Welfare at the University of Kansas, Lawrence.

Jeong Ah Yoo is a doctoral student at Rutgers University, School of Social Work, New Brunswick, New Jersey.

For reprints and permissions queries, please visit SAGE's Web site at http://www.sagepub.com/journalsPermissions.nav.

Downloaded from vaw.sagepub.com at PENNSYLVANIA STATE UNIV on September 18, 2016