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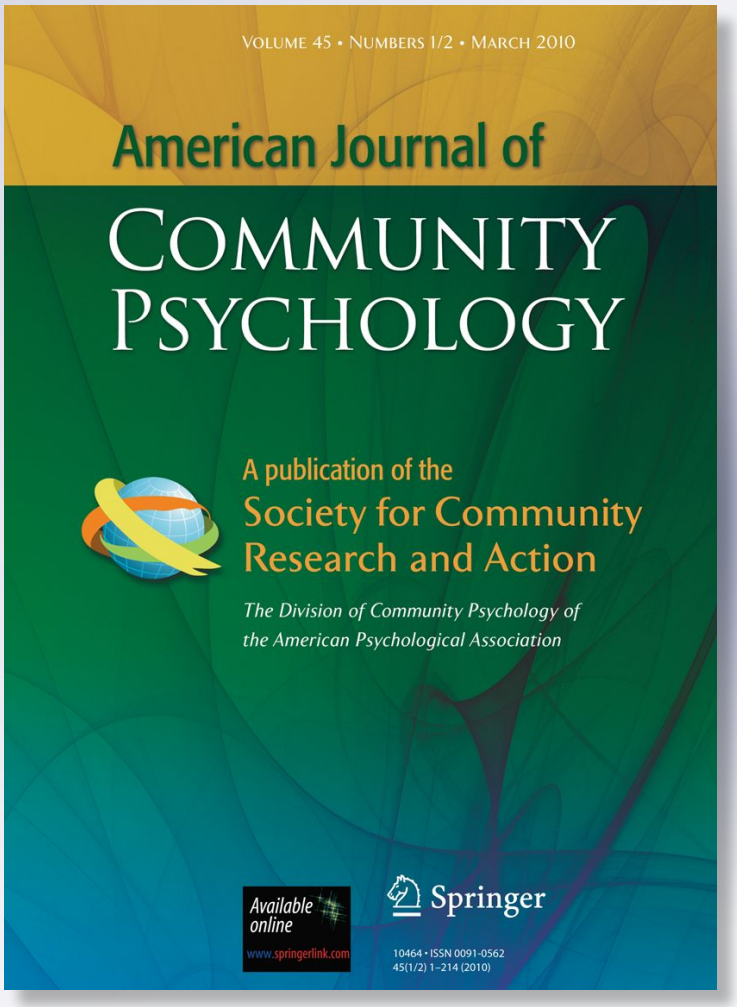
American Journal of Community Psychology

ISSN 0091-0562

Am J Community Psychol
DOI 10.1007/s10464-012-9494-x



Springer

Am J Community Psychol
DOI 10.1007/s10464-012-9494-x

ORIGINAL PAPER

A Model of Sexually and Physically Victimized Women's Process of Attaining Effective Formal Help over Time: The Role of Social Location, Context, and Intervention

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Abstract As empirical evidence has demonstrated the pervasiveness of sexual assault and intimate partner violence in the lives of women, and the links to poor mental health outcomes, attention has turned to examining how women seek and access formal help. We present a conceptual model that addresses prior limitations and makes three key contributions: It foregrounds the influence of social location and multiple contextual factors; emphasizes the importance of the attainment of effective formal help that meets women's needs and leads to positive mental health outcomes; and highlights the role of interventions in facilitating help attainment. We conclude with research and practice implications.

Keywords Sexual assault · Intimate partner violence · Help-seeking · Social location · Cumulative victimization · Intervention

Sexual assault (SA) and intimate partner violence (IPV) have severe deleterious effects on women's mental and physical health (Kilpatrick and Acierno 2003; Koss et al. 2003). Sexual assault victims are at increased risk of experiencing mental health problems such as depression and suicidality, physical health problems such as stomach and back pain, and substance abuse (Briere and Jordan 2004; Campbell et al. 2008; Ullman 2004). Approximately one-quarter to one-third of rape survivors develop post-traumatic stress disorder (PTSD) during their lifetime (Keane et al. 2006; Kilpatrick et al. 1992). Intimate partner violence is likewise linked to serious mental and physical health consequences, including substance use, chronic disease such as hypertension, and ongoing mental illness (Coker et al. 2002; O'Campo et al. 2006; Sutherland et al. 2001). Golding's (1999) meta-analysis of IPV and associated effects among women indicates high rates of depression (48%, in samples from the general population) and PTSD (64%, in shelter samples; general population samples were not available).

Social location, or one's position within intersecting systems of stratification such as socioeconomic status (SES), race/ethnicity, and gender (Kubiak 2005; Pearlin 1989), influences the likelihood of being sexually and physically victimized. Poor and low-income women of color including African Americans, Native Americans, Asian Americans, and Latinas, face heightened risk of both victimization and the resulting mental health sequelae (Campbell et al. 2008; Evans-Campbell et al. 2006; Ramos and Carlson 2004; Sokoloff and Dupont 2005; West 2004; Wood and Magen 2009; Yuan et al. 2006), which in turn contribute to mental health disparities (U. S. Department of Health and Human Services 2001). This increased risk in adulthood is due, at least in part, to higher rates of co-occurring sexual and physical victimization among poor and low-income female youths of color (Finkelhor et al. 2007; Kennedy 2008; Turner et al. 2006). Victimization prior to turning 18 has been demonstrated to predict sexual revictimization in adulthood (Arata 2002; Breitenbecher 2001; Classen et al. 2005; Messman-Moore and Long 2003; Siegel and Williams 2003) as well as IPV (Campbell and Soeken 1999; Carlson et al. 2003; Seedat et al. 2005; Whitfield et al. 2003), with cumulative victimization across

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Published online: 31 January 2012

the life course associated with elevated risk for poor mental health outcomes compared to single victimization (Astin et al. 1995; Bennice et al. 2003; Cole et al. 2005; Pimlott-Kubiak and Cortina 2003).

As empirical evidence has demonstrated the pervasiveness of sexual and physical victimization in the lives of women, and the association with poor mental health outcomes, attention has turned to examining how women seek and access formal help from different sources, including community-based service providers in areas such as mental health, safety needs related to victimization, material resources (e.g., housing, employment, food, cash assistance, child care), substance abuse, and health care (Allen et al. 2004; Campbell et al. 2001; Sullivan 2010). Effective help from formal providers can significantly reduce distress and negative interpersonal interactions among rape survivors (Campbell 2006) as well as the likelihood of revictimization among IPV survivors (Bybee and Sullivan 2002; Sullivan and Bybee 1999). In the field of SA, research has focused on the process of seeking and receiving help post-rape, and the ways that women may experience secondary victimization from the medical, legal, and mental health systems, with secondary victimization understood to exacerbate women's PTSD (Campbell 2008). In the area of IPV, researchers have focused on women's perceived barriers to obtaining help, and women's attempts at help-seeking (both typically examined retrospectively), while paying little attention to empirically examining women's actual *attainment* of effective services that meet their self-identified needs. For example, Liang et al. (2005) model of help-seeking among women who have experienced IPV is an important contribution to the literature, as it focuses on problem definition and appraisal, the decision to seek help, and the selection of a help provider, while emphasizing the critical role of sociocultural factors as well as the feedback loops that characterize the process. However, it does not conceptualize the receipt of help, or the degree to which women's needs are met and positive outcomes are facilitated, as part of the help-seeking process. Further, research on help-seeking in both fields typically does not incorporate an understanding of how social location, cumulative victimization, and co-occurring stressors and life events may influence what women's self-identified needs are, their attempts to obtain effective help, and their mental health.

In an effort to bridge this gap, we have developed a model of help-seeking and attainment among sexually and physically victimized women that makes three key contributions: (1) It foregrounds the influence of social location, cumulative victimization and adversity, community setting, and the developmental/situational context; (2) Emphasizes the importance of examining the *attainment* of effective formal help that meets women's needs and thus facilitates positive mental health outcomes; and (3) Highlights how interventions can facilitate the attainment of help within a variety of domains and promote positive mental health outcomes among women who have experienced sexual and/or physical victimization. Our model builds on the strengths of Andersen's (1995) Behavioral Model of Access to Health Care (see also Gelberg et al. 2000) while incorporating elements especially germane to women who are survivors of violence. Andersen's influential model (1995) depicts the use of health services, and a person's resultant health status, as outcomes predicted by predisposing characteristics such as demographic and social structural elements like ethnicity, as well as personal beliefs about health and the health care system, that act as barriers to access; enabling resources, understood as factors at the individual, interpersonal, family, community, or organizational level that facilitate access; and need, or a person's subjective perceptions about her/his level and type of health need. Gelberg et al. (2000) model expands on Andersen's approach by including a more detailed understanding of vulnerable population's possible predisposing characteristics and enabling factors. Predisposing vulnerable characteristics include acculturation level, residential patterns including homelessness, victimization history, and involvement with the criminal justice system, while enabling vulnerable resources include such factors as receipt of public benefits, availability of resources in the community, and a lack of barriers to access to health care.

Our model of help attainment builds on these broad frameworks while incorporating elements from Liang et al. (2005) model of IPV survivors' help-seeking process, as well as highlighting the importance of social location, multiple contextual factors, and cumulative victimization. Additionally, we emphasize the role of interventions as enabling factors that facilitate access to multiple forms of effective help and promote positive mental health outcomes among women who are survivors of sexual and/or physical violence (see Fig. 1). The figure illustrates our model of the help attainment process over time; it is meant to be a conceptual, heuristic model rather than one that depicts statistical relationships (e.g., path or structural equation models, mediation or moderation models) or follows the conventions of system dynamics or stock and flow modeling. The individual-level help attainment process is embedded within and fundamentally influenced by the contextual factors of social location, prior cumulative adversity and victimization, the community context and availability of resources, and the developmental/situational context. That is, these contextual factors shape each step of the process of survivors attaining help. The first two components of the process, perceived availability of help/fit and appraisal of needs, are understood to co-occur and be reciprocally influential. While the help attainment steps are depicted as progressing from left to right, the feedback

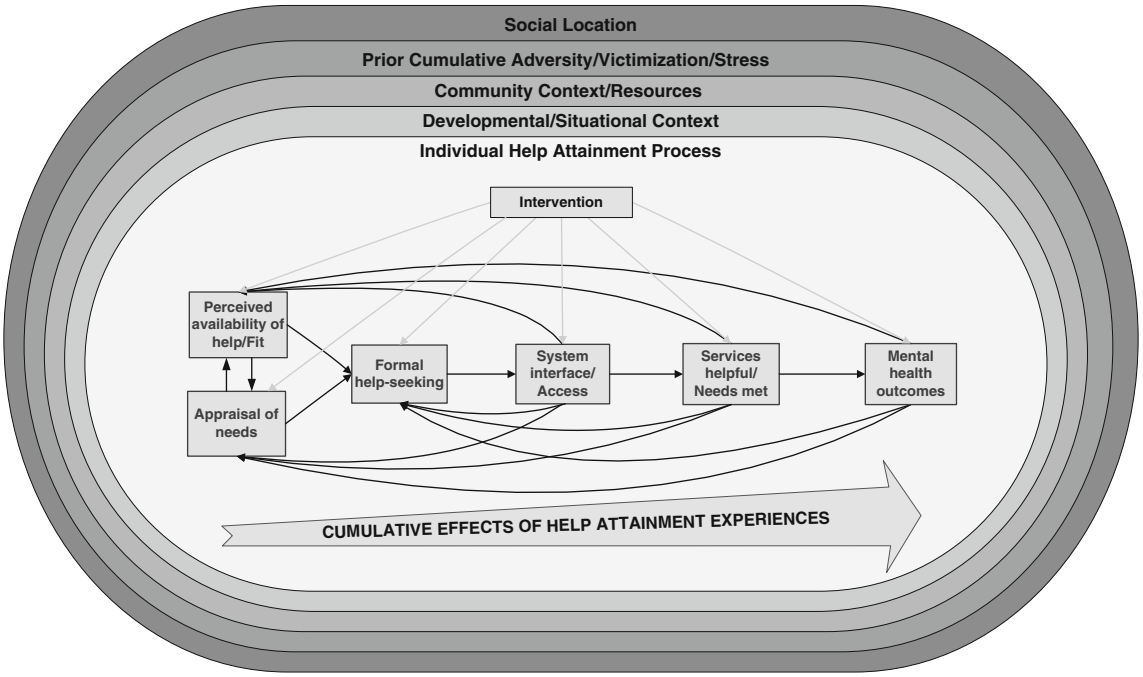

Fig. 1 Conceptual model of help attainment process

arrows are used to highlight the ways in which experiences at any stage of the process can in turn influence future attempts to secure formal help. For example, if a woman accesses formal help but finds that the services are not helpful and her needs are not met, in the future when she is appraising her current needs and assessing the availability of help from her point of view, she may be more likely to decide not to seek help because of what happened during that prior interface with formal services. The large arrow along the bottom of the process depicts how these negative experiences are conceptualized as accumulating or "snowballing" over time, thus creating further barriers to the attainment of effective help for survivors of physical or sexual violence. As depicted by the figure, intervention that facilitates help attainment and positive mental health outcomes can take place at any stage of the process. Our model makes a significant contribution to the literature on seeking help among SA and IPV survivors, and can be used to guide research and practice. The following sections further detail the components of the model. We conclude with a discussion of research and practice implications.

Contextual Variables as Barriers or Enabling Factors

Social Location, Cumulative Victimization, and Adversity

Social location fundamentally affects our lives. It shapes our access to resources and opportunities and plays a critical role in influencing exposure to different forms of sexual and physical victimization, negative life events, and chronic stressors, all of which are linked to disparities in mental health outcomes (Aneshensel et al. 1991; Snowden and Yamada 2005). People of color who are poor or low-income are disproportionately likely to experience negative life events and chronic stressors, including discrimination and stigma, with poverty itself understood as a chronic stressor (Belle 1990; Turner 2003; Turner and Avison 2003; Williams et al. 1997). Negative life events and chronic stressors are dynamically interactive and mutually influential: Each provides the context for the other and shapes a person's interpretation of said events and stressors (Pearlin 1989). Higher rates of exposure to negative life events and chronic stressors predict higher rates of mental health problems, such as depression, PTSD, and psychological distress, and reduced well-being (Grote et al. 2007; Kessler 1997; Lloyd and Turner 2003; Turner 2003; Williams et al. 1997).

Women, relative to men, appear to be especially likely to develop mental health problems such as depression and PTSD (Aneshensel et al. 1991; Belle 1990; Lloyd and Turner 2003; Tolin and Foa 2006; Turner and Avison 2003), with women's higher rate of sexual victimization—and the negative reactions it may engender—as well as severe forms of co-occurring violence across the life course understood as key contributors to this elevated risk for negative mental health sequelae (Campbell et al. 2008; Pimlott-Kubiak and Cortina 2003; Starzynski et al. 2005). Among women who have experienced sexual and

physical victimization, social location is both a predictor of heightened risk for exposure to violence and a powerful contributor to ongoing stressors such as poverty or homelessness, as well as negative life events such as the death of a family member or time in jail (Eby 2004; Kubiak 2005; Rayburn et al. 2005). In turn, women's experiences with cumulative sexual and physical victimization interact with chronic stressors like poverty, discrimination, and social isolation to exacerbate mental health outcomes (Campbell et al. 2008; Evans-Campbell et al. 2006; Goodman et al. 2009; Pimlott-Kubiak and Cortina 2003; West 2004).

As Andersen (1995) and Gelberg et al. (2000) note, social location also limits access to community service providers able to offer help. People of color with low SES face barriers to effective care including lack of culturally competent services, experiences with discrimination, and lack of health insurance (Snowden and Yamada 2005). Poor women of color who have experienced sexual and physical victimization are especially likely to face barriers to effective help (Ahrens et al. 2010; Eby 2004; Goodman et al. 2009; Kaukinen and DeMaris 2009; Sabina et al. 2011). For example, IPV survivors seeking services may face stereotypes that impede their access, such as the perception of South Asian women as passive, or the popular image of African American women as aggressive; these prejudices, in combination with services that do not appropriately address the material needs of low-income women, can present substantial barriers to the attainment of effective help (Dasgupta 2005; Sokoloff and Dupont 2005). Other vulnerable groups, such as poor women of color in abusive same-sex relationships, may face additional damaging stereotypes about their experiences that further limit their ability to obtain help (Hardesty et al. 2011). As a result, many low-income women of color who have experienced domestic violence will not seek formal help, instead relying on friends and family members (Ahrens et al. 2010; O'Campo et al. 2002). This is especially striking given that poor women of color are more likely than their White middle-income counterparts to experience severe IPV (West 2004). Likewise, White women are significantly more likely than women of color to seek help from formal service providers after experiencing SA (Amstadter et al. 2008). African American women, in particular, may experience negative, disbelieving reactions when they seek help, based on stereotypes about their supposed sexual availability (Ullman and Filipas 2001).

Community Context

The community context, particularly the availability and accessibility of both informal and formal resources, also shapes the process of seeking and obtaining effective help. Community problems tend to cluster together: High rates of neighborhood and family violence are associated with concentrated poverty, reduced social capital and collective efficacy, and limited resources and formalized service providers (Coulton et al. 2007; Sampson et al. 2002). As a result, people residing in these communities who have experienced trauma may face limited options for suitable care, and a fundamental lack of ecological fit when they do access help (Harvey 1996). Particularly among extremely poor women of color with extensive histories of cumulative sexual and physical victimization and high levels of need, such as women re-entering the community after leaving prison or jail, the community context plays a critical role in shaping the process of obtaining material resources as well as mental health services (Green et al. 2005). In many of these communities, social and economic disadvantage is the norm: With limited economic infrastructure in place, high unemployment and community crime, and a paucity of formalized service providers, the challenge of obtaining effective help is daunting (O'Brien 2006). Low-income rural women seeking help after SA or IPV, in particular Native women living on reservations, face additional hardship as they navigate limited, hard-to-reach resources and community values that include disapproval and blame aimed at survivors (Logan et al. 2005; Wahab and Olson 2004; Weaver 2009).

The cultural aspects of a community additionally influence sexually and physically victimized women's options when they attempt to access help. Cultural beliefs about SA or IPV may hinder the acknowledgment of the victimization of women in these communities, thus limiting the services available and stigmatizing women seeking help (Ahrens et al. 2010; Liang et al. 2005; Lindhorst and Tajima 2008). For example, Mexican–American women report that cultural values emphasizing family unity, traditional gender roles, and a taboo against sharing family secrets can lead to victim-blaming and barriers to disclosing and seeking help among those who have experienced sexual or physical violence (Ahrens et al. 2010). On the other hand, community-based, indigenous, holistic services may provide victimized women with effective help in addressing their multiple needs and serve as a gateway to other resources in the community (Goodman et al. 2005; Sokoloff and Dupont 2005). Examples of successful community-based approaches include local African American church involvement in fostering dialogue about IPV, engaging in monitoring of service provision within the community, and providing advocacy for survivors of violence (West 2005); and the development of a IPV hotline for Korean American women, which directly challenged cultural norms about the primacy of family harmony, shame, and respect for male authority and became a critical resource for women in the community (Park 2005).

Developmental and Situational Context

Life course theory, with its examination of the role of cumulative adversity over the course of people's lives, provides the framework for conceptualizing the influence of the developmental context on the process of seeking and accessing help. The life course approach emphasizes the dynamic, contextualized nature of development, and the importance of transitions and trajectories that demarcate the life course. Different forms of adversity, such as victimization, chronic stressors, negative life events, and discrimination, are understood to accumulate differentially over time—based largely on social location—leading to diverging trajectories and increasing health disparities (Hatch 2005; O'Rand 2002). Transitions, in which people's roles and statuses change such as becoming a parent, immigrating to a new country, leaving an abusive partner, or re-entering the community after serving time in jail, are typically times of increased vulnerability to stress (Hutchison 2003; McLeod and Almazan 2006). Indeed, the transition from adolescence to young adulthood is marked by heightened risk for both victimization and the onset of mental health disorders (Turner and Lloyd 1995). Thus, a woman's developmental stage in the life course influences her experience of stress and cumulative adversity, while shaping her needs as well as her options for accessing help. Transitional periods may also be times of increased receptivity to interventions that promote positive change; in this sense, the developmental context can be viewed as a facilitator of enabling or protective resources (Hatch 2005; Kennedy et al. 2010).

There are multiple situational context factors that influence the process of seeking and obtaining effective formal help among women who have been sexually or physically victimized. Factors that have received empirical support include a woman's relationship to the perpetrator (e.g., stranger vs. intimate partner rape), the perceived severity of the victimization, the presence of children, and her immediate context (e.g., residing in a domestic violence shelter). Research on SA survivors' likelihood of disclosing and seeking help indicates that situational circumstances that represent the stereotypical "classic rape" scenario, particularly a stranger as the perpetrator, positively influence help-seeking (Clay-Warner and McMahon-Howard 2009; Kaukinen 2004; Starzynski et al. 2005). Multiple studies have found a relationship between IPV severity and help-seeking, such that as the severity worsens, the likelihood of formal help-seeking increases (Barrett and St. Pierre 2011; Macy et al. 2005; Nurius et al. 2011). Children also appear to play a role: Research suggests that the presence of children in the home, as IPV witnesses or victims themselves, is also a significant predictor of women seeking help (Hardesty et al. 2011; Meyer 2010); at least one study of SA survivors' help-seeking indicates a similar relationship between the presence of children and the decision to seek help post-rape (Ullman and Filipas 2001). Finally, researchers who have studied patterns of seeking help among IPV survivors have found that shelter residence is an important positive predictor of women's usage of social and legal services, which tend to co-occur over time (Cattaneo et al. 2007).

The Process of Seeking and Obtaining Effective Help in Dynamic Interplay with Contexts and Time

Appraisal of Needs and Availability of Help

The first step in the process involves the appraisal of needs, concomitant with an assessment of the availability of help and its fit with self-identified needs. The needs appraisal stage is complex, involving the problem definition, socially and culturally-influenced beliefs about the problem, and the costs and benefits of accessing help. Particularly for sexually and physically victimized women who are poor, facing multiple unmet needs, and in a stressful transitional period in their lives, defining the problem can be very complicated. Women may define their most pressing problem as a need for basic material resources such as housing, employment, clothing, and food, with victimization-related mental health services less of an immediate priority (Eby 2004; Goodman et al. 2009; Kubiak and Arfken 2006). However, women who appraise their IPV as a severe threat, and have diminished informal social networks as well as poor mental and physical health, are more likely to seek help (Macy et al. 2005).

Beliefs about mental health problems and treatment, as well as specific ideas related to victimization, influence the needs appraisal process as well and may pose barriers to seeking help. These ideas are influenced by the community context as well as by personal experiences over time. In examining why African Americans and Latina/os have higher rates of unmet mental health needs compared with Whites, researchers have focused on several factors such as prior discrimination by mental health providers, negative beliefs about mental health including discomfort in discussing personal matters, social stigma related to being identified as having a mental health problem, and distrust of formalized mental health providers (Diala et al. 2000; Ojeda and Bergstresser 2008; Vega et al. 2001, 2007). Women of color who have been sexually and physically victimized may harbor these beliefs, as well as ideas specific to sexual and physical violence, both of which may serve as barriers to seeking help. Women of color can face particular stigma related to being victimized, particularly if it occurs within the family or via an acquaintance: Stigma-related beliefs include

that they should "tough it out alone" and endure the violence; that women who are victimized are stupid and blameworthy, even deserving of the abuse; that violence within intimate relationships is normal and pervasive, so there is nothing that can be done; and that sexual and physical victimization are private matters, even shameful, that are best kept within the family (Alvidrez 1999; Bauer et al. 2000; Morrison et al. 2006; Petersen et al. 2004, 2009; Sabina et al. 2011; Weaver 2009).

For some women, the perceived costs of seeking help may outweigh the anticipated benefits (Liang et al. 2005). Women who have experienced IPV may fear the involvement of child protective services, the possibility of deportation, potential revictimization from service providers, and what the perpetrator might do should they seek help; women who have been victimized by African American intimate partners in particular may feel pressure to protect them from a racist criminal justice system (Fugate et al. 2005; Latta and Goodman 2005; Rhodes et al. 2010; Sokoloff and Dupont 2005). Women who have experienced SA may expect that they will be blamed, face negative reactions, or not be believed if they disclose the assault to formal service providers (Patterson et al. 2009). Finally, if women do make the decision to seek help related to victimization, they may be thwarted by a perceived lack of available, appropriate, culturally-congruent services in their communities. For example, women who do not speak English, who have criminal justice system involvement, who have substance abuse or severe mental health problems, and who have myriad unmet material needs may believe—rightfully so—that there are not services available that can effectively meet their needs (Donnelly et al. 1999; Goodman et al. 2009; Kubiak and Arfken 2006; Liang et al. 2005; Ramos and Carlson 2004; Sabina et al. 2011).

Seeking Formal Help

Women who have been sexually and physically victimized who do seek help are more likely to approach informal supports for help (e.g., friends and family members) rather than formal service providers, in part related to the barriers just described (Campbell 2008; Kaukinen 2004; Liang et al. 2005; Lipsky et al. 2006). Social location is influential: Women of color are less likely to seek help from service providers, compared to White women, with lower SES (particularly lower educational level) associated with reduced likelihood as well (Amstadter et al. 2008; El-Khoury et al. 2004; Kaukinen 2004; Lipsky et al. 2006). Community context also likely plays a role (Lindhorst and Tajima 2008), though this contextual factor has rarely been explored in the empirical work on victimization and formal help-seeking. Longitudinal examinations of help-seeking over time indicate that women who seek help from one source or provider are significantly more likely to be seeking help from other providers; in other words, seeking formal help is likely to co-occur over time among victimized women, with one form of help-seeking enabling access to other forms (Cattaneo et al. 2007; Goodman et al. 2005). As with the needs appraisal stage, women of color who are poor or low-income may face barriers during the help seeking stage. They may encounter inaccessible services, transportation or child care problems, or lack of program eligibility when they seek out formal service providers for help, particularly if they live in rural areas (Bauer et al. 2000; Kubiak and Arfken 2006; Latta and Goodman 2005; Logan et al. 2005; Macy et al. 2005; Rojas-Guyler et al. 2008).

Accessing and Receiving Effective Formal Help that Promotes Positive Mental Health Outcomes

Much less empirical work has been devoted to examining what happens when women who have been sexually and physically victimized manage to access and receive help via formal services: What are their experiences like? Are they able to receive help that effectively addresses their self-defined needs? Does effective service receipt result in positive mental health outcomes? These areas have been relatively unexplored to date, particularly in the field of IPV. Gordon (1996) reviewed twelve studies of victimized women's perceptions of the helpfulness of community services. She found that, though there was great variability in terms of perceived helpfulness, in general women identified staff's ability to listen respectfully and believe their story as key responses. More recent work by Zweig and Burt (2007) indicates that, among IPV survivors, feeling a sense of control as well as positive behaviors among staff are positively associated with perceived helpfulness; among SA survivors, only positive staff behavior was a significant predictor of perceived helpfulness. For both groups of women, positive staff behavior and a sense of control were positively associated, and negative staff behavior was inversely correlated, with their willingness to use services again. In this way, interface with a formal help provider may be not only ineffective in meeting current needs, but can also negatively influence a woman's future appraisal of needs, perceived availability of help, and formal help-seeking process.

Campbell's work on rape survivors' experiences with formal service providers (legal, medical, and mental health systems) indicates that sexually assaulted women frequently have traumatizing experiences with formal providers, especially within the legal and medical systems. Though survivors' experiences with mental health providers and rape crisis centers are generally perceived as more

helpful than their contact with legal and medical entities, 25–30% of women report that their experiences with these providers are not helpful, even hurtful (Campbell 2005, 2008; Campbell et al. 2001). Thus, experiences with formal service providers may result in secondary victimization and the exacerbation of PTSD or other problems such as depression, rather than resulting in positive mental health outcomes for women who have been raped (Campbell 2008; Ullman and Filipas 2001).

In the area of IPV research and practice, the scant empirical evidence suggests that women may be disbelieved, or their experiences minimized, when they self-disclose IPV to community service providers (Hardesty et al. 2011; Sullivan 1997). Women of color who are poor or low-income may face discrimination from providers related to their race/ethnicity, immigration status, or limited English proficiency (Bauer et al. 2000; McNutt et al. 2000; Richie and Kanuha 1993). Further, they may experience prejudice even within domestic violence service providers and shelters (Donnelly et al. 1999; Gillum 2008). Women who are poor may prioritize the attainment of material or tangible resources over victimization-related services. As a consequence, they oftentimes find that service providers do not meet their needs as they have defined them; they may resist identifying as "battered," never fully engage in the helping process, and terminate services before any mental health benefits have been realized (Eby 2004; Fugate et al. 2005; Gillum 2008; Goodman et al. 2009; O'Campo et al. 2002). Poor women of color with complex histories of victimization, chronic stressors, and negative life events, such as women returning to their communities after time in jail, report very high unmet needs up to a year after release: Services they do manage to obtain are frequently inadequate to meet their needs, promote positive mental health outcomes, and reduce their likelihood of re-arrest (Freudenberg et al. 2005; Green et al. 2005). These ineffective interfaces with formal service providers can influence future needs appraisal, perceived availability of help, and formal help-seeking (Liang et al. 2005); women may simply give up hope and stop seeking help from formal sources.

The Role of Interventions in Enabling Access to Multiple Forms of Help and Promoting Positive Mental Health Outcomes

While sexually and physically victimized women—particularly women of color who are poor or low-income—face many barriers to seeking and attaining effective help, well-designed interventions play a critical role in enabling access and promoting positive mental health outcomes. From a life course/cumulative adversity perspective, risks such as victimization, chronic life stressors, negative life events, social isolation, and poor mental health tend to cluster together and build strength over time (O'Rand 2002). These risk chains can be successfully interrupted and new life trajectories begun through effective intervention; times of transition are understood to be particularly amenable to intervention (Hatch 2005). Interventions, then, can be understood as facilitating important protective processes by interrupting risk chains, reducing the impact of risks, and promoting feelings of self-efficacy as well as opportunities that would not otherwise be available (Rutter 1987). From this perspective, a community-based intervention designed to effectively partner with SA or IPV survivors can not only serve as a critical source of support and help, but also act as a catalyst to enable access to other forms of help. For example, an IPV survivor might work with an advocate to define what her immediate needs are, assess what the fit is between her needs and what is available in her community, and then seek out sources of aid that address her self-defined needs.

In the area of service provision for sexual assault survivors, recent research has focused on empirically evaluating the effectiveness of interventions such as rape crisis center advocates and sexual assault nurse examiner programs (Campbell 2006). Advocates interface with the legal and medical systems on rape survivors' behalf, thus enabling more effective attainment of help. Advocates also work to ensure that survivors' needs will be met during the immediate aftermath post-SA, and help reduce the likelihood of secondary victimization by the medical and legal systems. In turn, survivors report less depression and guilt, and greater likelihood of seeking further help in the future (Campbell 2006). After experiencing SA, social support can be a key resource to aid in adaptive coping, buffer the negative effects of the assault, reduce self-blame, and provide useful resources (Kaukinen and DeMaris 2009; Patterson et al. 2009).

Similarly, recent work in the field of IPV has examined the effectiveness of an advocacy intervention for IPV survivors. The results from a community-based, randomized controlled trial with a 2-year longitudinal follow-up indicate that a brief advocacy intervention for IPV survivors was effective in reducing their risk of re-abuse and improving their access to community resources, quality of life, and level of social support over time (Bybee and Sullivan 2002; Sullivan and Bybee 1999). The advocacy intervention is holistic, client-driven (vs. services-, funding-, or diagnosis-driven), and strengths-based. Advocates partner with women who have experienced IPV and work with them to define what their needs are, seek help from multiple service providers, and obtain effective help that meets their self-defined needs (Sullivan 2003). The researchers hypothesize that the survivor-centered, holistic approach, with an emphasis on

both attainment of material resources and social support, fostered increased quality of life as well as feelings of control and self-efficacy, factors understood to contribute to positive mental health outcomes among sexually and physically victimized women (Bybee and Sullivan 2002; Frazier 2003; O'Neill and Kerig 2000).

Research and Practice Implications

Our model is heuristic, designed to foster new ways of thinking about research and practice in the areas of SA and IPV, seeking help, services provision, interventions, and mental health outcomes. Research efforts on these topics would benefit from greater focus on the influence of social location, cumulative victimization and adversity, the community setting, and the developmental/situational context. How do these different factors interact or interrelate to shape seeking and attaining help for survivors of SA and IPV? Does cumulative victimization impede seeking help or does it enable it via a higher rate of PTSD, which has been found to predict the odds of help-seeking among SA survivors (Amstadter et al. 2008)? How do the particular assets and challenges of the community context shape the help attainment process for women? Are young women disproportionately likely to fall through the cracks and fail to obtain effective help, given their heightened vulnerability to victimization and mental health problems (Turner and Lloyd 1995)? Additionally, as researchers we must begin to shift our attention from help-seeking to help attainment. While the process by which women decide to seek help, define their needs, and then attempt to obtain help are key, the actual interface with organizations as well as the effectiveness of the help received are just as important, if not more so. Critical questions in this area include: How do we adequately measure the effectiveness of help? Effective from whose point of view? What sorts of organizational and community-level changes are needed to facilitate the provision of more effective help for SA and IPV survivors? What are the mechanisms by which effective formal help shapes positive mental health outcomes?

Among practitioners working with women who have been victimized by sexual or physical violence, it is crucial to assess for prior cumulative victimization/adversity history in a detailed manner and develop clinical approaches that incorporate an understanding of the effects of cumulative victimization on mental health outcomes. Practitioners working in poor and low-income communities of color must develop effective outreach strategies to connect with women and build their trust in formal service providers. Once they have made a connection, they must work diligently to retain women by meeting their self-defined service needs, which may prioritize material resources, rather than imposing a clinical approach that is practitioner-driven (Sullivan and Bybee 1999). Particularly for women who have experienced sexual or physical victimization, a sense of control is paramount (Zweig and Burt 2007). Providers must be mindful of the developmental and situational characteristics that seem to influence seeking and attaining help, such as transitional periods, the severity of victimization, and the presence of children, and create services that acknowledge these contributing factors.

Finally, researchers must partner with community-based service providers to develop, implement, and evaluate interventions for women who have experienced SA or IPV. Much more work needs to be done to better understand how intervention efforts can facilitate women's decision to seek help, their access to effective services, and their positive mental health outcomes. For example, are interventions at the point of system interface most effective in fostering positive mental health outcomes, or does the appraisal of needs stage benefit most? Does this vary by form of victimization (e.g., SA vs. IPV)? How do particular interventions interact with participants' social location and cumulative victimization history, as well as the community setting, to influence seeking and attaining effective help? These are critical questions that research and practice in these areas can begin to address. For women who have experienced sexual or physical victimization, effective help that is grounded in strong conceptual and empirical understanding can make the difference between isolation, hopelessness, and mental health problems, and support, self-efficacy, and a sense of well-being.

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